

KIDS ARE DIFFERENT:
How Knowledge of Adolescent
Development Theory Can Aid
Decision-Making in Court

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Lourdes M. Rosado, Editor

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AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

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Juvenile Court Training Curriculum

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This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM
June 2000

Preface

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

- Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*
- Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*

Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*

Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*

Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a “tool kit” containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer -- is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

Executive Summary

The goal of Module One is for participants to develop a working knowledge of key aspects of adolescent development, and to learn how to apply this knowledge to their decision-making at critical junctures in the juvenile court process. Participants will gain an appreciation of how teenagers develop their cognitive skills, moral framework, social relations, and identity. This knowledge will aid juvenile court professionals in assessing each child at important stages in the juvenile court process, including intake, detention, waiver, adjudication and disposition. Specifically, an understanding of adolescent development will help court personnel to identify those factors that led to a particular child's involvement in the court system and what interventions are likely to be most effective for that child.

This Module focuses on five key areas of development: 1) cognitive, 2) moral, 3) identity and social, 4) biological, and 5) competence (mastery of skills) development. After participating in Module One, juvenile court personnel will be able to better answer the following questions:

Cognitive Development

- ! How do adolescents think?
- ! How does adolescent thinking differ from that of children and that of adults?
- ! How does adolescent thinking increase the likelihood of taking risks and engaging in undesirable behavior as compared to the thinking of children or adults?

Identity and Social Development

- ! How do adolescents develop an identity?
- ! What role do family, peers, and the larger community play in identity development?

Moral Development

- ! How do adolescents' concepts of right and wrong develop, and how are they expressed in adolescence?
- ! How do peers and the family influence an adolescents' moral reasoning?

Biological/Physical Development

- ! What are the major physical changes that occur during adolescence?
- ! How do these physical changes influence adolescent behavior?

Competence Development (Mastery of Skills)

- ! How do adolescents develop competence?
- ! How important is it for adolescents to feel competent in the eyes of their peers, their parents, and in their own eyes?
- ! What are some of the sources adolescents have for developing competence?

Table of Contents

I. INTRODUCTION	1
A. Goal of this module	1
B. Where in the law do we acknowledge that juveniles are different?	1
C. Adolescent development can help us understand how and why young people behave	1
D. Adolescent development is relevant to our daily practice	2
II. SOME BASIC FACTS ABOUT ADOLESCENT DEVELOPMENT	5
A. Research on adolescent development focuses on normative behavior	5
B. Adolescence provides a learner's permit to adulthood	5
C. Adolescents develop along different dimensions at different rates	6
D. Development in any domain is a gradual, non-linear process	6
E. Differences between individual adolescents in the rate of development	6
F. A single trait cannot indicate a juvenile's level of development	6
III. MAJOR AREAS OF ADOLESCENT DEVELOPMENT	7
A. Cognitive Development	7
B. Identity Development and Social Development	15
C. Moral Development	25
D. Biological/Physical Development	32
E. Competence Development (the mastery of skills)	35
Bibliography	38
Appendix A - CASE LAW RECOGNIZING THAT JUVENILES ARE DIFFERENT	A1
APPENDIX B - SMALL GROUP EXERCISE WORKSHEET	B1
APPENDIX C - CASE STUDIES FOR USE IN MODULE ONE EXERCISES	C1
APPENDIX D - SUGGESTIONS FOR MOVIES FOR AUDIOVISUAL AIDS	D1

I. INTRODUCTION

A. **Goal of this module.** The goal of the module is to give participants a working knowledge of key aspects of adolescent development – cognitive, moral, identity, social, biological, and competence (mastery of skills) development – to inform decision-making at critical junctures in the juvenile court process.

B. **Where in the law do we acknowledge that juveniles are different?** There are a number of areas in case law, the common law, and legislation in which the Supreme Court, lower courts and legislatures, respectively, have treated juveniles differently from adults based on the assumption that juveniles are developmentally different from adults.

Interactive Exercise:

Ask participants to generate a list of where in the law we recognize that juveniles are developmentally different from adults. Below is a sample.

1. **Outside of the Juvenile Justice System.**

a. Statutory age determinations passed by legislatures including: when juveniles can vote, buy alcohol and cigarettes, see X-rated movies, obtain tattoos or body piercing, sit on a jury, get married without parental permission, and seek medical treatment, including abortions, without parental permission; when juveniles must be in school; how many hours juveniles can work at different ages. *See Appendix A for relevant excerpts from case law.*

b. **The Treatment of Juvenile Status When Juveniles Make Contracts.** *See Appendix A for relevant excerpts from case law.*

2. **Within the Juvenile Justice System**

a. **Legislative Determinations of the Ages of Juvenile Court Jurisdiction.**

b. **The Treatment of Juvenile Status in Fifth Amendment Case Law.** *See Appendix A for relevant excerpts from case law.*

c. **Juveniles' Amenability to Treatment and Rehabilitation.** *See Appendix A for relevant excerpts from case law.*

d. **Juvenile court statutory schemes, common law principles, and accompanying case law that require decision-makers to take into account, *inter alia*, a juvenile's level of maturity in making decisions about where the juvenile will go in the system, including competence to stand trial/assist counsel, transfer to adult court, and in what kind of facility a juvenile shall be detained pending trial.**

C. **Adolescent development can help us understand how and why young people behave the way they do.** By understanding the cognitive, moral, identity, social, biological, and competence development of adolescents, we can make better judgments about how to handle youth who come to juvenile court. We can better understand what led to the behavior that got them to court, and make better decisions about what kinds of interventions are likely to be effective with them.

D. **Adolescent development is relevant to our daily practice in juvenile court.** As practitioners in juvenile court, we have a variety of goals: keeping our communities safe, holding young people accountable for their actions, and deterring delinquent behavior. At the same time, we recognize that adolescence is a time of great change in an individual's life, and that adolescents should not be held to the same standards as adults. Adolescent development enables us to understand the most significant influences in young peoples' lives, and to frame responses by the juvenile justice system in the most appropriate ways. **There are at least five decision points in the juvenile system where assessment of the individual adolescent** — and the way in which knowledge of development theory can help one to make that assessment -- **appear to be especially significant:** intake, detention, whether to proceed in juvenile or adult court, adjudication, and disposition.

1. **Intake.** When the police first take a juvenile into custody, in contrast to the procedure for adults, they usually bring the juvenile to an intake point where a probation officer or other intake staff persons makes an initial decision about how to proceed. The intake point may be at a probation department office, the juvenile detention center, a police station, or a location in the community. The intake person has several options, including releasing the juvenile to a parent, placing the juvenile in a community-based or other temporary residential setting, or confining the juvenile in the juvenile detention center. The intake person's knowledge and understanding of juveniles in general, the individual characteristics of the particular juvenile, and the circumstances of the alleged offense will play a large part in the decision. Intake staff may utilize information on the physical and psychological maturity of a youth, the influences of parents and peers, the competence of the youth to understand and follow the rules of a non-secure placement, and the amount of risk involved in releasing the youth into the community in determining whether to release the juvenile or detain him.

Interactive Exercise:
Ask a member of the audience to briefly describe the intake procedure in the jurisdiction, the key decisions that are made at this juncture, and the criteria used to make the decisions. Ask members of the audience who regularly perform intake to give examples of cases where aspects of adolescent development (i.e., size of the individual, his/her level of maturity or immaturity, the individual's susceptibility to peer pressure) strongly influenced the intake decision to divert or move forward with a petition.

2. **Detention.** The juvenile's first appearance in court usually occurs at a detention hearing. Like the intake person, the judge must decide whether to release the

juvenile to a parent, place the juvenile in a community setting, or hold the juvenile in secure detention. Juveniles in juvenile court do not have a constitutional right to bail, so the judge's decision to release or detain is usually determinative. The judge usually receives input from the probation department, and may also get information from the prosecutor and defense counsel (if one has been appointed or retained). Again, judges may utilize information on the physical and psychological maturity of a youth, the influences of parents and peers, the competence of the youth to understand and follow the rules of a non-secure placement, and the amount of risk involved in releasing

the youth into the community in determining whether to release the juvenile or detain him.

Interactive exercise:

Ask a judge in the audience to describe the criteria that s/he uses in determining whether to detain a child pre-trial. Ask the judge to give examples of cases where aspects of adolescent development (i.e., size of the individual, his/her level of maturity or immaturity, the individual's susceptibility to peer pressure) strongly influenced the detention decision to detain, release or release with conditions.

3. **Juvenile or adult court.** The decision whether a youth should be tried in adult criminal court is another critical point in the juvenile court process where developmental information may be useful. Depending upon the statutory framework in a jurisdiction, that decision may be made at a number of points. Traditionally, the decision is made by a judge after a motion by the prosecutor and an adversarial hearing. In an increasing number of jurisdictions, the choice is made solely by the prosecutor before proceedings

commence, as a decision to charge a youth in juvenile or adult court. See STATE RESPONSES TO SERIOUS AND VIOLENT JUVENILE CRIME (Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, July 1996). In still other jurisdictions, youth charged with certain offenses automatically start in adult court, but a judge may decide to send the youth to juvenile court after a hearing. Whenever the decision is made and whoever makes it, developmental and social information -- particularly on amenability to treatment, risk of re-offending, and assessment of physical, emotional, and cognitive development -- is useful to those responsible for making the decision.

Interactive exercise:

Ask a member of the audience to briefly describe the procedure in the jurisdiction by which juveniles are tried in court. Ask judges and/or prosecutors to give examples of cases where aspects of adolescent development (i.e., size of the individual, his/her level of maturity or immaturity, the individual's susceptibility to peer pressure) strongly influenced their decision to transfer or not transfer to adult court, or to direct file or not direct file in adult court.

4. **Adjudication.** The adjudication phase of juvenile court proceedings is analogous to trial in adult court, but here again there are important differences. Unlike adults, juveniles do not have a constitutional right to a jury trial, so the juvenile court judge is the trier of fact. Developmental theories that inform an

understanding of the juvenile's intent and culpability, and competence to stand trial may be critical to the judge's decision whether to sustain the charges or dismiss them.

5. **Disposition.** Finally, the disposition stage of juvenile court proceedings typically involves substantially more options than are available in adult court. With recommendations from the probation department and input from the prosecutor and defense counsel, the judge can impose a wide variety of sanctions, ranging from unsupervised release to parents to closely supervised probation or electronic monitoring, placement in a non-secure community program, placement in a secure residential program, or commitment to a locked correctional institution. Developmental information may assist all of the participants in the process in recommending appropriate disposition options.

II. SOME BASIC FACTS ABOUT ADOLESCENT DEVELOPMENT

- A. **Research on adolescent development focuses on what is normative or typical behavior rather than what is desirable behavior.**
1. **Developmental psychologists are concerned with describing and identifying behavior that is predictable or common for adolescents.** For psychologists, “normal” means “typical” or “common” or “predictable.” They focus on determining which behaviors are typical reactions to the many changes associated with adolescence. They do not focus on the value judgments necessary to determine whether these behaviors are desirable. **Example:** Experimentation with alcohol or marijuana is a common practice among adolescents, even though society neither views such behavior as desirable nor condones it.
 2. **Much of the behavior exhibited by delinquents is behavior that is not abnormal for adolescence.** We see unacceptable behavior, but it is typically the result of adolescent thinking, identity and morality struggles, etc., that are within the range of normal adolescent development. Behaviors such as experimenting with drugs, shoplifting, skipping school, and staying out late are common adolescent behaviors. More serious behaviors – such as driving while intoxicated, joining a gang, getting into fights – may result from misplaced priorities or immature judgment. Without minimizing the fact that an offense is unacceptable, we can recognize the processes that led up to it, and use that knowledge to develop programming that helps adolescents identify errors in their thought processes and see other options to their behavior.
 3. **Similarly, unlawful or unacceptable behavior may be maladaptive in the larger social context, but may seem logical to the adolescent in his or her particular contexts (e.g., the peer group or family).** Thus, vandalizing property may be illegal, but an adolescent may choose such behavior if it is the price of membership in a desired peer group such as a gang. Using drugs may not seem unacceptable to an adolescent if other members of his family regularly engage in such behavior.
 4. **The development we will be discussing in this module is normative or typical adolescent development.**
 5. In Module Four, we will discuss in detail the effects of abuse and trauma on adolescent development, specifically how these factors can lead to abnormal development.
- B. **Adolescence provides a learner’s permit to adulthood.** Adolescence is a time in which developing juveniles make mistakes and learn from them. All of us had to make mistakes and learn from them when we were young, and we should expect adolescents to do the same. Risky behavior (i.e., behavior that has a high probability of negative outcomes) is normal for adolescents.

- C. **Individual adolescents develop along different dimensions at different rates.** Adolescents mature in some respects before others, and maturity in one area or domain should not lead to the assumption of maturity in other domains. Throughout most of adolescence, individuals are like children in some ways and like adults in other ways. In this session, we are looking at adolescent development in a number of areas or domains:
1. cognitive (intellectual) development
 2. identity and social development
 3. moral development
 4. physical development
 5. competence development (mastery of skills)
- D. **Development in any domain is a gradual, non-linear process, with stops and starts and regressions.** No juvenile develops a particular capacity overnight.
- E. **There are great differences between individual adolescents in the rate of development in any single domain.** Thus, for example, two adolescents of the same chronological age may greatly differ in their level of cognitive or physical development.
- F. **It is impossible to assess a juvenile's level of development by looking at a single trait, such as size or chronological age, because there is significant variation among individuals in the rate (how fast change takes place) and pattern (in what order changes take place) of developmental change.** Similarly, a juvenile's level of development cannot be determined by simply looking at a single act of misbehavior. Developmental milestones are at best approximate, and are roughly organized around early adolescence (approximately ages 10-13), middle adolescence (14-18), and late adolescence (18-20).

III. MAJOR AREAS OF ADOLESCENT DEVELOPMENT

A. Cognitive Development

1. Questions this material should answer

- a. How do adolescents think?
- b. How does adolescent thinking differ from that of children and that of adults?
- c. How does adolescent thinking increase the likelihood of taking risks and engaging in undesirable behavior as compared to the thinking of children or adults?

2. Five major cognitive changes that occur during adolescence:

- a. **Possibilities.** Adolescents become better able than children to think about what is possible, instead of limiting thought to what is real. Children's thinking is oriented to the here and now and to things and events that they can observe directly. Adolescents develop the ability to generate alternative possibilities and explanations in a systematic manner, to compare what they actually observe with what they believe is possible, and to think hypothetically.
- b. **Abstraction.** Adolescents become better able to think about abstract concepts. Children's thinking is more bound to observable events and concrete objects — things that they can see, touch, and grasp in their hands. Adolescents begin to recognize that certain concepts are intangible and cannot be quantified or measured. For example, a young child will equate being religious to going to church every week. Adolescents begin to recognize that being religious depends to a large extent on what one believes, not just on what one does.
- c. **Thinking about thinking.** Adolescents begin thinking more about the process of thinking; they become more reflective. Adolescents are able to monitor their own thinking and to explain the processes they have used to get to a certain decision or act. Adolescents exhibit increased introspection, self-consciousness, and intellectualization.
- d. **Thinking in multiple dimensions.** Adolescents develop the ability to think about things in multiple ways at the same time. Children typically examine things one part at a time. Adolescents develop the capacity to approach problems with more sophisticated lenses, considering multiple dimensions and weighing those dimensions before taking a course of action.
- e. **Relativity.** Adolescents develop the ability to see things in relative terms, as opposed to absolute, black-or-white terms. They are more likely to question others' assertions and less likely to accept facts as absolute truths. Adolescents' belief that everything is relative can become so overwhelming that they become extremely skeptical.

-- BUT --

3. **THERE IS A DISTINCTION BETWEEN WHAT ADOLESCENTS ARE CAPABLE OF THINKING AND WHAT THEY ACTUALLY DO.** These cognitive capacities progressively become part of the young person's repertoire. But adolescents do not utilize these cognitive capacities consistently over time or over a variety of situations. Adolescents may have mature thought processes some times but not at others. Other characteristics of adolescent thinking as well as external factors can interfere with or compromise their ability to employ "adult-like" thinking and planning on a consistent basis. These characteristics/factors include:
 - a. **Risk-taking and sensation-seeking.**
 - (1) **Risk-taking behavior peaks in adolescence.**
 - (a) An adolescent may pursue a different course of action than an adult when confronted with the same situation -- even though the adolescent engages in a similar decision-making process of considering and evaluating different courses of actions and possible consequences -- because the adolescent puts a different value on various consequences than the adult does, or doesn't consider all the consequences. Thus, an adolescent may value the approval of peers more than the potential danger of engaging in illegal activity.
 - (b) *In court, you may see an adolescent who otherwise appears to be quite bright and responsible, but who nevertheless has engaged in behavior that is clearly unlawful and irresponsible. In such a situation, it is important to find out what other values are more important or relevant to the adolescent than obeying the law and acting in a responsible way.*
 - (2) **Risk-taking is related to the concept of sensation-seeking.**
 - (a) Sensation-seeking is the need for varied, novel and complex sensations and experiences and the willingness to take physical and social risks for the sake of such experiences. Because adolescents value new experiences more than adults do, they may undertake risky behaviors even though they may recognize possible dangerous consequences.
 - (b) *Thus, in court you may see adolescents who experiment with many different drugs, or who engage in unprotected sexual activity with many partners, or who make money from selling drugs and wear flashy clothes and jewelry. Although illegal and/or unwise, this behavior may stem from sensation-seeking that gets out of control.*
 - b. **Present-oriented thinking.**

- (1) Adolescent approaches to time differ from those of adults. Generally, adolescents either seem unable to think about the future (i.e., they can't think past the present), or they discount the future and weigh more heavily the short-term risks and benefits from decisions.
- (2) *In court, you may see intelligent adolescents with no prior record who commit minor offenses and jeopardize their whole future. You wonder how they could have done something so stupid. Part of the answer may be that they literally could not think about the future and how their actions might have serious consequences.*

c. **Egocentrism.**

- (1) Adolescents often become self-conscious and self-absorbed. Intense self-consciousness sometimes leads teenagers to mistakenly believe that others are constantly watching and evaluating them. Egocentrism interacts with an adolescent's present-oriented thinking to lead an adolescent to only see the difficult circumstances which s/he is currently facing and not see beyond into the future. Adolescents often have a related belief that they and their experiences are unique in the world.
- (2) *In court, you may see adolescents who will not cooperate with probation staff or other authority figures, or who are super-sensitive, almost paranoid, about anyone else telling them what to do. Adolescent egocentrism may also make it appear that a young person has no remorse.*

d. **Perceived invulnerability.**

- (1) Many teenagers believe that they cannot get hurt, that they are invulnerable, invincible, and (with their inability to think into the future) immortal. These beliefs contribute to adolescents weighing risks differently than adults.
- (2) This can lead them to risky behavior with potentially dangerous consequences, such as unprotected sexual activity, because they believe that they are special, different from anyone else, and therefore cannot get pregnant or contract sexually transmitted diseases.

e. **Magical or wishful thinking.**

- (1) This is common among adolescents when they feel cornered, when they are confronted with undesirable alternatives, or when they have difficulty thinking of a way out of a dilemma. They seem to put aside any rational thinking and come up with a "magical" solution that adults recognize as obviously unrealistic. In line with this, adolescents often view the consequences of their actions as "accidental" or "surprising," when adults would easily predict a bad outcome.

- (2) *In court, you may see adolescents who commit crimes in front of several witnesses, and think they will not get caught. Instead, they think that the police will not find the witnesses, or the witnesses will forget what they saw.*

f. **External factors can interfere with cognition**

- (1) **Stress and fear** can also interfere with an adolescent's decision-making capabilities. For example, a teen will worry about punishment for an action and do something to avoid that punishment that is far worse than the original action — such as not going home at all because s/he fears punishment for arriving late, or not going in for any of their court-mandated drug testing appointments after missing one appointment.
- (2) **Learning difficulties** compromise the ability of some adolescents to digest information and often lead to faulty thinking. It is estimated that 30-50% of children involved in the juvenile court system have some type of learning disability, as compared to 4.5% in the general population. *Module Five focuses on the special education needs of children in the juvenile justice system.*
- (3) **Previous victimization** influences how adolescents think when they feel threatened. A significant proportion of children in the juvenile justice system have a history of abuse. Previously-victimized children have a heightened sense of danger and self-protection. Behind some crimes that appear predatory is a thought process that is triggered by past victimization and compromised by an exaggerated response to fear. Understanding how that response cycle influences the adolescent's behavior is key to identifying treatment that will help the adolescent think differently in the future. *Module Four specifically focuses on the link between maltreatment and delinquency.*

SUMMARY OF KEY CONCEPTS IN COGNITIVE DEVELOPMENT

During adolescence, teens develop the capacity to think in more complex ways. But this capacity develops at different rates among adolescents. Moreover, adolescents often do not use the highest level of rational thinking of which they are capable. Other factors – including perceptions of risk and time that are different from those of adults, egocentrism, and stress – compromise their ability to apply rational thinking.

AUDIOVISUAL AIDS

Trainers can show the following clips from movies to illustrate key concepts in adolescent cognitive development and stimulate discussion. (Times given indicate the scene(s) placement in the movie.)

Trainers may also consult Appendix D for additional suggestions for movies to use in this module.

Kids (1995) d. Larry Clark

14:00-21:30

Scenes of a group of adolescent girls interspersed with scenes of a group of adolescent boys. Both groups are discussing sex, and it is apparent that many of them are having unprotected sex with multiple partners. The boys specifically discuss how they dislike using condoms, that they don't know anyone with AIDS, and everyone dies eventually so they may as well have fun now.

DEVELOPMENT CONCEPTS ILLUSTRATED: risk-taking; magical thinking; sense of invulnerability; present-oriented thinking.

21:30-23:00, 25:00-27:00

Two of the girls we saw earlier are tested for HIV and find out their results.

Just Another Girl on the I.R.T. (1993) d. Leslie Harris

23:00-25:50

Scene of the main character, Chantel, and two girlfriends discussing sex and birth control. Although she is aware of news coverage about the AIDS epidemic, one of the girls refuses to use condoms. Her rationale is that the only people who get AIDS are gay men and intravenous drug users, and she is not having sex with "nobody like that." Moreover, she concludes that she is going to die anyway.

DEVELOPMENT CONCEPTS ILLUSTRATED: risk-taking; magical thinking; sense of invulnerability; present-oriented thinking.

54:00-55:15, 57:15-57:30, 1:05:00-1:08:15, 1:10:30-1:11:30, 1:12:45-1:13:40

In this series of scenes, Chantel refuses to accept that she is pregnant and that she needs to come up with a plan to deal with it. Instead, she decides to ignore it, saying "maybe it's just a dream and it will go away." She develops elaborate schemes to hide her pregnancy from her mother, including buying the same clothes in bigger sizes and throwing out food in the middle of the night so that it appears that she is just eating a lot. Chantel takes the money her boyfriend gave her for an abortion and takes her friend on a shopping spree instead.

DEVELOPMENT CONCEPTS ILLUSTRATED: magical thinking; how stress and fear can impact cognition; present-oriented thinking.

Straight Out of Brooklyn (1991) d. Matty Rich
(these scenes also illustrate concepts in the moral development section)

1:40-6:00

In the movie's opening scene, the main character, Dennis, and his sister, Caroline, clean up their father's mess from his drunken night. (Their father is an alcoholic who is physically abusive towards their mother.) Dennis tells Caroline that he will risk his life to raise money to get out of Brooklyn.

21:30-25:30

Dennis and his two friends, Larry and Kevin, plan an armed robbery to raise money to leave Brooklyn. The friends plan to intercept money belonging to a local drug dealer. Dennis next speaks to his girlfriend Shirley about getting out of Brooklyn. Shirley discusses college and then earning money. But Dennis says it's too long to wait and he needs immediate satisfaction.

DEVELOPMENT CONCEPTS
ILLUSTRATED: *risk-taking; present-oriented thinking; inability to think through the possible consequences of actions; magical or wishful thinking; making a necessary and morally justified departure from a recognized rule (i.e., robbery is wrong); how stress and fear can impact cognition.*

1:02:00-1:05:00, 1:07:30-1:11:00, 1:12:50-1:19

After the boys commit the robbery, they begin to consider the potential consequences of their actions. Dennis loses Shirley because of the robbery; Dennis' family gets into an argument about Dennis' robbery, which leads to the fight that results in his mother's death; the drug dealer's gang comes after Dennis and eventually kills Dennis' father.

Girlstown (1996) d. Jim McKay
(these scenes also illustrate concepts in the moral development section)

27:00-29:30

The film's three main characters – Emma, Patty, and Angela – vandalize a car belonging to Rich, the boy who raped Emma. They do this in broad daylight, in the parking lot of the school, without regard to the strong possibility that someone will catch them in the act.

DEVELOPMENT CONCEPTS
ILLUSTRATED: *present-oriented thinking; risk-taking; inability to focus on the possible consequences of their actions; the effect of previous victimization on decision-making; the dominance of unswerving loyalty to friends and undying opposition to perceived unfairness in adolescents' moral schemes.*

43:00-45:10

Emma tells her friend Dylan that she is glad that she wrecked Josh's car. Josh expresses concern that Emma is getting into trouble with

her girlfriends, one of whom he describes as a juvenile delinquent. Emma was accepted to Columbia University and Dylan warns that she is throwing her future away. Emma, who also had a close friend commit suicide recently, replies that she cares very little about her future right now.

45:10-48:00

Angela tells her mother that she was suspended from school for fighting. Angela explains that the girl "dissed Nikki" (the friend who recently committed suicide). When her mother states that fighting will not bring Nikki back, Angela replies "I know, but it felt good at the time" and that she has to stand up for what she believes in.

1:15:20-1:19:30

Emma confronts Richard, the man who raped Nikki, her deceased friend. When he shows no remorse (she tells her friends that she thought he would at least look guilty), the three friends decide to beat him up. Again, they do this on the street in front of many people, without regard to the possible consequences.

Star Maps (1997) d. Miguel Arteta

2:45-3:45, 27:30-28:30

Carlos, the movie's main character, tells his family members that he will become a big actor and make lots of money. He needs to make money to care for his family, which includes his mentally ill mother. To achieve his goal, which

he never questions as unrealistic, Carlos decides to work for his father, who is a pimp and has battered his mother. Despite the danger, Carlos insists that working for his father will not be a problem.

*DEVELOPMENT CONCEPTS
ILLUSTRATED: teens will engage in
magical thinking when faced with
an impossible situation.*

Interactive Exercise on Cognitive Development

Teen profile: Andre, Age 14

Andre's story is that of a robbery "gone wrong." In the time leading up to the robbery, Andre's life was in a downward spiral. He was abusing drugs and was increasingly dependent on the group of criminal adults who were selling him the drugs. He often saw these adults later harm people to whom they sold drugs. Andre became worried that they would do the same to him. Andre began to experience a running video in his mind that these adults would follow him home, and then harm his grandparents and siblings. He became very frightened for himself and his family. Andre decided that the only way to prevent these adults from harming him or his family was for him to leave home. But to do that he needed money, and Andre concluded that the only way for him to get the money was to rob someone.

Andre decided to rob a cab driver. Andre decided to carry a gun because he was small and didn't think anyone would take him seriously if he didn't have a weapon. Andre didn't picture himself as a robber, and had never carried a gun before. Andre got drunk and hailed a cab, but left the cab because he couldn't go through with it. But then the video of his family being harmed by the drug dealers started running in his head and he hailed a second cab. Andre thought that he would show the gun to the cab driver and then tell the driver to drive to a specific location and park the vehicle. He thought that he would then tell the driver to give him money, receive the money successfully, and then exit the car without any complications. Andre shot the cab driver when the driver, who was much bigger than him, lunged into the back seat when Andre brandished the gun. Andre's sole thought became 'I have to get out of this taxi,' and he couldn't think of another way out of his dilemma. To this day, Andre still views what happened as an accident (the gun just "went off") as opposed to the possible/probable consequence of carrying a gun and attempting to rob that person.

Discussion questions:

- ! What can we say about Andre's cognitive process in deciding to commit a robbery?
- ! In what ways were his processes typical of an adolescent's? Different from an adult's? Should this make a difference in our assessment of Andre's culpability?

Development concepts illustrated by Andre's profile:

- ! Andre's thought process was non-linear - not an adult's logic - in moving from Point A (deciding that he needed to protect his family to Point Z (his ultimate conclusion that he needed to rob someone to accomplish this).
- ! His robbery plan was simplistic. He didn't consider that the gun he brandished to show he meant business would go off, or he would pull the trigger, hurting or killing someone.
- ! He didn't think through alternative scenarios about what could happen, and what he should do if the plan didn't go as planned, i.e., when his plan went awry, he thought his only option was to pull the trigger; he didn't think to exit the cab, thereby doing less harm than he intended.
- ! Prior to the incident, his cognitive capacities were impaired by drugs and fear. During the incident, his cognition was impaired by stress.

(Note to trainers: this profile is of an actual teenager. Trainers are greatly encouraged to substitute profiles of teenagers with whom they have worked to illustrate development concepts in this module.)

B. Identity Development and Social Development

1. Questions this material should answer

- a. How do adolescents develop an identity?
- b. What role do family, peers, and the larger community, play in their developing identity?

2. Adolescence is a time of important psychological and psycho-social development which affects the way teenagers feel about themselves (identity), their ability to function responsibly on their own (autonomy), their relationships and interpersonal behaviors (intimacy), and their sexual feelings (sexuality).

3. Identity Development.

- a. **During adolescence, teenagers attempt to establish a coherent, stable identity.**

- b. **"Trying on" different personalities, interests and ways of behaving is a necessary part of the process of putting together an identity.** Thus, it is important for teenagers to have an opportunity to do this type of exploration in a safe environment in which such experimentation will not lead to negative and irrevocable consequences.

- c. **Family and identity.**

- (1) That safe environment, ideally, is the family. The central core of adolescent identity comes from the nurturing and success they find in their family, and through which they learn that they are loving and capable individuals. The sense of belonging the adolescent gets from the family is the framework for identity. When teenagers "try on" different selves they are often making a choice to explore a personality that is the same (or the opposite of) other family members. Often teenagers describe themselves in reference to family members: "I'm like my grandfather" or "I'm not anything like my older brother."

- (2) *On the other hand, adolescents who do not have families that provide nurturing and success may have difficulty developing feelings of competence and self-confidence, or loving relationships toward others. When they are neglected, abused, and belittled, and their families are full of conflict, they may never develop such feelings. In court, you may see adolescents who have lived for many years in constant conflict, who have been emotionally neglected or physically or sexually abused, and who show it in their behavior.*

- d. **Peers and identity.**

- (1) Young people need to belong. Group membership, including distinguishing dress, hair styles and mannerisms, can add to the sense of belonging. In court, you may see all of these on display.

- (2) In early adolescence, around ages 13 or 14, youngsters are particularly susceptible to peer pressure. Moreover, at any age, boys tend to be more susceptible to peer pressure than girls.
- (3) Peers provide recognition, advice, and encouragement, and may be more unconditionally accepting than adults. *That is why gang memberships, "in crowds," memberships in high school "cliques," and similar peer groups can be so important to adolescents and, to some extent, substitute for their families.*
- (4) But there is sometimes an overemphasis on the influence of peers on adolescent behavior. While peers greatly influence day-to-day identity choices (hair, dress), family has a powerful effect on adolescents' basic values and choices.
- (5) In addition, peer pressure can be pro-social (as opposed to anti-social). *In court, this is particularly important in thinking about placement programs for adolescents. Young people who have been negatively influenced by peers may do well in group settings which stress group cohesion and reliance upon each other to accomplish basic tasks.*

e. **Autonomy Development.**

- (1) **Adolescence is a gradual transition to being a self-governing person. The development of independent behavior is a central task of adolescence.** It is a *necessary* task: in order to become adults, adolescents must develop the cognitive and social skills they will need to live in society and become less dependent on others for emotional support.
- (2) Physical changes and appearances both enable adolescents to become more autonomous, and cause adults to treat them as though they were more autonomous.
- (3) The development of autonomy can be a difficult experience for adolescents and for their families. Even under the best of circumstances, the process may cause emotional and social disruptions as adolescents change their relationships with family members and develop new roles in the world. A strong foundation of love and support can help everyone over the rough spots. For adolescents whose families are in turmoil, the process can be more dramatic and more painful. The adolescent quest for autonomy can turn into hostility toward figures of authority.
- (4) *In court, you may see teenagers who seem to have no respect for their parents or for court personnel. Their development of autonomy is not a justification for being disrespectful toward the court or disobeying directives, but it may only be a somewhat exaggerated example of what all teenagers go through, compounded by family, peer, and neighborhood difficulties.*

- f. **Intimacy and Interpersonal Relations.** During adolescence, individuals develop an increase in the need for intimacy, in the capacity to have intimate relationships, and in the extent to which -- and the way in which -- this capacity is expressed.

(1) **Peer relations.**

- (a) Close peer relationships are key to healthy social development.
- (b) Adolescents' experience with peer relationships changes in four important ways:
 - i) Adolescents spend more time with peers than do children.
 - ii) Adolescent peer groups are less monitored by adults than children's groups.
 - iii) Adolescents have greater contact with opposite-sex friends.
 - iv) Adolescents interact in increasingly larger groups of friends, from pairs to cliques to crowds (which represent a social identity).
- (c) Advent of dating and romantic relationships.

(2) **Family relations.**

- (a) As adolescents separate from family, they begin to view family rules and regulations differently, and there is a temporary distancing.
- (b) BUT the influence of families, and especially parents, does not disappear from adolescents' radar screens. What happens is that during adolescence, the influence of peers increases.
- (c) There is an ongoing need for nurturing parents who clearly express their values and the rules they live by because young people derive so much of their identity from the family.

g. **Sexuality.**

- (1) Learning to think of oneself as a sexual being, to deal with sexual feelings, and to enjoy physical contact with others is an important part of adolescence.
- (2) Sexuality presents adolescents with a number of important concerns: what are the sources of their new feelings, what role should sex play in their lives, how should they control their new body functions, which partners should they choose and how should they relate to them, how much experimentation are they comfortable with.
- (3) Generally, boys are more likely to consider sex recreational, and girls are more likely to focus on intimacy and closeness, but there are wide variations among individuals.

(4) There are significant cultural differences in adolescent sexual behavior, from age of initial experimentation to relationships with partners.

h. **Interaction of Cognitive Thinking and Social Relationships.** Thinking about social relationships becomes more abstract, more multidimensional, and more relativistic during adolescence with the development of cognitive abilities. Adolescents develop the capacity to:

(1) understand that people's personalities are not one-sided, people can have multiple interests or agendas, and that social situations can have multiple interpretations. This, in turn, allows adolescents to have more sophisticated relationships; and

(2) take the perspective of others, which enables adolescents to develop intimate relationships.

SUMMARY OF KEY CONCEPTS IN IDENTITY DEVELOPMENT AND SOCIAL DEVELOPMENT

Over time, adolescents attempt to establish a coherent identity. Adolescents "try on" different personalities, which makes their behavior difficult to predict. Many adolescents get caught between the values of their family, church, etc., and the lure of the street and the rampant violence they live in; this results in an identity struggle for the adolescent. Peer relations can influence teens positively or negatively. Even though peer relations dramatically increase in importance, family relations still retain importance and youth look to their parents for values and morals.

AUDIOVISUAL AIDS

Trainers can show the following clips from movies to illustrate key concepts in adolescent identity and social development and stimulate discussion. (Times given indicate the scene(s) placement in the movie.)

Kids (1995) d. Larry Clark

1:00-1:00:03

Party scene of adolescents drinking, smoking, and kissing. Younger teens are being "educated" by older teens; the former try to emulate the behavior of the latter -- by talking

***DEVELOPMENT CONCEPTS
ILLUSTRATED: acceptance by
peers is important to teens, and
younger teens, particularly boys,
are more susceptible to peer
pressure.***

about sex and getting high – to fit in.

Stand and Deliver (1988) d. Ramon Menendez

11:30-12:30, 13:25-17:45, 21:00-22:40, 25:45-26:50, 27:30-29:30

The following scenes between a teenager named Angel and his math teacher Mr. Escalante (nicknamed Mr. Kimo) illustrate a teenager going through an identity struggle similar to that experienced by Darrell (see *teen profiles that follow*). Angel is part of a gang and is very concerned about his image among his friends. After Mr. Kimo embarrasses one of Angel's fellow gang members in class, Angel challenges Mr. Kimo's authority by slapping his face lightly. Angel is quick to get involved in fights and will hang out with his friends all night. In a particularly telling scene, Angel asks Mr. Kimo for an extra book to keep at home – that way he can do his homework without his "homiez" seeing him carrying a book. Angel is obviously close to his family (as demonstrated by the scene with his grandmother) and has formed a close relationship with Mr. Kimo. At the same time he is living a life separate from his family.

DEVELOPMENT CONCEPTS ILLUSTRATED: *importance of peer recognition; autonomy development; the need to challenge adult authority; the importance of bonding with adults outside the family unit.*

Boyz in the Hood (1991) d. John Singleton

25:30-29:30

Scene in which a young Trey and his father have a conversation about his life. The scene depicts Trey's father's involvement in Trey's life and his commitment to steering Trey in the right direction. Scene ends with Trey and his father witnessing Trey's friends, Doughboy and Chris, being arrested.

37:00-45:00

Scene between a teenage Trey and his father demonstrates their close relationship and ability to speak candidly about issues such as sex and birth control. At the beginning of the scene, we see Trey return a lost infant to his drug-addicted mother, and face down another youth pointing a gun at him.

DEVELOPMENT CONCEPTS ILLUSTRATED: *the importance of family on influencing a youth's values and choices, and in developing an identity; adolescents "try on" different identities; adolescents need to belong; they develop closer peer relationships and separate from their families to some extent to develop a separate identity; the importance of being able to experiment with new identities within a safe environment.*

My So-Called Life – Pilot Episode (1994) d. Scott Winant

The pilot of this television show (available in many video stores) follows the main character,

Angela, as she experiments with a new identity. Angela dyes her hair red and starts wearing “grunge” clothes. She tells the audience that lately she can’t even look at her mother without wanting to stab her repeatedly and how her newly-emerged breasts have come between her and her father. Angela gives up her longtime friend Sharon and stops working on the yearbook, because they are too mainstream and cliché. Instead she befriends Rayann, a party girl, and Ricky, a bisexual Latino boy who wears eyeliner. The episode, which is approximately 49 minutes in length, has many scenes that would be useful in this section.

Paradise Lost: The Child Murders at Robin Hood Hills (1996) d. Joe Berlinger & Bruce Sinofsky

This movie chronicles the murder trial of three teenagers -- Jessie Misskelley, Jr., Damien Echols, and Jason Baldwin -- who are subsequently convicted of the brutal murders of three second-grade boys in Arkansas. The teenagers stood out in their community because they wore black, listened to heavy metal bands such as Metallica, and one (Echols) believed in the Wicca religion. Many in the community labeled them Satanists and part of the prosecution’s theory was that the teenagers murdered the boys in a ritualistic act. The following scenes raise the question of whether the teens’ clothing and music choices were normal adolescent behavior, i.e., the need to “try on different personalities” or, instead, were evidence of more troubling and dangerous beliefs.

7:04-7:20

The mother of one of the slain boys is interviewed. When asked if she believes the suspects were Satanists, she quickly replies yes, because “they look like freaks.”

11:10-12:45, 1:14:10-1:14:40, 1:22:30-1:23:25,
2:02:30-2:03:30

Interviews with the teenage boys, in which they claim that the police think they murdered the children because they “stood out.” Echols points out that people ridicule or try to destroy what they don’t understand. He discusses the importance of his friendship with Baldwin and their common interests.

***DEVELOPMENT CONCEPTS
ILLUSTRATED: difficulty in
determining whether teens
exploration of alternative identities
is normal development or a signal
that teens are developing more
troubling attitudes and beliefs.***

1:08:45-1:09:15

Prosecution’s expert on the occult testifies that Satanists typically wear black clothing, black fingernails, and dyed black hair.

1:12:45-1:14:00

Echols’ family claims that the community blames their son because he wore black clothing; many people wear black clothing, including themselves, and they are not Satanists.

1:43:45-1:44:35

A teenage girl testifies that she heard Echols confess to the killings. On cross examination, the girl acknowledges that she thought Echols was weird because he was dressed all in black, and had long, jet black hair that was shaved on one side.

2:05:20-2:06:00

A police officer testifies that Echols had books by Stephen King and a book on the occult, and that he thought it was strange material for anyone to have.

Streetwise (1984) d. Martin Bell (documentary)

27:30-33:30

Tiny (Erin), a 14 year-old prostitute in Seattle, interacts with her mother, and we hear voice overs from each of them about the other. The mother – a self-admitted alcoholic who is in an abusive relationship -- knows that Tiny is a prostitute; however, she has made no effort to get Tiny out of this life. The mother complains about how little she makes as a waitress, and that she almost fell off her chair when Tiny came home with \$200. The mother rationalizes that there is nothing she can do to stop Tiny, "it's just a phase," and Tiny will do it anyway. In a voice over Tiny expresses concern about her mother's abusive husband; we learn that he broke her mother's leg at one point. The mother and daughter are able to relate to each other only on a superficial level – talking about eyeshadow and the mother teasing the daughter that she should eat everything on her plate. This scene contrasts well with the father-son scenes from *Boyz in the Hood* which are discussed above.

***DEVELOPMENT CONCEPTS
ILLUSTRATED: the importance of
family on influencing a youth's
values and choices and in
developing an identity.***

Interactive Exercise on Identity Development

Teen profile: Darrell, Age 15

Darrell has grown up in a conflict that is more and more common for adolescents today – he is caught between the middle-class values of his family and those of the violent neighborhood in which he lives.

Darrell has good relations with his parents, who are separated. His parents are both actively involved in his life; they both have steady, blue-collar jobs. They are a loving, religious family with strong moral values. Darrell was raised to be a caring, well-behaved young man. He is an only child, and describes himself as spoiled. Darrell is protective of his family and wishes he could earn money to move them out of their bad neighborhood. Darrell is a very diligent student in a college prep program at school, and one could easily

classify him as a nerd.

But Darrell also sees the young hustlers on the street; he is intrigued by their ability to earn money and to impress girls with their slick cars. Darrell drinks on the weekends. Darrell writes off his drinking as benign, and simply describes it as his way of “letting off steam.” He felt responsible when people got hurt while he was riding in a stolen car driven by a drunk friend, but he denied that he was a risk taker. Darrell describes himself as basically a good person -- he says he has a nice personality and knows right and wrong, but he has a bad side that comes out once in awhile.

He has successfully hidden his street life from his family, teachers, and classmates, and essentially has two lives in two separate worlds. Everyone was shocked when Darrell was shot walking out of a concert when he was 14; however, this event did not spur him to be any more truthful regarding his second life. Darrell thinks that he’s the only one going through this, and does not recognize that his problem is an identity struggle. Furthermore, he doesn’t think that the situation is resolvable, as he doesn’t see himself as having to make a choice between two paths: being a successful college student or being a hustler.

Discussion questions:

- ! How is Darrell’s identity development typical of adolescence? Atypical?
- ! What can be done to help Darrell choose the path to being a successful college student, and reject the life of a hustler?

Development concepts illustrated by Darrell’s profile:

- ! Darrell is engaged in a typical adolescent identity struggle. He is “trying on” different personalities.
- ! Darrell’s drinking is a symptom of his identity struggle; it’s his way of being a different person than the nerd in school.
- ! Darrell’s family provides a safe environment in which he can experiment with different selves. In this way, his situation is distinguishable from Yvonne’s (see *profile which follows*). However, his wider social environment is dangerous and thus his experimentation could lead to negative outcomes.
- ! Darrell’s thinking – that he’s the only one going through this – demonstrates adolescent egocentrism. His failure to change his ways after being shot outside a concert demonstrates a sense of invulnerability. He is a risk-taker and a sensation-seeker. His thinking is present-oriented. In all these ways, Darrell’s development is that of a typical teenager.

Teen profile: Yvonne, Age 16

Yvonne says she has never been good at anything. She has experienced great difficulty in learning to read, and still has severe problems with spelling, grammar, and deciphering instructions. “How my eyes see the words and how they finally come out are two different things.” She would ask teachers for help in school, but threw repeated temper tantrums when she did not feel that they provided her enough assistance. As a result, Yvonne’s teachers became increasingly frustrated by her. Yvonne had repeated 4th grade when she was referred for special education at age 11. However, tests determined that she was of average intelligence, and Yvonne was subsequently placed in a program for kids with behavior problems, not learning disabilities. Four years after placement in special education, and three different schools later, Yvonne is still reading at a third grade level, and she can do multiplication but not division.

Yvonne’s home life has been marked by domestic violence, and she has not formed a close relationship with any family member. She became the girlfriend of a drug dealer in her neighborhood at age 16 and is fully compliant with his wishes. She felt the recognition of his gang, which provided her with a sense of belonging and appreciation.

Yvonne continues to have trouble with self control and gets angry easily. She was arrested recently for assaulting a police officer, who had come to arrest her boyfriend for selling drugs. Yvonne has no positive view of herself in the future, and has no clue what she would do if her boyfriend were to receive a long prison term.

Discussion questions:

- ! In what ways has Yvonne’s identity development been that of a typical adolescent? Atypical? Has Yvonne formed her own identity?
- ! How can development theory explain the social and intimate relationships that Yvonne has formed?
- ! What could be done to help Yvonne form a more positive image of herself?

Development concepts illustrated by Yvonne’s profile:

- ! Yvonne’s need to belong to a group - in this case, her boyfriend’s gang - is a normal part of adolescent development.
- ! Yvonne has not formed her own identity; she is an extension of her boyfriend.
- ! Yvonne’s need to belong to a gang is exacerbated by the fact that she lacks a safe, nurturing family life.

- ! Yvonne lacks a safe environment in which to try on different selves.
- ! Yvonne's efforts to become an autonomous person are hampered by her low self-esteem.
- ! Yvonne's behavioral problems have prevented her from progressing in school which, in turn, shapes her image of herself and impedes her development into a self-governing person.

(Note to trainers: these profiles are of actual teenagers. Trainers are greatly encouraged to substitute profiles of teenagers with whom they have worked to illustrate development concepts in this module.)

C. Moral Development

1. Questions this material should answer

- a. How do adolescents' concepts of right and wrong develop, and how are they expressed in adolescence?
- b. How do peers and the family influence an adolescents' moral reasoning?

2. Adolescents progress through stages of maturation in terms of moral reasoning and moral behavior.

a. Moral reasoning of the young child -- "Pre-conventional" moral reasoning.

- (1) The moral reasoning of the young child is based on self-interest.
- (2) The focus is on rewards and punishments associated with different courses of action.
- (3) Young children accept what others say is right or wrong.

b. Moral reasoning of the early adolescent — "Conventional" moral reasoning.

- (1) The moral reasoning of the young adolescent is based on how s/he will be judged by others for behaving in a particular way. The reason to be good is to earn social approval, and they begin to look beyond the immediate consequences of an action and toward the impact of their actions on their relationships with others.
- (2) Children in their elementary years who are at the conventional level of moral reasoning are concerned with pleasing their parents and other adults.
- (3) During junior high school, children become more concerned with impressing their peers. Some moral decisions are more likely to be based on what will make one popular or accepted by peers.
- (4) BUT although most adolescents are able to reason at this level in "hypothetical" situations, their actual behavior may not always reflect their reasoning ability.
- (5) Behavior is dependent upon many factors, such as situational facts, that affect the adolescent's decision-making process.

c. Advanced moral reasoning — "Post-conventional" moral reasoning.

- (1) At this stage, the individual begins to view society's rules as relative and subjective, and questions social conventions.
- (2) In late adolescence or early adulthood, an individual MAY begin to shift from reasoning in terms of social approval to reasoning in terms of important principles, such as justice and fairness. In other words, an

individual may follow society's rules NOT just because they are society's rules but because the individual has grappled with the moral principles underlying these rules and has decided to accept them as his or her own.

(3) BUT post-conventional moral reasoning is relatively rare, even in adults. Most adolescents follow "conventional" moral reasoning, i.e., the reason to be good is to earn social approval and to benefit their relationships with others. Indeed, the importance of peers generally in the lives of adolescents reinforces the influence of peer groups on moral decisions.

3. **Significant factors that shape adolescents' moral development.**

Adolescents derive their moral values from:

- a. their families
- b. their peers
- c. their relationships
- d. spiritual influences
- e. popular culture (movies, t.v. shows, music).

4. **Other aspects of adolescent moral reasoning.**

- a. **Adolescents are "fairness freaks."** With their increased cognitive abilities, adolescents often embrace principles with a vengeance. They insist idealistically on what should be, and are intolerant of anything that seems unfair or arbitrary. Further, in line with their own development of personal autonomy and resistance to authority figures, they will challenge social conventions in the name of principle. Thus, although they know that theft is illegal, they will say that a homeless person is justified in stealing food because he is hungry. They can develop elaborate philosophical arguments to justify their behavior, especially when they are being held accountable for misconduct. As part of their adolescent egocentrism, they may not challenge the general validity of a rule or regulation, but will argue that the rule is not applicable in *their* case or that the facts in their case justify an exception.
- b. **The role of gangs.** In addition to the other attractions of gangs discussed earlier, gangs can provide adolescents with a set of clear rules. The rules may be based on philosophical or moral principles -- e.g., unswerving loyalty to friends, undying opposition to perceived unfairness -- and may reduce the number of options available and thereby make decision making much easier.

SUMMARY OF KEY CONCEPTS IN ADOLESCENT MORAL DEVELOPMENT

Juvenile behavior that results in unacceptable and harmful outcomes is often motivated by the juvenile's own moral values. Reckless behavior can be highly moral to the young person within the morality system and external environment s/he is operating in. For example, a teen may think it's okay to carry a gun to protect himself. Or a teen may think it is okay to assault someone who has harmed a friend. Thus, what may look immoral or amoral to an outsider may in fact be a highly moral act to the teen, a justified and indeed necessary departure from a recognized rule. Loyalty and fairness are highly valued by teens and weigh heavily in their moral reasoning.

AUDIOVISUAL AIDS

Trainers can show the following clips from movies to illustrate key concepts in adolescent moral development and stimulate discussion. (Times given indicate the scene(s) placement in the movie.)

Boyz in the Hood (1991) d. John Singleton

1:31:00-1:41:30

In the scene immediately preceding this one, Trey's close friend, Ricky, is murdered by a 27-year-old gang member who Ricky had insulted the previous night. Angered by the murder of his friend, Trey sets out with Ricky's brother, Doughboy, in pursuit of the killer. Trey decides at the last minute to get out of the car. Doughboy, however, avenges his brother's death.

DEVELOPMENT CONCEPTS ILLUSTRATED: the importance of family on influencing a youth's values and choices; loyalty as an important value to teens. See also write-up in identity development section above.

Strapped (1993) d. Forest Whitaker

The main character in this movie, Kwan, spent six months in jail for drug dealing and is now trying to make a better life for himself and his girlfriend, Latitia, who is pregnant with their child. When Latitia is arrested for selling drugs, Kwan needs cash to bail her out and his income from working as a bicycle messenger isn't enough. Kwan eventually turns to gun selling to raise the money. The scenes that follow show the complex moral scheme by which Kwan and his friends live by. They also demonstrate the limits on their cognitive thinking.

10:30-12:00

Kwan speaks to a young boy, who Kwan witnessed murder another child earlier. Kwan expresses concern that the boy is carrying a gun. He asks the young boy, "Wasn't he your friend? Don't you feel bad?" and is upset when the boy shows no remorse.

21:00-22:15

Kwan's mother expresses concern that Kwan may be getting into trouble again. Kwan responds that he has responsibilities for Latitia and the baby.

26:00-28:10

When Kwan visits Latitia in jail, she defends her actions, saying that she was only trying to make money to get Kwan a leather jacket and to provide for the baby. Kwan tells her that she needs to do right by the baby; Latitia replies that she thought that was what she was doing.

36:00-41:30

Kwan and his friend, Bamboo, sell a gun to a 10 year-old boy, and Kwan is troubled by the sale. When Kwan shares his concern with Bamboo, the latter explains that they have to look out for themselves. Moreover, he rationalizes that if the kids don't buy guns from him they'll just buy them from someone else. When Kwan visits Latitia in jail, he tells her that he has a new "job" and he will bail her out soon so that they can leave Brooklyn.

47:45-50:00

Kwan's mother catches him with a lot of cash and confronts him. Kwan replies that he has to take care of his child, that he is doing whatever he has to do to move his family out of the neighborhood.

All Over Me (1997) d. Alex Sichel

37:30-39:45

In this scene between the movie's two main characters – Claud and Ellen – Claud questions Ellen about her knowledge about a murder. The audience knows that Ellen witnessed her boyfriend, a drug dealer named Mark, murder a man because he was gay. Ellen refuses to talk about what she saw -- "He made me swear – if you made me swear" -- even though she is obviously distressed (Ellen starts cutting her hand.) Ellen's

DEVELOPMENT CONCEPTS ILLUSTRATED: *Kwan clearly knows that carrying and selling guns are wrong. Kwan thought that his unacceptable behavior was a justified and necessary departure from a rule that he acknowledges because he was doing it to help his family achieve a better life. Kwan's cognitive capacity is limited because he does not think through the possible consequences of his actions, i.e., that he'll either be arrested or killed and will no longer be able to provide for his family.*

DEVELOPMENT CONCEPTS ILLUSTRATED: *the weight of loyalty in a teenager's morality scheme; how stress and fear can overwhelm cognition; the need of teenagers to feel that they belong.*

loyalty to Mark overrides her need to share this information with her good friend. From earlier scenes, we know that Ellen is very dependent on Mark. She runs away from home often; although we don't know the situation at home it is evident that Ellen does not have a close relationship with her family. She relishes her identity as Mark's girlfriend and the "adult" life that she shares with him, including engaging in sexual activity and using drugs.

Dead Homiez (1996) d. Billy Wright

17:00-23:20, 26:15-32:00

In these two scenes, actual former and current members of the Crips gang in Los Angeles speak about the moral ethos of the gang. In the first scene, a former member, who is 30 years-

old, describes his first drive-by shooting, stating that he was facing 25 years for attempted murder "for something I wasn't thinking about doing. There is no thinking in the life of a gang banger." In the second scene, the soliloquy by a current gang member who appears to be in his 20s demonstrates the unswerving loyalty observed by gang members. Even though he has to go everywhere "strapped" and he has taught his kids how to get on the floor of the car when they hear gunfire, he tells the audience that he will retaliate whenever someone hurts one of his "homiez."

***DEVELOPMENT CONCEPTS
ILLUSTRATED: the moral scheme
observed by gangs.***

Straight Out of Brooklyn (1991) d. Matty Rich -- See write-up in cognitive development section above.

Girlstown (1996) d. Jim McKay -- See write-up in cognitive development section above.

Interactive Exercise on Moral Development

Adolescent profile: Victor, Age 15

Victor is facing waiver to adult court for stabbing another student during a fight in school. He says that he started to carry a knife for protection because he felt threatened in school. Victor thinks that carrying and using a knife is okay in self defense. He explained, "I have never considered robbing someone or stealing. I know that's wrong. Weapons are for unavoidable situations when you have to protect yourself; when it's him or me." Victor also feels that carrying a knife is okay because it's the norm in his school. He explains, "In school everyone has to stand their ground and be big and bad. The only way to make it is to act tough, so everyone knows not to mess with you." With regard to the stabbing, Victor feels that he had to do an unavoidable wrong to protect himself and others.

Yet Victor's responses to hypothetical moral dilemmas show respect for the rights of others and empathy, values he learned from his family and church. For example, when

posed with the hypothetical of some friends taking down stop signs at an intersection, he immediately responds that what they did was wrong, stupid, not funny, and dangerous. He is outraged that someone will get hurt. Victor says that you should call police, but you should call them from a phone booth so that the police don't know who's calling. Should the person calling the police identify culprits? Victor hesitates -- what they did was illegal but won't turn them in.

Discussion Questions:

- ! What could be going on morally with Victor that could allow all these things to be true of Victor's moral reasoning?
- ! How do we evaluate a child's judgment when it is based on a different moral system from an adults?
- ! How do we create programming for this juvenile so that he will not engage in this dangerous and unacceptable behavior?

Development concepts illustrated by Victor's profile:

- ! Victor has a set of behavioral values. He sees his reckless behavior (carrying a knife, stabbing someone in self-defense) as justifiable given the environment he lives in.
- ! Victor is a typical teen in that he highly values loyalty. He wouldn't turn in his friends for taking down the stop signs.

(Note to trainers: this profile is of an actual teenager. Trainers are encouraged to substitute profiles of teenagers with whom they have worked to illustrate development concepts in this module.)

Adolescent Profile: Alonso, Age 15

Alonso was arrested for gun possession. Alonso chose a girlfriend from another gang, and he got beaten up a lot because of it. He said he started carrying a gun to keep his enemies from attacking. Alonso thought that everyone would somehow know he was carrying a gun, and thus they wouldn't attack him.

In one hypothetical posed to Alonso, a teenager was left by his/her drug addicted parents to care for an infant. Alonso was asked: should the teenager steal milk to feed the baby? Alonso first came up with alternatives to stealing: leave the child with a responsible adult, get work, and then borrow to buy milk until you get your first paycheck. When pressed whether you should steal the milk if you could not pursue this alternative course of action and you knew you wouldn't get caught, Alonso said that if you were sure you

wouldn't get caught, then it would be okay. But Alonso stated that because the possible consequences of getting caught are going to jail and consequently being separated from the child, it is not a wise thing to do.

Alonso said, "I have never considered robbing and stealing from someone. I know that's wrong. Weapons are only for unavoidable situations when you have to protect yourself, when it's him or me. Adults don't understand how threatened kids feel everyday. The only way to make it is to act tough so everyone knows not to mess with you. In school, everyone has to stand their ground and prove they are big and bad. Everyone is trying to prove they're better than everyone else. "

Discussion Questions:

- ! How can Alonso know right from wrong and still make the decision to carry a gun? How do we evaluate /understand the moral principle that Alonso is evoking? How do we deal with it?

Development concepts illustrated by Alonso's profile:

- ! When asked to consider hypothetical moral dilemmas, Alonso demonstrated advanced moral development, showing acceptances of laws and rules, and mutual respect for people.
- ! Alonso is operating within a morality system. Alonso, like Victor (*see preceding profile*), felt that his unacceptable behavior (carrying a gun) was a justified departure from a known rule. He felt that his actions were moral because he wasn't using the gun to rob anyone, but to protect himself.
- ! Alonso engaged in magical thinking: he thought that people would just "know" that he was carrying a gun and therefore they would not attack him. He thought he would never have to use the gun, and that no one would ever get hurt.

(Note to trainers: this profile is of an actual teenager. Trainers are greatly encouraged to substitute profiles of teenagers with whom they have worked to illustrate development concepts in this module.)

D. Biological/Physical Development

1. Questions this material should answer.

- a. What are the major physical changes that occur during adolescence?
- b. How do these physical changes influence adolescent behavior?

2. Some basic facts about puberty

- a. "Puberty" refers to the biological and physical changes associated with adolescence.
- b. There are enormous individual differences in the onset and progression of puberty. Puberty occurs for most children between ages 12 and 13, though some children begin as early as 8 or 9.
- c. There are gender differences in the onset of puberty. Girls typically begin to show outward signs of puberty between the ages of 8-13, whereas boys begin to show the outward signs between the ages of 10-15.
- d. Puberty is characterized by certain physical changes, including:
 - (1) Growth spurt. There is a dramatic increase in height and weight during adolescence.
 - (2) Sexual maturation. This includes changes in the genitals and breasts, growth in pubic, facial and overall body hair, and growth of the sex and reproductive organs.
 - (3) Changes in body composition. There are changes in the quantity and distribution of fat and muscle. By end of puberty, males have more muscle and less fat than females. Special note on eating disorders: the development of eating disorders appear in part to be triggered by these changes in appearance during puberty.
 - (4) Changes in circulatory and respiratory systems.
- e. *Because of the great variability in individual development, an adolescent who appears physically mature in court -- tall, solid, with facial hair -- may nevertheless be quite immature in cognitive, social, and moral development. Judgments regarding intellectual ability and other characteristics of individual adolescents should not be based solely on physical appearance. This may be particularly important when considering program placement -- physical appearance may have limited value in determining which program is appropriate for a particular youth.*

3. Physical changes of puberty affect adolescents' self-image, mood and relationships.

- a. Rapid increases in hormone levels in early puberty are associated with increased irritability, impulsivity and aggression (in boys), and depression (in girls).
 - (1) **However, the “raging hormone hypothesis” — that hormones completely explain all out-of-control behavior by adolescents — is a myth.** Juveniles are not victims of their hormones. It is now generally recognized that hormones do not play as large a role in adolescent moodiness as once thought. More recognition is given to environmental or social factors, such as interpersonal difficulties, failure and rapidly changing situations, as affecting mood.
 - (2) The effect of hormones on mood appear to be strongest in early adolescence when hormonal levels are highly variable and characterized by rapid fluctuations, and the effect lessens in later adolescence as hormone levels stabilize.
 - b. Rapid growth and dramatic physical changes alter adolescents’ images of themselves. However, the effects of physical maturation on self-image must be considered in the broader social context. For example, social scientists have found that the physical changes of puberty have a negative effect on the self-image of girls (and less so for boys) when girls are dealing with other environmental changes (i.e., beginning to date).
 - c. Puberty affects parent-child relationships. Puberty appears to increase distance between adolescents, especially mothers, and the physical changes of puberty may influence the shift in adolescents’ interests towards peers who are experiencing similar physical changes.
4. Variations in timing of puberty affect adolescents' social and emotional development in various ways.
- a. Because juveniles who physically mature earlier appear older, they are often treated as if they are more mature psychologically when this is not necessarily true. *Thus, if there are several gang members in court, the biggest adolescent may not be the leader.*
 - b. Adolescents who mature late, especially boys, are often viewed negatively by their peers and left out of group activities.
 - c. Those who mature early tend to be at a social advantage.
 - (1) Because of the emphasis boys place on athletics, early-maturing boys tend to be more popular, have higher self-esteem, and are more confident than average or late maturers.
 - (2) Early maturing girls tend to be more popular with their peers. BUT they are more likely to feel self-conscious and awkward because they are uncomfortable with the attention (both positive and negative) that their new appearance attracts.

- d. Early-maturing boys and girls are more likely than average- or late-maturers to engage in more risky behaviors during early adolescence, such as experimentation with drugs, sex and delinquency.

SUMMARY OF KEY CONCEPTS IN BIOLOGICAL/PHYSICAL DEVELOPMENT

Hormonal changes, particularly during early puberty, are associated with behavioral changes in adolescents; however, environmental factors also play a large role. The physical changes that occur during puberty affect adolescents' self-image, moods, and relationships with others. Physical attributes are not indicative of where a child is developmentally in other areas, but the timing of the physical changes associated with puberty may also affect adolescents' social and emotional development.

AUDIOVISUAL AID

Trainers can show the following clips from movies to illustrate key concepts in adolescent biological/physical development and stimulate discussion. (Times given indicate the scene(s) placement in the movie.)

My So-Called Life – Pilot Episode (1994) d. Scott Winant

5:15-6:15

In this scene, Angela tries to talk with her father about school. Her father, however, is clearly uncomfortable because she is walking around in nothing but a towel. Angela says that her breasts have become between her and her dad, who have had a close relationship.

***DEVELOPMENT CONCEPTS
ILLUSTRATED: how a teenager's
changing body can affect his/her
relationships with family and
peers.***

My So-Called Life – Guns and Gossip Episode (1994) d. Marshall Herskovitz

31:00-33:30, 38:00-39:35

A rumor is circulated in school that Angela and Jordan have slept together. In these two scenes between Angela and Jordan, the former expresses – in the form of voice overs – her confusion about her emerging sexual feelings.

Kids (1995) d. Larry Clark

53:00-57:00

Pool scene during which teens admire each other's bodies, engage in some sexual touching, and discuss sexual experimentation.

*DEVELOPMENT CONCEPTS
ILLUSTRATED: sexual maturation
and its affect on peer
relationships; the lag between
sexual development and cognitive
development.*

E. **Competence Development (the mastery of skills).** Adolescents need to feel competent, to feel that they are effective and successful in some area. Competence is not used here in the sense of competence to stand trial, or competence to waive Miranda rights. Instead competence in this context means the quality of being good at something, i.e., mastering a skill. A number of state legislatures have revised their juvenile acts to make the development of competencies one of the primary purposes of their juvenile justice systems.

1. **Questions this material should answer.**

- a. How do adolescents develop competence?
- b. How important is it for adolescents to feel competent in the eyes of their peers, their parents, and in their own eyes?
- c. What are some of the sources adolescents have for developing competence?

2. **Adolescents need to be good at something.** Doing well in something -- school, arts, sports, socially, or in a hobby -- is necessary to becoming a responsible adult. Having success is how adolescents learn about self-regulation, responsibility, pride and humility.

3. What is striking about the delinquent population is the large number of juveniles who come into the system without having achieved competence in a discrete area. This is not to say that these juveniles are not talented; instead, their talents have not been developed. Moreover, some of them are "good" at being delinquent, which is their avenue of competence.

4. Many adolescents do not have significant opportunities to experience success. For those with learning disabilities, limited ability to concentrate or immature social skills, we must specially tailor assistance to encourage competence.

5. Opportunities for success, coaching to reduce failure, and recognition of small steps are necessary to teach juveniles how to succeed.

6. How to generate motivation is less clear, especially for young people who have low aspirations because they do not have family members who have achieved success in education or employment.

7. Identifying and building on a teen's existing talent is a more successful strategy for helping a teen to develop competence than imposing someone else's views of what the teen should be good at. Adults usually impose school as the way that kids must succeed, often overlooking other fruitful areas for the development of their talents.

SUMMARY OF KEY CONCEPTS IN COMPETENCE DEVELOPMENT

Developing competence (being good at something) is critical to ensuring a successful transition from adolescence to adulthood. Identifying and building on a teen's existing talent is a more successful strategy for helping a teen to develop competence, than imposing your views of what the teen should be good at.

Interactive Exercise:

APPLYING ADOLESCENT DEVELOPMENT THEORY TO YOUTH IN THE JUVENILE JUSTICE SYSTEM

(Note to trainers: see "Tips for Trainers" on next page for discussion points to use in this exercise.)

Step 1: Break the audience into small groups. (If at all possible, make sure that there is representation from each of the professions – judges, prosecutors, defense attorneys, and probation officers -- in each group.) Ask each group to select one individual to act as the group's recorder and reporter. Hand out the small group exercise worksheet attached as Appendix B.

Step 2: Ask each group to review one of the case studies attached in Appendix C. *(Or substitute your own case studies – see "Tips for Trainers" below.)*

Step 3: Ask each group to discuss and answer the questions on the worksheet. The individual appointed as the recorder should record the group's answers to the questions on the worksheet and be prepared to report on the group's answers.

TIPS FOR TRAINERS

Interactive Exercise on Applying Adolescent Development Theory to Youth in the Juvenile Justice System

For this exercise, trainers ideally should use profiles of real teenagers who have gone through the juvenile court in their jurisdictions. The sample profiles in Appendix C illustrate the level of case detail that should be provided for the purposes of this exercise.

Trainers should assign facilitators to small groups. If that is not possible, the trainer should rotate through the small groups. Below is a list of questions that the facilitators and/or trainers can raise in the small groups to stimulate discussion:

- ! How does the youth's physical size influence your judgment about her or him?
- ! What does chronological age tell you about the youth's risk for violence? Ability to change? The way the system should hold him or her accountable?
- ! What does the youth's susceptibility to peer influence, propensity to take risks, sense of identity, and/or the ability to see the consequences of his or her conduct, tell you about the youth's developmental status?
- ! How, if at all, are your judgments about the youth's developmental status influenced by the youth's gender?
- ! How does your view of the youth's developmental status affect the way you think the youth should be held accountable at various stages of the juvenile justice process? Put another way, in what ways do you think the youth's developmental status is normal or typical for adolescents? How should the answer to that question affect the decision to divert the youth from the system, petition the juvenile court, detain the youth or transfer the youth to criminal court? How might the answer affect your choice of disposition?
- ! If you believe that you need more information before you can make a certain decision called for on the worksheet, explain what information you need and why. How will having that information influence your decision?

Bibliography

Note to trainer: *trainer should consult the literature review included under separate cover for additional reference materials and suggestions for assigned readings for training participants.*

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Appendix A

CASE LAW RECOGNIZING THAT JUVENILES ARE DIFFERENT

1. **The Treatment of Juvenile Status in Fifth Amendment Case Law.** The Supreme Court has identified a number of factors which render minors "different" from adults for the purposes of determining the voluntariness of juvenile confessions during custodial interrogations.
 - a. **The Supreme Court has recognized that minors are generally less mature than adults and, therefore, are more vulnerable to coercive interrogation tactics.**
 - i. The Court reasoned in *Haley v. Ohio*, 332 U.S. 597, 598-601 (1948) (holding that murder confession extracted from 15-year-old boy at 5:00 a.m. after 5 hours of interrogation by officers acting in relay - and without youth having aid of family, friends, or counsel present - was involuntary and violated due process) that a fifteen-year-old boy "cannot be judged by the more exacting standards of maturity. That which would leave a man cold and unimpressed can overawe and overwhelm a lad in his early teens.... We cannot believe that a lad of tender years is a match for the police in such a contest. He needs counsel and support if he is not to become the victim first of fear, then of panic. He needs someone on whom to lean lest the overpowering presence of the law ... crush him."
 - ii. *In re Gault*, 387 U.S. 1, 55 (1967), the Court reasoned that when juveniles testify in court, "the greatest care must be taken to assure that the admission was voluntary, in the sense not only that it was not coerced or suggested, but also that it was not the product of ignorance of rights or of adolescent fantasy, fright or despair."
 - b. **The Court also has noted that minors generally lack critical knowledge and have less capacity to understand the meaning of the Miranda warning.**
 - i. In *Haley v. Ohio*, 332 U.S. 597, 598-601 (1948), the Court dismissed the state's argument that the juvenile defendant confessed after being advised of his right not to make a statement and that it could be used against him, pointing out that reliance on the warnings incorrectly "assumes ... that a boy of fifteen, without aid of counsel, would have a full appreciation of that advice and that on the facts of this record he had a freedom of choice."
 - ii. In *Gallegos v. Colorado*, 370 U.S. 49, 54-55 (1962) (holding that confession obtained from 14-year-old boy who had been held by police for five days without access to counsel, family, or friends was invalid. Even though boy was advised of his right to counsel, he did not ask for either lawyer or his parents), the Court reasoned as follows: "[A] 14-year-old boy, no matter how sophisticated, is unlikely to have any conception of what will confront him when he is made accessible only to the police.... We deal with a person who is not equal to the police in knowledge and understanding of the consequences of the questions and answers being recorded and who is unable to know how to protect his own interests or how to get the benefits of his constitutional rights . . . He cannot be compared with an adult in full possession of his senses and knowledgeable of the consequences of his admissions."

- c. **The Court also has recognized that minors generally have a limited ability to foresee the consequences of their actions.** The Court in *Gallegos*, 370 U.S. 49, 54-55 (1962) went on to find that a fourteen-year-old " would have no way of knowing what the consequences of his confession were without advice as to his rights - from someone concerned with securing him those rights - and without the aid of more mature judgment as to the steps he should take in the predicament in which he found himself."
- d. Following the Supreme Court's reasoning,
- i. **A number of lower courts have treated youth as a particularly important factor in assessing the voluntariness of a waiver of Miranda rights.** See, e.g., *Woods v. Clusen*, 794 F.2d 293 (7th Cir. 1986); *Williams v. Peyton*, 404 F.2d 528 (4th Cir. 1968); *Shelton v. State*, 287 Ark. 322, 699 S.W.2d 728 (1985); *State in the Interest of S.H.*, 61 N.J. 108, 293 A.2d 181 (1972); *People v. Ward*, 95 A.D.2d 351, 466 N.Y.S.2d 686 (N.Y. App. Div., 2 Dep't 1983); *State v. Caffrey* 332 N.W.2d 269 (S.D. 1983).
 - ii. **Several state courts have similarly held that the presence or absence of a parent or other interested adult is another significant factor in assessing the voluntariness of a waiver.** See, e.g., *State v. Jackson*, 118 Ariz. 270, 576 P.2d 129 (1978); *In the Interest of Thompson*, 241 N.W.2d 2 (Iowa 1976); *McIntyre v. State*, 309 Md.2d 607, 526 A.2d 30 (1987); *State v. Hogan*, 297 Minn. 430, 212 N.W.2d 664 (1973); *Commonwealth v. Williams*, 504 Pa. 511, 475 A.2d 1283 (1984); *Therault v. State*, 66 Wis. 2d 33, 223 N.W.2d 850 (1974).
 - iii. **Some state courts have set rules requiring that a parent or other interested adult be present during a juvenile's interrogation.** See, e.g., *Lewis v. State*, 259 Ind. 431, 288 N.E.2d 138 (1972); *Commonwealth v. A Juvenile* (No. 1), 389 Mass. 128, 449 N.E.2d 654 (1983); *State in the Interest of S.H.*, 61 N.J. 108, 293 A.2d 181 (1972); *In re E.T.C.*, 141 Vt. 375, 449 A.2d 937 (1982); *State in the Interest of Dino*, 359 So.2d 586 (La. 1978), cert. denied, 439 U.S. 1047 (1978). **Other jurisdictions require the same by statute.** See, e.g., *People v. Maes*, 194 Colo. 235, 571 P.2d 305 (1977) (COLO. REV. STAT. § 19-2-102(3)(c)(I)); *In the Interest of J.A.N.*, 346 N.W.2d 495 (Iowa 1984) (IOWA CODE ANN. § 232.11(2)); *State v. Smith*, 317 N.C. 100, 343 S.E.2d 518 (1986) (N.C. GEN. STAT. § 7A-595); *J.T.P. v. State*, 544 P.2d 1270 (Okla. Crim. App. 1975) (OKLA. STAT. ANN. tit. 10, § 1109)).
 - iv. **Other state courts have recommended that police officers or other designated officials give minors in custody a simplified Miranda warning.** See, e.g., *State v. Benoit*, 490 A.2d 295 (N.H. 1985); *Beaver v. State*, 824 S.W.2d 701 (Tex. Ct. App. 1992).
 - v. **A number of courts have applied what they call a reasonable juvenile test to determine whether or not a youth was "in custody" for Miranda purposes.** See, e.g., *Commonwealth v. Philip S.*, 594 N.E.2d 880 (Mass. App. Ct. 1992); *In re M.D.S.*, 345 N.W.2d 723 (Minn. 1984); *In re Robert H.*, 599 N.Y.S.2d 621 (App. Div. 1993); *In re Valerie J.*, 538 N.Y.S.2d 307 (App. Div. 1989); *In re Chad L.*, 517 N.Y.S.2d 58 (App. Div. (1987)); *In re L.L.B.*, No. 90-1944, 1991 WL 44651, at *4 (Wis. Ct. App. Feb. 20, 1991).

2. Juveniles' Amenability to Treatment and Rehabilitation.

- a. **The Supreme Court has recognized that children, as contrasted to adults, are less blameworthy for the offenses they commit because they are less capable of evaluating the possible outcomes of different courses of action, and they are more vulnerable to external pressures.**
 - i. "Inexperience, less education, and less intelligence make the teenager less able to evaluate the consequences of his or her conduct while at the same time he or she is much more apt to be motivated by mere emotion or peer pressure than is an adult. The reasons why juveniles are not trusted with the privileges and responsibilities of an adult also explain why their irresponsible conduct is not as morally reprehensible as that of an adult." *Thompson v. Oklahoma*, 487 U.S. 815, 835 (1988).
 - ii. "[A]dolescents, particularly in the early and middle teen years, are more vulnerable, more impulsive, and less self-disciplined than adults. Crimes committed by youths may be just as harmful to victims as those committed by older persons, but they deserve less punishment because adolescents may have less capacity to control their conduct and to think in long-range terms than adults.'" *Eddings v. Oklahoma*, 455 U.S. 104, 115 n. 11 (1982) (citing to 1978 Report of the Twentieth Century Task Force on Sentencing Policy Toward Young Offenders).
- b. **Most state statutory schemes for judicial transfer on juveniles to adult court require the juvenile court to make a finding as to whether or not the juvenile is amenable to treatment. This is premised on the assumption that juveniles, because they are still in development, are more easily rehabilitated than adults, who have completed their development.**

3. The Treatment of Juvenile Status when Juveniles Seek Abortions.

- a. In a series of cases challenging state statutes restricting the ability of minors to obtain abortions, the Supreme Court has recognized that **"during the formative years of childhood and adolescence, minors often lack ... experience, perspective, and judgment,"** as well as **"the ability to make fully informed choices that take account of both immediate and long-range consequences."** *Bellotti v. Baird*, 443 U.S. 622, 635, 640 (1979). In *Belotti*, the Court held that because minors often lack capacity to make fully informed choices, states may reasonably determine that it is desirable for minors to consult with their parents when seeking abortions.
- b. The Court also has held, however, that state legislatures may not enact statutes giving parents an absolute veto power over a minor's decision to obtain an abortion. *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) (invalidating state statute requiring that unmarried minors obtain parental consent for abortions). A state statutory scheme also must provide a judicial bypass which allows the pregnant teenager to go directly to court to demonstrate either that she is mature, informed, and can make a decision regarding an abortion,

independently from and without the consent of her parents, or that an abortion is in her best interest even if she is not able to make an independent decision. *Bellotti*, 443 U.S. at 642-50. **In drawing this distinction - between a mature versus immature teenager -- the Court has implicitly recognized that chronological age alone is not a sufficient indicator of a minor's ability or inability to hypothesize different courses of action and their possible outcomes, or to judge which action is in her best interest.**

4. **The Ability of Minors to Disaffirm Contracts.** Courts have adopted a general rule allowing minors to get out of contracts in order to protect minors, because they are "immature in both mind and experience and [therefore] should be protected from his own bad judgments as well as from adults who would take advantage of him." *Kiefer v. Fred Howe Motors, Inc.*, 39 Wis.2d 20, 24, 158 N.W.2d 288, 290 (1968). See also *Statler v. Dodson*, 195 W.Va. 646, 651-52, 466 S.E.2d 497, 503 (W.Va. 1995); *Pankas v. Bell*, 413 Pa. 494, 501-02, 198 A.2d 312, 315 (1964).

APPENDIX B

SMALL GROUP EXERCISE WORKSHEET

Part A

APPLYING ADOLESCENT DEVELOPMENT THEORY TO KIDS IN THE JUVENILE JUSTICE SYSTEM

You've all encountered this teenager. Drawing on your personal experience, and *applying what you have learned today about adolescent development theory*, discuss and answer the following:

1. What may explain the juvenile's actions which led to his/her arrests? What can development theory tell you about why the child in the case study acted the way s/he did in these situations?
2. Identify the undesirable behavior the juvenile has engaged in. Based on what you know now about adolescent development, is the behavior in the range of normal adolescent development? Are the juvenile's actions the result of typical adolescent thinking, and identity and morality struggles and so forth? If yes, how? If no, why not? Is the unacceptable behavior adaptive to the environment or social context the juvenile is living in? If yes, how?
3. What do we know about this juvenile's level of cognitive development? Is this juvenile able to plan? Is s/he able to hypothesize about different consequences from alternative courses of action? Is s/he a risk-taker? Is s/he future or present oriented? What other characteristics of typical adolescent thinking can you identify in this juvenile's thought processes? What external factors may be interfering with this juvenile's ability to think maturely?

4. What do we know about how this teenager views him or herself? What and who are the major influences -- both positive and negative -- on this juvenile's identity development? Is there any evidence that this juvenile is struggling to define his/her identity? What is this juvenile's level of dependence on/independence from his/her family? Peers?

5. What do we know about this teenager's moral reasoning? What can you identify as this juvenile's moral values? What are the sources of this juvenile's values?

6. What impact, if any, has this juvenile's physical development had on his/her identity? His/her relationships?

7. Has this juvenile had the opportunity to develop competency in any area? If yes, which areas and why was the juvenile successful in developing the competency? If no, identify fruitful areas for this juvenile's competency development?

8. What does development theory suggest to you about strategies for helping this juvenile modify his behavior? What type of programming does it suggest for the juvenile?

9. What do you know about the juvenile in the case study from what s/he said? How s/he acted? What s/he looked like? His/her surroundings? The people s/he's hanging out with?

SMALL GROUP EXERCISE WORKSHEET

PART B

APPLYING ADOLESCENT DEVELOPMENT THEORY TO DIFFERENT STAGES IN THE JUVENILE COURT PROCESS

The state of Euphoria includes in its definition of “delinquent act” any conduct that would be a misdemeanor or felony if committed by an adult. A “child” is anyone between the ages of 10 and 17 who is charged with committing a delinquent act. Euphoria’s juvenile code has as its mission protection of the public and providing delinquent youth with a course of treatment, rehabilitation and supervision through a balanced approach of holding the youth accountable and promoting competency development.

Your county has a secure detention center of 60 beds, an eight-bed group home for boys, and a probation unit that supervises youth prior to trial. Euphoria State law permits pre-trial detention of a youth who represents a risk of flight, or who is “a danger to himself or others.” Adjudicatory hearings must be held in ten days if youth are detained. If youth are released, they will have their hearings in two to four weeks.

Judges can transfer youth to adult criminal court upon the prosecutor’s motion and a written submission that addresses whether the juvenile is an appropriate, or “fit,” subject for juvenile court jurisdiction. The juvenile court can determine that the juvenile is not amenable to treatment in the juvenile system after considering:

- ! the degree of criminal sophistication shown by the youth;
- ! whether the youth can be rehabilitated prior to the expiration of the juvenile court’s jurisdiction (which, in Euphoria, is the 21st birthday);
- ! the minor’s previous delinquent history;
- ! success of previous attempts by the juvenile court to rehabilitate the minor;
- ! the circumstances and gravity of the offense alleged in the petition.

Dispositions in Euphoria’s juvenile court must be made in the least restrictive setting consistent with protecting the public and the best interest of the child.

1. You are the probation department's intake officer. You have the discretion to drop the case, refer the youth to diversion or community-based accountability programs, or file a delinquency petition and send the case to juvenile court. Based upon what you have learned today, are there any developmental considerations that would affect your choice? What are they? How would this youth's developmental status have to differ for you to reach a different conclusion?

2. You are the probation officer or judge charged with making the initial detention decision. Based upon what you have learned today, are there any developmental considerations that would affect your decision regarding detention? What are they? How would this youth's developmental status have to differ for you to reach a different conclusion? How would your system have to be configured – either with respect to processing of cases or alternatives to detention – for you to reach a different conclusion?

3. You are the judge. The prosecutor has moved to transfer the youth's case to criminal court. Based upon what you have learned today, are there any developmental considerations that would affect your decision regarding transfer? What are they? How would this youth's developmental status have to differ for you to reach a different conclusion?

4. You are the probation officer who is making a recommendation regarding disposition, or the judge entering an order of disposition. Based upon what you have learned today, are there any developmental considerations that would affect your decision regarding detention? What are they? How would this youth's developmental status have to differ for you to reach a different conclusion?

APPENDIX C

CASE STUDIES FOR USE IN MODULE ONE EXERCISES

(Note to trainers: Trainers should ideally substitute profiles of real teenagers who have gone through the juvenile court in their jurisdiction for use in these exercises.)

Case Study: Denise E. (age 15)

Denise has been charged with armed robbery.

Information known at time of arrest/detention hearing:

Denise is a five-foot tall, white female who grew up in a racially-diverse, working-class urban neighborhood. At age 12, Denise was arrested with two older teens and charged with robbery and simple assault after “shaking down” a classmate for small change. She was placed on a pre-trial probationary status, paid restitution and did community service. When Denise was 13, she was discharged from a group home operated by the county child welfare agency after she assaulted a social worker who was trying to restrain another resident at the home. Denise had been placed in the home when her great aunt Jane said she could no longer live with her. Denise now lives with Jane.

The police report indicates that Denise was arrested with two 16-year-old girls, and all three have been charged with robbery after a purse snatch outside a supermarket. The victim broke her wrist after falling to the pavement. The report further states that one of Denise’s co-defendants brandished a knife and snatched the purse, while Denise shouted encouragement. Denise told police that she was present, but says that she thought her friend was only going to ask customers for money as they exited the supermarket. When her friend snatched the purse, she helped her flee (“I had to back her up”), but she hadn’t known that her friend had a knife.

Information known at time of transfer hearing/disposition:

Denise and her half-brother were removed from her mother’s home when Denise was seven after they were physically abused by mother’s boyfriend (now her husband). The children also witnessed the boyfriend strike their mother. Except for one year at the group home, she has lived with her maternal great aunt, Jane, and her brother since then. Denise recently revealed that she was also sexually abused by her mother’s current husband before her removal from the home.

Denise’s social history shows that at age 10, Denise became violent with Jane and was admitted to a short-term residential program. She returned to Jane’s home within a month, but, at age 12, Denise was removed from Jane’s home again because Jane said she could no longer control her; child welfare placed her in a group home. But after the group home assault, Denise was returned to Jane’s care.

Denise says she gets along with her mother, whom she calls daily and visits occasionally. She is upset with her mother for marrying a person who physically abuses her. Denise started using alcohol and marijuana at age 13 and is sexually active. She attends school regularly, and does not have a record of truancy or behavioral problems in school.

Case Study: Kevin M. (age 16)

Kevin has been charged with burglary.

Information known at time of arrest/detention hearing:

Kevin, a six-foot-three-inch tall, 170-pound African-American male from a middle-class urban neighborhood, has been arrested twice in the past year. The first time was for riding in a stolen automobile; the second was for driving his father's car under the influence of alcohol. Kevin was adjudicated delinquent after the first offense. He was placed on probation, ordered to pay restitution and fines and perform community service. Charges were dropped after the second offense, as his father declined to press charges. He was intoxicated at the time of both arrests. He is on intensive probation supervision from the first offense and, as a result, a probation officer visits his home twice a week.

Kevin was arrested after he was found in a neighbor's garage and set off a silent alarm. The police report states that there was alcohol on his breath at the time of arrest. Kevin's parents live together.

Information known at time of transfer hearing/disposition:

Kevin's mother was 16 when he was born. His parents have lived together ever since, but they remain unmarried. When Kevin was 11, his father, a heavy drinker and regular user of cocaine, attempted suicide. This event marked the beginning of Kevin's drop in school performance and beginning of emotional difficulties. Kevin attended therapy for one year after his father's suicide attempt, but he was not expressive in either individual or group sessions. Kevin reportedly hides razors and knives when his father drinks.

Kevin is very involved in team sports (particularly soccer) and does relatively well in school. However, his mother complains that the friends with whom he hangs out are part of the "popular" crowd who drink a lot. Kevin began drinking and using marijuana at age 14.

Kevin denies having a drinking problem. He says he "can control" it, telling his probation officer to "get off my back."

Results of psychological testing show that Kevin is of average intellectual functioning. When asked about the offense, Kevin said that he went into the garage for a soccer ball, which he thought the neighbor might have. Though he didn't know the neighbor well— the neighbors lived half a block away and were not close to his family— he saw no reason why the neighbor would mind.

Case Study: Crystal L. (age 13)

Crystal L., a 5'3" African-American female, is charged with aggravated assault.

Information known at the time of intake/pretrial detention hearing:

According to the police report, officers arrived on the scene at 12:30 AM to find two teenage girls (not Crystal) fighting in the street. When the officers arrested the two girls who were fighting, Crystal and a teenage boy began yelling at the police officers. The officers repeatedly told Crystal and the teenage boy to calm down, but the two continued to yell at the officers while they handcuffed the girls; the commotion drew a large crowd. After the girls were placed in the car, the teenage boy took a swing at one of the officers, who then restrained the teenage boy. Crystal then threw a bottle at the officer, and was arrested.

The police report gives as Crystal's address a foster care group home. A call to the group home confirms that Crystal has lived there since last year. The director says that generally her behavior at the home is good, but she sometimes misses curfew and she has been missing a lot of school. A records check reveals that Crystal had one previous delinquency adjudication when she was 12; Crystal pled guilty to simple assault and disorderly conduct. According to the police report, Crystal gave a statement to the effect that all she was trying to do was find out where they were taking her cousin Dana, the police had no business taking them in, and that it was just a simple fight and Crystal and her boyfriend were breaking it up when the police came.

Information known at the time of transfer hearing/disposition:

Crystal's family was referred to the county child welfare agency when Crystal was 4 ½ years old; Crystal's mother was unable to adequately care for Crystal and Crystal's seven older siblings due in large part to her drug addiction. Crystal was committed to the county child welfare agency for 2 ½ years; during that time she lived with her father's sister, Angela, who is also the mother of her cousin Dana. Crystal did return to her mother for a time when her mother stopped using drugs. But by the time Crystal was 11 years old, the child welfare agency placed her again with her aunt Angela because her mother had relapsed. Crystal was placed in the group home at age 12, after her arrest last year, because her aunt Angela felt she could no longer control Crystal, and she was a bad influence on Dana. A review of the court file reveals that her arrest last year was for a similar offense as the current charges: Crystal had been fighting with her cousin Dana when the police tried to break it up. Crystal shoved a police officer into the side of his squad car. Crystal was placed on probation for the adjudication last year, which she completed. Crystal is in a special education class at school. Although Crystal is physically mature, she speaks slowly and sometimes looks bewildered when you are talking to her.

Case Study: Juan M. (age 14)

Juan M., an Hispanic male, is charged with arson.

Information known at the time of intake/pretrial detention hearing:

According to the police report, witnesses saw Juan and a 13-year-old boy throwing lit matches into a shopping mall dumpster earlier that evening. The dumpster fire spread to the adjacent toy store, causing extensive damage to the exterior walls. When he was arrested in front of his apartment house later that evening, Juan made a statement to the police that he had been looking for toys in the dumpster with his friends, and that another boy who was with him had thrown the matches into the dumpster. He made a second statement at the police station that they had just lit the matches to see better into the dumpster because it was dark out, and one of the matches just fell in. Juan has two prior adjudications: one for unauthorized use of a vehicle (passenger) when he was 12 and a second for destruction of property (for vandalism in a local playground) last year. Juan lives at home with his mother, who says that Juan is always acting out, but that she wants him home with her.

Information known at the time of transfer hearing/disposition:

Juan grew up in a fatherless household headed by his mother; his father had no involvement with him until last summer. Juan has been in special education from kindergarten until sixth grade because of emotional problems and a learning disability. He was mainstreamed last year, but is doing very poorly and is very frustrated with his school work, according to his mother. Juan has problems with school attendance, cutting classes to go to the arcade and out in the neighborhood. His mother reports that Juan is good at fixing things around the house, like the radio, and Juan says he would like to study electronics. School records show that Juan has tested well for activities that require speed and visual-motor coordination, but he does poorly in math and has poor verbal skills.

Juan has been involved in therapy since elementary school because of his behavioral problems. He admits that he has a temper control problem which leads to his provocation of altercations with his peers. Juan also has problems in school, where his record shows that he has thrown tantrums at teachers and punched walls. Juan said that he is afraid of crowds and feels that other kids try to hurt him for no reason. He reports that his mother often screams at him and threatens to place him in foster care. Juan currently takes medication for depression and hyperactivity.

Case Study: Bobby J. (age 17)

Bobby is a White male who is charged with felony destruction of property.

Information known at the time of intake/pretrial detention hearing:

Bobby lives in a predominantly White, affluent suburb of a major city. He was arrested last night for vandalizing a nearly-finished, but still unoccupied home during an unauthorized party of more than 100 teenagers. According to press reports, three other local youth – ranging in age from 17 to 21 – had distributed flyers in the area, announcing a keg party at \$5 a head last Saturday night. An unoccupied home -- owned by a couple unrelated to any of the organizers -- was listed on the flyer as the party's location. Scores of teens and young adults showed up and during the course of the night caused approximately \$250,000 in damage. They smashed dozens of windows, kicked and punched holes in the walls and ceilings, damaged marble counter tops and urinated on appliances. The police have arrested approximately a dozen young people, one of whom identified Bobby as being one of the party-goers who smashed in windows with a football helmet. Bobby has never been arrested before. He lives with his parents.

Information known at the time of transfer hearing/disposition:

Bobby is an average student at the local high school, where he is a junior. He plays varsity football and is very committed to his sport. Bobby's home life is unremarkable; he grew up with his parents, both of whom work, and has two younger siblings.

Bobby says that he had not seen the flyer advertising the party, but heard about it from one of his buddies on the football team. Bobby has attended a number of keg parties, usually at the home of a friend or acquaintance whose parents were out of town. He arrived at the party at around midnight with some of his teammates. When he got there the party was in full swing. He admitted that a number of people appeared drunk and some guys were urinating in the living room. Bobby says he and his football buddies drink regularly on the weekends, but that night he probably drank more than he usually did. He explained that he didn't go into the party intending to do any harm. He remembers his teammate Steve was joking around, wearing his football helmet while he danced. Bobby remembers taking the helmet off of Steve's head, and then swinging it into a glass window; before he knew it, he was smashing a number of windows. Bobby says that he never would have done anything like that if he hadn't been so drunk. Bobby says he knew that they were in the house without the owners' permission.

Bobby's parents are shocked. They did not know where Bobby was that night; they don't keep tabs on Bobby or give him a curfew because he's always been a good kid.

APPENDIX D

OTHER SUGGESTIONS FOR MOVIES TO BE USED IN CONJUNCTION WITH THIS MODULE

The Basketball Diaries

Poetic Justice

Blackboard Jungle

Pretty in Pink

The Breakfast Club

Rebel Without a Cause

Bye-Bye Birdie

Romeo & Juliet

Clerks

Sleepers

Dead Poet's Society

Slums of Beverly Hills

Dangerous Minds

Stand By Me

Endless Love

Welcome to the Dollhouse

Grease

West Side Story

Hair

What's Eating Gilbert Grape?

Lord of the Flies

The Wild Ones

Ordinary People

*TALKING TO TEENS
IN THE JUSTICE SYSTEM:*
Strategies for Interviewing
Adolescent Defendants,
Witnesses, and Victims

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Lourdes M. Rosado, Editor

AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

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JUVENILE LAW CENTER

Juvenile Law Center is a non-profit public interest law firm that advances the rights and well being of children in jeopardy. Founded in 1975, JLC is one of the oldest legal services firms for children in the United States. JLC uses a range of strategies -- including individual advocacy, reform of state and national law and policy, and training of public defenders and lawyers for children -- to improve the juvenile justice and child welfare systems. The children we serve include abused or neglected children placed in foster homes, delinquent youth sent to residential treatment facilities or adult prisons, and children in placement with specialized health and education needs. JLC works to ensure that children and youth are not harmed by -- but instead receive appropriate care from -- the systems that are supposed to help them.

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YOUTH LAW CENTER

Youth Law Center is the leading national legal advocacy program working on juvenile justice issues. For the past 22 years, YLC staff have worked with defense attorneys, prosecutors, judges, and probation officials in virtually every state throughout the nation. In addition to authoring a major text, *Representing the Child Client*, and more than two dozen articles, book chapters, and other publications on the representation of minors, YLC staff have conducted literally hundreds of trainings and presentations throughout the country on delinquency-related matters, conditions of confinement, liability, alternatives to detention, and coordination of services.

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This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM

June 2000

PREFACE

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*

Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*

Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*

Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*

Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a "tool kit" containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can be assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer -- is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

EXECUTIVE SUMMARY

The goal of Module Two is for participants to develop techniques for successfully interviewing adolescents involved in the court system, whether they are defendants, witnesses or victims. Juvenile court personnel engage in one-on-one discussions with teenagers on a daily basis to obtain critical information for decision-making purposes. For example, defense attorneys interview their clients to develop an investigation plan and trial strategy. Prosecutors talk to victims and witnesses to determine whether and how to prosecute. Probation officers gather information for disposition planning, and then regularly meet with supervisees to monitor compliance with terms of probation.

This Module first reviews the unique aspects of adolescent development that have implications for interviewing adolescents. Several developmental considerations -- such as limitations in cognitive capacities, present-oriented thinking, egocentricity, and perceptions of authority figures -- impact the interview dynamic. This Module helps interviewers learn how to factor these considerations into, for example, their demeanor and approach during the interview and the language they use. Participants learn how to gauge a young person's level of language competence and how they process information so that they can structure their questions accordingly.

By critiquing videotaped interviews and engaging in role-plays, participants develop critical skills for successful interviewing, including techniques for:

- putting the child at ease and developing rapport
- conveying a non-judgmental demeanor
- obtaining the maximum amount of information in a limited time frame
- defusing an angry teenager

The Module also includes sections on interviewing special populations, such as adolescents who are depressed, younger adolescents (ages 11-13), and teenagers who are victims of sexual assault/abuse.

Table of Contents

I. Introduction	1
A. Goal of this module	1
B. Types of adult-juvenile interviews	1
C. Summary of major themes to be discussed	2
II. Learning about good and bad interview techniques from critiquing interviews	3
III. How the Unique Aspects of Adolescent Development Impact the Interview Dynamic	7
A. Implications of developmental considerations on interviewing	7
B. The challenge of differences in cognitive capacities.	7
C. Identity development and social development	8
D. Competency development (i.e., mastering skills).	9
IV. Strategies for Successful Interviewing	10
A. Strategies employed depend on a variety of factors	10
B. Interviewer must assess youth on three different levels.	10
C. Building rapport and putting the teenager at ease is key	10
D. Implications of adolescent cognitive development.	12
E. Implications of identity, social, and moral development	14
F. How to interview teenagers with an “attitude”	15
G. How to defuse an angry young person	16
H. How to interview a young person who is depressed	17
V. Interviewing Younger Adolescents	19
A. Facts about younger adolescents	19
B. Implications for interviewing young adolescents	19
VI. Interviewing Adolescent Victims of Sexual Assault/Abuse	20
A. Why teenagers may be unwilling to disclose sexual assault/abuse	20
B. What leads teenagers to disclose sexual abuse	20
C. Additional strategies for establishing rapport	21
D. Strategies for gathering information	22
E. Closing the interview	22
APPENDIX A - SCRIPTS FOR ROLE PLAYS	A1
APPENDIX B - SMALL GROUP EXERCISE WORKSHEET	B1
APPENDIX C - INSTRUCTION SHEETS FOR INTERVIEW ROLE PLAYS	C1

I. Introduction

- A. **Goal of this module.** To identify and learn techniques for successfully interviewing adolescents involved in the court system, including adolescent defendants, witnesses and victims.
- B. **What types of adult-juvenile interviews take place within the juvenile justice system?**

Sample list of adult-juvenile interviews:

- **Intake interview of juvenile defendant.**
ADULT INTERVIEWER: typically a probation officer.
PURPOSE OF INTERVIEW: When juvenile first taken into custody by police, taken to an intake point where a probation officer or other intake staff makes an initial decision on how to proceed (i.e., whether to detain the juvenile or release him/her pending the first court appearance).
- **Cellblock interview with juvenile defendant.**
ADULT INTERVIEWER: Public Defender, court-appointed attorney.
PURPOSE OF INTERVIEW: to gather information in preparation for preliminary hearing during which judge will make decision whether to detain or release the juvenile pre-trial.
- **Full interview of juvenile defendant**
ADULT INTERVIEWER: Public Defender, court-appointed attorney.
PURPOSE OF INTERVIEW: to gather all relevant information about the alleged offense and events leading up to arrest, so that attorney may commence investigation, file relevant motions and prepare for trial.
- **Disposition interview of juvenile defendant.**
ADULT INTERVIEWER: probation officer, court social services.
PURPOSE OF INTERVIEW: to gather information about the juvenile from which a treatment plan can be fashioned.
- **Probation check-ins with juvenile defendant.**
ADULT INTERVIEWER: probation officer.
PURPOSE OF INTERVIEW: to monitor juvenile's compliance with terms of court-ordered probation.
- **Interview with adolescent witness.**
ADULT INTERVIEWER: prosecutor; defense attorney.

Interactive Exercise

Elicit from participants a list of the adult-juvenile interviews that are conducted at different points in the juvenile court system. For each type of interview, ask the participants to briefly describe the following:

- job title/function of the adult(s) conducting the interview.
- purpose of interview (What will the information be used for?).
- typical physical environment in which the interview takes place.
- when (in the chronology of court proceedings) does the interview take place.
- types of questions asked.
- type of information conveyed to the adolescent interviewee.

PURPOSE OF INTERVIEW: for prosecutor: to gather information to make initial decision about whether/what to charge, and to anticipate testimony if case goes to trial. For defense attorney: to anticipate testimony if case goes to trial.

- **Interview with adolescent victim/complainant.**

ADULT INTERVIEWER: prosecutor; defense attorney.

PURPOSE OF INTERVIEW: for prosecutor: to gather information to make initial decision about whether/what to charge, and to anticipate testimony if case goes to trial. For defense attorney: to anticipate testimony if case goes to trial.

- C. **Summary of major themes to be discussed.**

1. Interviewers should employ "developmentally-sensitive questioning." This means that the interviewer must gauge the juvenile's level of language competence and how they process information, and structure the questions accordingly. In general, interviewers must avoid asking long questions with a lot of information and choices when interviewing young people.
2. Building rapport and putting the young person at ease is key to a successful interview.
3. Interviewer must be sensitive to structuring questions and using a tone of voice that is non-judgmental.
4. Interviewer must always ask him/herself to what extent a young person's behavior during an interview is caused by the way you interview him/her, and to what extent is his behavior an indicator of really who s/he is.

Interactive Exercise:

Ask participants to describe the following with regard to interviews they conduct with juveniles in the court system, to generate list of potential topics for discussion throughout the class.

- What external factors impact the quality of the interview?
- What thwarts your ability to have a successful interview?
- What factors contribute to a successful interview?
- What aspects of the interview are you most comfortable with?
- What aspects of the interview process do you find most difficult?
- Describe techniques you have used (and with what degree of success) to:
 - " put an adolescent at ease, build a rapport with the adolescent.
 - " gauge if an adolescent is understanding you.
 - " clarify slang that the juvenile is using but you do not understand.
 - " get an adolescent to give you more than a shrug or a monosyllabic answer.

Interactive Exercise:

Show photo of a child in a "closed off" position. Ask: What assumptions does the audience make about the child from his body language. Would it change the interviewer's technique if they knew (fill in the blank) about the child, i.e., that they were abused, parents are drug abusers, lives in a neighborhood where one out of four children carry guns, etc.

I. Learning about good and bad interview techniques from critiquing interviews

Interactive Exercise:

CRITIQUING ADULT-JUVENILE INTERVIEWS IN THE JUVENILE COURT SYSTEM

(Note to trainers: see box on page 5 entitled "Tips for Trainers" for teaching and discussion points to use in this exercise.)

The purpose of this exercise is for participants to identify poor and successful interview techniques by watching adult-juvenile interviews.

Step 1: Ask participants to view the interview simulation videotape included with this curriculum, or one or more of the video clips suggested below. Or role play one of the simulated interviews attached as Appendix A.

Step 2: Hand out the small group exercise worksheet included as Appendix B. Break the audience into small groups. (If at all possible, make sure that there is a representation from each of the professions -- judges, prosecutors, defense attorneys, and probation officers -- in each group.) Ask each group to select one individual to act as the group's recorder and reporter.

Step 3: Ask each group to discuss and answer the questions on the worksheet for each video and/or role play that was viewed. The individual appointed as the recorder should record the group's answers to the questions on the worksheet, and be prepared to report on the group's answers.

AUDIOVISUAL AID

Trainers can show the following clips from movies to illustrate key concepts and stimulate discussion. (Times given indicate the scene(s) placement in the movie.)

Kids (1995) d. Larry Clark

21:30-23:00, 25:00-27:00

Two teenage girls – Jenny and Ruby – go to a clinic to be tested for HIV and other STDs. The tests are preceded by information-gathering interviews with health professionals. In the second scene, the girls receive their test results.

45:00-48:00

In this scene, a cab driver notices that his teen passenger, Jenny, is upset and attempts to get Jenny to talk about what is bothering her. At first, Jenny is reluctant to talk. The cabdriver is persistent but not overbearing, and uses praise and warmth to get Jenny to open up.

My So-Called Life – Guns and Gossip Episode (1994) d. Marshall Herskovitz

At the beginning of this episode, two key events occur. A gun goes off in the school hallway while class is in session, and Brian Krakow has some knowledge about what occurred. In addition, a rumor begins circulating around school that Angela and Jordan have slept together.

12:45-14:40, 25:10-26:00, 35:00-36:10, 44:00-45:30

In this series of scenes, the school principal – sometimes in the presence of the police – interviews Brian to find out what he witnessed. The principal threatens Brian to pressure him into revealing what he knows.

22:15-23:50

In this scene, a teacher engages his class in a discussion about how they feel about guns in school. One student – Ricky – tells the teacher that teenagers are sometimes justified in carrying guns to protect themselves, and that adults just don't understand how threatened teenagers feel today. (In a later scene, 39:30-42:30, Ricky tells Angela that he wants people to think that he carries a gun because he gets harassed a lot.)

24:15-25:00, 27:00-28:10

A school guidance counselor talks with students about their feelings regarding the gun incident.

20:15-21:30, 28:10-31:00

Angela's mother confronts Angela about the rumor that Angela has slept with Jordan. Later Angela and her mother have a discussion about sex.

Stand and Deliver (1988) d. Ramon Menendez

46:00-47:40

Math teacher Mr. Kimo tries to talk Frank out of his plans to quit school to work a forklift.

48:45-50:45

Mr. Kimo teases Claudia when she daydreams in class; later Mr. Kimo comforts Claudia when she breaks down in tears over the stress of being a teenager.

Streetwise (documentary) (1984) d. Martin Bell

8:30-10:00, 11:20-14:00

Tiny, a 14 year-old girl who works as a prostitute, is interviewed by a health professional regarding her sexual history prior to a gynecological examination. The interviewer is not shown on tape, but pay attention to her tone of voice and the wording of her questions. (This scene contrasts well with the health clinic scene in *Kids* described on the page 3.)

Menace II Society (1993) d. Allen and Albert Hughes

22:00-24:15

K.D. is watching *It's a Wonderful Life* with his grandparents when his friend Kevin comes to the door. K.D.'s grandfather attempts to talk with the two teenagers about the "trouble" they've been getting into on the street, quoting the Bible. Kevin replies that he doesn't think God cares much about them, because where they live is messed up.

Straight Out of Brooklyn (1991) d. Matty Rich

1:00:00-1:01:45

Shirley's employer sees that the teenager is troubled, and engages her in a conversation. Shirley admits that she is worried that Dennis is going to do something stupid. (We know from earlier scenes that Dennis is planning to commit an armed robbery in order to raise money to leave Brooklyn.)

TIPS FOR TRAINERS

Interactive Exercise on Critiquing Adult-Juvenile Interviews

It is important for trainers to choose and modify role plays of interviews so that they accurately depict practice in your jurisdiction. Trainers are greatly encouraged to find additional video clips and/or develop role plays of adult-juvenile interviews that accurately portray the experiences of professionals in your jurisdiction if the ones supplied with this module are not appropriate. Where possible, we suggest recruiting teenagers from local acting troupes, high school drama clubs, etc., to play the role of the interviewee for exercises in this module. The trainer or other course facilitator should play the role of the interviewer.

The following interview techniques and adolescent behavior should be illustrated by the video clips and/or role plays that you choose to exhibit in order to stimulate discussion and create a foundation for teaching points.

An interviewer employing poor interview techniques:

- ! fails to develop rapport with young person and put him/her at ease.
- ! fails to respond to young person's questions and concerns.
- ! uses words and phrases that young person is not likely to understand.
- ! asks questions and makes statements that sound judgmental (because of wording and/or tone).
- ! asks close-ended questions which don't allow the young person to describe his/her experience.
- ! gets stuck in a standoff or stalemate with young person over a disputed fact (i.e., whether young person committed the charged offense, whether young person goes to school) and interviewer does not negotiate around the dispute to continue interview.

An interviewer employing good interview techniques:

- ! develops rapport with young person and puts him/her at ease.
- ! calms an anxious or hostile young person.
- ! responds to young person's questions and concerns without getting stuck on them for the entire interview.
- ! clearly communicates his/her role and the purpose of the interview.
- ! uses simple words and short sentences.
- ! asks open-ended questions and follow-up questions that are successful at getting the young person to tell his/her story.
- ! successfully gets an interview back on track when young person becomes fixated on one question or statement.

If you are creating your own role play, young person should do/exhibit one or more of the following during the interview:

- ! answers many questions with a yes, no, shrug, or okay.
- ! becomes fixated on correcting a statement made by the interviewer (i.e., the police say you committed this offense, it says here that you don't go to school, etc.).
- ! becomes increasingly hostile and frustrated by the interviewer's questions.
- ! exhibits trouble understanding what the interviewer is asking, and so responds to the questions but with the inappropriate information.
- ! constantly interrupts the interviewer.
- ! begins talking as soon as the interviewer gets into the room (i.e., I didn't do it, I didn't see anything, etc.).

II. How the Unique Aspects of Adolescent Development Impact the Interview Dynamic

A. **Developmental considerations that we discussed in Module One have implications for the demeanor and approach of the interviewer, for the language to be employed during an interview, as well as for the structure of the questions to be asked.**

B. **Differences in cognitive capacities between the adult-interviewer and adolescent-interviewee pose challenges to a successful interview.**

1. **Adolescents process questions differently from adults.**

a. Children's and adolescents' abilities to comprehend what others say to them and to express themselves through language progress as they mature. In general, adolescents begin to think and express themselves more like adults than children, as they are developing abilities to think that are more efficient and effective. However, these intellectual changes are gradual, and it is not until middle or late adolescence that these abilities become integrated into the individual's general approach to thinking and reasoning.

b. It is also important to keep in mind that many adolescents who have contact with the juvenile justice system have learning disabilities and attention deficits. (Module Four specifically focuses on special education issues.)

c. **Implications for interviewing:** Adult interviewers must gauge an adolescent's ability to process language, his/her level of vocabulary, ability to abstract, and other indicators of cognitive development in order to structure appropriate questions. We will be discussing specific techniques that you can use to pose developmentally-sensitive interview questions.

2. **Adolescents think more in the present and have trouble focusing on the future.**

a. Adolescents' attitudes about time differ from those of adults. Generally, adolescents seem to discount the future more and weigh more heavily the short-term (as opposed to long-term) consequences -- both the risk and benefits -- of decisions. Adolescents will be more concerned about what will happen that day, and have more difficulty talking about an event that won't occur until some time in the future. Thus, for example, in a cellblock interview, a teenager wants to know if he will be released that day, but you're asking him questions about whether he will go back to school, a seemingly irrelevant, future event.

b. **Implications for interviewing:** Interviewers have to make the connections -- between what information the interviewer is seeking and the teenager's interests -- for the teenager to see. The interviewer has to somehow address the teen's immediate concerns to put the interview back on track.

3. **Adolescents are fairness fanatics.**

- a. With their increased cognitive abilities, adolescents often embrace principles with a vengeance. They insist idealistically on what should be, and are intolerant of anything that seems unfair or arbitrary. Further, in line with their own development of personal autonomy and resistance to authority figures, they will challenge social conventions in the name of principle.
- b. A common mistake that interviewers make is assuming that if they apologize for having little time, the adolescent should be able to work efficiently on the interviewer's clock. However, teens will often feel resentful about the interviewer's time constraints, and feel cheated. Or adolescents will sometimes get stuck on correcting what they believe is an incorrect statement in the course of an interview, and have trouble moving on, thus stalling the interview.
- c. **Implications for interviewing:** An interviewer must learn how to navigate around sticking points like these to put the interview back on track. We'll discuss techniques interviewers can use.

C. Identity Development and Social Development

1. Egocentricity.

- a. As we learned in Module One, adolescents tend to be egocentric. Intense self-consciousness sometimes leads teenagers mistakenly believe that others are constantly watching and judging them. They doubt that others -- especially adults -- can really understand their unique experience.
- b. **Implications for interviewing:** Critical to a successful interview is the ability of the interviewer to build trust so that the teenager can feel that s/he can confide in the interviewer. This includes asking questions in a non-judgmental way. We will discuss, during this class, strategies interviewers can use for building rapport and trust with the youthful interviewee.

2. Identity development.

- a. As we discussed in Module One, adolescence is a time when young people attempt to establish a coherent, stable identity, and, in the process, "try on" different personalities, interests and ways of behaving. Young people often look to their peers to form their identity, and they have a need to belong. Even seemingly innocent questions about a young person's friends can be interpreted by the young person as a criticism of him/her and therefore the young person's view of himself or herself.
 - (1) For example, adolescents react strongly when someone implies that they should not dress in a certain way or do an activity that defines them as part of a group.
 - (2) Furthermore, they are likely to be loyal to family and friends and get much angrier than an adult would when something negative is implied about people

who are important to them (even those people who have abused or neglected them or are known substance abusers and criminals).

- b. **Implications for interviewing:** Interviewers must take special care to structure questions and use a tone of voice that conveys to the young person that the interviewer is not judging the young person but is instead truly interested in who s/he is.
3. **Relationships with authority figures.**
- a. It is not uncommon for young people to mistrust adults, and to be fearful of strangers. Adolescents, when questioned by persons in authority, assume that there is no common ground between them. They expect adults to be judgmental, even if they appear friendly, and therefore some teens are unresponsive to adult questions. Other young people react to authority figures by being susceptible to adult suggestion and overly eager to please.
 - b. **Implications for interviewing:** Rapport-building is the necessary foundation for a successful interview. Adults typically use eye contact to convey interest. A young person, however, will sometimes interpret a stranger making eye contact with him/her as a sign of aggression. Therefore, the adult must gauge the situation before deciding whether to use eye contact. Moreover, in general two adults should not interview an adolescent at the same time, because the adolescent will feel "ganged up on." With a child who the interviewer senses is overly eager to please, the interviewer should reassure the child that s/he will not be judgmental of the child's answers (i.e., "I'm going to continue to help you as your attorney no matter what you tell me about what happened that day") and simply wants to hear the child's viewpoint.
- D. **Competency Development (i.e., Mastering Skills).** Talking about what s/he (and his/her family) has done well is a way to build rapport and get the adolescent more involved in the interview.

III. Strategies for Successful Interviewing

- A. **The strategies to be employed during the interview depend on a variety of factors**, including the adolescent's developmental level, the purpose of the interview, the adolescent's relationship with the interviewer, the interpersonal styles of the interviewer/interviewee, the interview setting itself, and the effect of the current situation on the adolescent.
- B. **Interviewer must assess the juvenile on three different levels for a successful interview, and tailor his/her interview techniques accordingly.**
1. **What is this young person's level of development?**
 - a. What level of cognitive thinking has s/he achieved?
 - b. Where is s/he in his/her identity formation and in his/her social relations with peers, adults?
 - c. What is his/her moral value system? Where does s/he derive it from?
 - d. Has s/he achieved success in any area of his/her life?
 - e. What impact does his/her level of physical development have on how s/he acts? How s/he feels about himself or herself?
 2. **Are there any disturbances in the adolescent's normal development?** Past trauma? Depression? Aggression? Extreme risk taking?
 3. **What is the impact of the current situation on the adolescent and his/her ability to communicate in an interview?** Witnesses and victims have experienced something upsetting prior to the interview. Juvenile defendants are worried about what will happen if they talk. Juveniles are often hesitant to talk with adults, especially about sensitive or weighty matters.
- C. **Building rapport and putting the teenager at ease is the key to a successful interview.**
1. It is important for the interviewer to motivate the interviewee to answer the questions to the best of his or her abilities. This is known as rapport building. The interviewer must deliberately create a comfortable environment in which the adolescent trusts the interviewer enough to disclose potentially embarrassing and disconcerting information. Creating such an environment is accomplished through both verbal and non-verbal means. The first few minutes of the interview are crucial for reducing the adolescent's anxiety and building trust. The success of the interview relies upon the interviewer investing the effort to put the adolescent at ease during the first few minutes.
 2. **General tips for rapport building:**

- a. **Don't confuse good intentions with rapport building.** It is unwise to assume that an interviewer's good intentions alone or genuine interest in the young person will get things off to a positive start. Being a friendly person with an interest in what they young person has to say does not guarantee a successful interview. This is not necessarily because the young person is "being difficult," although unresponsiveness to a friendly interviewer is frequently misinterpreted as a lack of cooperation.
- b. **Start conversation with non-threatening, less serious topics.** This technique will decrease the youth's anxiety.
- c. **Follow the adolescent's lead.** Encourage the adolescent to tell his or her own story without interruption. If the interviewer is patient, many of the questions will be answered without putting the adolescent on the spot. Be an attentive listener: nod in agreement and make encouraging comments. Again, body language that is calm and conveys openness increases relaxation, which helps the adolescent tell his/her story.
- d. **Potential problems:**
 - (1) The interviewer may feel pressed and want/need to skip directly to the information gathering stage.
 - (2) The interviewer may not have confidence that the juvenile will answer his/her questions in the allotted time.
- e. **Recognize the juvenile's strengths.** Talking about what s/he (and his/her family) has done well usually gets the adolescent more involved in the interview (this is called adopting a "one down approach"). This is in contrast to an authoritative, all-knowing stance, which can frighten and/or alienate adolescent interviewees, who do not come to the interviews of their own volition. The interviewer can ask questions of the child/adolescent in an area in which s/he has interest or knowledge. By expressing curiosity and asking the child/adolescent's opinion, the interviewer is creating a sense of "empowerment" that will facilitate the interview process.
- f. **Find common interests and let the juvenile talk about them.** Adolescents who are defendants, witnesses, and victims may be of a different race, culture, class and/or gender than the interviewer. If the interviewer reaches out, usually there is something both are interested in: sports, hobbies, fashion, music, local events, or a family similarity. The interviewer should encourage the teen to "teach" a topic about which the teen is knowledgeable. The interviewer should not talk a lot about himself/herself. The purpose of this technique is to reduce the adolescent's anxiety and increase his/her self-confidence.
- g. **Do not take the adolescent's behavior personally.** Do not assume that the adolescent is being uncooperative on purpose and/or specifically in response to you. S/he may not easily communicate with adults. S/he may be responding

with fear to an unfamiliar and threatening situation. His/her initial lack of trust may be a result of past victimization.

- h. **Use a technique known as "pacing."** Specifically, rapport is promoted through matching the behavior of the interviewee, including body posture and movements (unless the juvenile is tense/rigid, then interviewer wants to model calm body posture) respiratory rhythm, speed of conversation and voice tone and volume. To do this well, one needs practice, otherwise this becomes intrusive, distracting the juvenile, and producing unwanted effects.
- i. **Match predicates with those being used by the interviewee.** Predicates are verbs and the words used to explain actions or conditions, either adjectives or adverbs. Some adolescents use visual predicates (e.g., "I see what you mean," or "things are looking brighter") while others use auditory (e.g., "I hear what you're saying," or "That sounds terrible") or feeling predicates (e.g., "I've got a lot of heavy problems"). Most individuals have a preferred method of processing information, and "matching" their preferred style can be a powerful rapport-building technique.
- j. **Invite the adolescent to ask questions any time during the interview** about what will happen next in court and about the role of the interviewer in that process.
- k. **Work on building and maintaining rapport throughout the interview process.** Rapport building is a continuous process between the interviewer and the interviewee. It can always be improved; unfortunately, the reverse is also true. While good rapport can withstand much stress during the interview process, insufficient effort to maintain rapport throughout can have deleterious effects.
- l. **Don't confuse rapport-building with saying anything just to be liked.** Working "too hard" to establish rapport can also have unwanted effects. If the child/adolescent perceives the interviewer as being disingenuous, the child/adolescent will be less open to questioning. The key is balance. An effective interviewer learns when and when not to address rapport building during the interview process.

D. Implications of adolescent cognitive development for interviewing.

- 1. **Gauge the adolescent's language competence and ability to process information.**
 - a. It is crucial that an interviewer examine an adolescent's use of language before attempting to acquire the desired information. This is of particular importance when interviewing adolescents from different cultural backgrounds, and adolescents for whom English may be a second language. If possible, this can be done prior to the interview (e.g., by listening to conversations that the juvenile has with adults in his/her life). If this can not be accomplished prior to the interview, the first few minutes of the interview can be used for this purpose,

while simultaneously establishing rapport. Talk about basic, inconsequential issues first. Listen to the way they talk, the words they use, and the level of complexity of their sentences. Then shape your subsequent questions accordingly.

- b. Verbal communication abilities can also be tied to cognitive processing. Therefore, knowing if a juvenile has auditory processing problems, attention deficits, or low intelligence prior to the start of the interview can help prepare the interviewer to ask questions specifically designed to factor in these disabilities.
- c. One way to determine how the juvenile best processes information is to listen to the types of predicates s/he uses. Some adolescents use visual predicates (e.g., "I see what you mean," or "things are looking brighter.") while others use auditory (e.g., "I hear what you're saying," or "That sounds terrible.") predicates. Most individuals have a preferred method of processing information, and facilitating their use of this preferred method can help put the adolescent at ease and allow for better information gathering.

2. **Avoid long questions with a lot of information loaded in them.**

The adolescent will have to spend a lot of time digesting all the information before answering. Along the same lines, plan your first two sentences of introduction carefully so that you can clearly communicate the purpose of your interview and put the adolescent at ease. An overly long introduction will cause the adolescent to tune out.

3. **Avoid giving more than one option in a question.**

Doing so may confuse teenagers, especially those with auditory processing problems, attention deficits, or low intelligence. Direct simple questions are more easily processed. The interview can clarify an adolescent's answer to a question by presenting two choices if the two choices are clearly distinguished. **Example:** "Earlier you said that you were scared when that happened. Now it sounds like you are saying you were angry."

Interactive Exercise:

Present the audience with some yes-no-okay-shrug type questions and ask the audience to rephrase them in a way such that the adolescent could not respond with a yes, no, okay, or shrug.

EXAMPLES:

How's school going?

vs.

What subject are you best in at school, followed by, That's a really hard subject, what do you like about it?

When was the last time that you saw your father?

vs.

What's the most fun you can remember having with your father, followed by a comment about the positives in their relationship.

4. **Use visual props to facilitate conversation.** Some adolescents understand better if the interviewer uses simple visual props. Similarly, some teenagers can demonstrate what happened more effectively by using visual props — such as drawing diagrams — than they can with words alone.
5. **Avoid asking for abstract thinking.** Don't ask questions that start with the phrase "What if...?" This can frustrate interviewer's attempt to gather factual information.
6. **Avoid analogies.** For example, let's say that the interviewee shares the interviewer's interest in basketball. Chances are that the adolescent plays by such different rules that s/he will not be able to understand the interviewer's basketball analogy.
7. **Ask open-ended questions** that require the young person to describe the subject areas in which the interviewer is interested.
8. **Avoid questions that can be answered with a yes, no, okay, or shrug.** It is difficult to invent interesting follow-up questions to draw out answers after a teenager gives you a yes, no, okay or shrug, so it's better not to phrase questions that can be answered in such a way.
9. **Ask questions when you do not understand.** It is not offensive to clarify. Many adolescents use terms or phrases the interviewer will not understand. If an adolescent uses a word in a way that seems out of context, it may be slang to the interviewer. One way to clarify is through the use of reflection (e.g., Tell me if I got this right . . .).

Interactive Exercise:

Present some "why/how could you" questions and ask the audience to rephrase them in a way that does not sound judgmental.

EXAMPLES:

Why were you out after curfew?

vs.

It must be hard to get in by curfew.

Why is your school attendance so bad?

vs.

There must be something bad about school that makes you not want to go.

Why were you carrying a knife?

vs.

Tell me what you were thinking when you put the knife in your waistband.

E. Implications of identity development, social development and moral development on interviewing.

1. **Don't start questions with "why" or "how could you."** Questions that start like this convey judgment even if the interviewer does not mean to be accusatory, and thus provoke defensiveness. The adolescent does not hear them as "wondering" questions.
 2. **Do not move too quickly into inquiring about offense-related matters.** Sometimes requesting permission to start talking about a difficult subject helps. Inviting him/her to tell the story will make him/her less anxious than questioning.
 3. **Generally avoid having two adult interviewers with one adolescent.** Even two friendly interviewers can be overwhelming for an adolescent who has concentration difficulties or threatening for an adolescent who has been abused and does not want someone else to be in control.
- F. **How to interview teenagers with an "attitude"?** Strategies for interviewing teenagers for whom it is difficult to have empathy:
1. Find a way to relate to the teenager without agreeing with or condoning his or her bad behavior. View the teenager as someone interesting to interview. You are not condoning the bad behavior by conveying that you think there is someone worth getting to know behind the facade.
 2. Don't get caught up in defending your own values or voicing your disapproval of the teenager's behavior. Again, don't take it personally. Let the teenager "strut their stuff" but don't let it fluster you. If

AUDIOVISUAL AID

Trainers should show the following video clips. (Times given indicate the scenes placement in the movie.)

Just Another Girl on the I.R.T. (1993) d. Leslie Harris

15:30-20:30, 57:30-59:00

In the first scene, the movie's main character, Chantel, challenges her history teacher to discuss contemporary problems affecting her and her classmates. The teacher responds poorly and the two engage in an argument that ends with the teacher sending Chantel to the principal's office. In the scene that immediately follows, the principal tells Chantel that she has to act more like a "lady" and discourages Chantel in her goal of graduating from high school one year early. In the third scene, Chantel's history teacher reacts negatively to her class presentation, in which she discusses the inaccurate portrayal of the size of Africa and other countries on Eurocentric maps.

Discussion question:

Chantel is obviously bright and articulate. Her demeanor and use of obscene language, however, are off-putting and offensive to the adults in her life. What specific suggestions do you have for Chantel's teacher and principal as to how they could have communicated more productively with Chantel?

the teenager sees that s/he can't get a rise out of you, s/he then has to figure out a new way of dealing with you.

G. How do you defuse an angry young person during an interview?

1. Be interested in the young person. Don't respond to the young person's anger, and don't be pressured by your own agenda as the interviewer. Pretend that you are meeting this young person over someone's kitchen table. It is pretty irresistible for even an angry adolescent to have someone take a genuine interest in him/her.
2. The interviewer should counter aggressive/defiant posture of the interviewee with calm, sincere smiles and straight eye contact. The interviewer should regard the aggressive/defiant body language as an opportunity for showing positive human contact rather than allowing fear or repulsion to sabotage interviewer's task.
3. Empathy is the enemy of aggression. An empathic interviewer helps foster a climate of calm and safety, the survival *prerequisites* for genuine and productive communication during the interview.
4. Many violent youth were victims of child maltreatment and/or have witnessed violence at home or in their community.
 - a. The experience of early trauma leads to hypersensitivity to arousal in the face of threat, with responses taking the form of aggression. Interviewer should be aware of his/her own body language and speech. Be relaxed before entering interviewing area, walk calmly, and sit in a relaxed posture. Breathe in, smile, give reassuring eye contact. Present a secure, inviting atmosphere. Ask questions slowly in a gentle manner. Sit interviewee facing (rather than with back) to the room's door.
 - b. Youth exposed to violence at home and in the community are likely to not trust adult capacity and motivation to ensure their safety; these youth, therefore, believe they must take matters into their own hands. Avoid statements such as "You can trust me." They usually only increase interviewee's hyper-vigilance. Instead use statements such as, "You're probably thinking 'Who is this person and why should I tell him (her) anything?' I respect that. So we'll take this interview slowly, and you'll have the space to check me out as we go along, alright?" This usually has a calming effect, and often elicits a smile. In the process, the possibility for trust has been planted.
 - c. Traumatized youth require calming and soothing environments to increase the level at which they are functioning. Pay particular attention to noise level during interview. Limit or avoid outside interruptions. Allow for brief moments of silence when answers are slow to come. Interpret gaps of information and difficulty with answering as likely to be anxiety-related. Take one or two short breaks if it's a lengthy interview.
 - d. Traumatized youth are likely to evidence terminal thinking (i.e., an absence of future orientation). Defiance and non-compliance from an interviewee may often hide learned apathy from past abuse and trauma. "What's the point of answering

these stupid questions?..." is the *spoken* part of the defiant response, and "...if I'm doomed anyway?" is the *unspoken* part of the response. As a strategy, address the terminal thinking, not the defiance. For example, the interviewer could say: "I know this whole interview might seem like it's not going to make a difference in the long run. But right now, what you have to say is important to me. I respect what you have to say."

- e. Issues of shame are paramount among violent youth because of their personal and collective experiences (e.g. victimization, poverty, and racism). Statements such as "He beat me up because I'm Black" or "Nobody gave a d— because I'm just a kid from the projects" are best left alone or validated with "Things must have been tough for you." Allowing such statements opens up the interviewee to reveal more information. Replies such as "Quit the victim mode, will you?" have the opposite effect of shutting the youth down.

H. **How to interview a young person who is depressed.**

1. **Some facts about teenage depression.**

- a. Prominent feature of depression in adolescence is constant irritability (as opposed to adults, who express more sadness).
- b. Depression in adolescence is frequently associated with problem, acting out behaviors.
- c. Once depressed, an adolescent tends to get stuck in depression because s/he withdraws and alienates others. It is often difficult for parents and teachers to get depressed adolescents involved in activities and with others.
- d. Depression is an under-examined phenomena in adolescence, because most adults expect that adolescents will be depressed. It is important however to distinguish periodic depressed moods from depression.
- e. The prevalence of major depressive disorder among adolescents has been reported to be between 1.8 % and 17%. This variability is a result of different assessment methods being employed.
- f. Once hospitalized for depression, there is a high likelihood that the adolescent will be hospitalized again.

2. **Signs of depression in teenagers:**

- ! depressed or irritable mood most of day
- ! diminished pleasure in almost all activities most of the day
- ! significant weight gain/loss
- ! insomnia or hypersomnia
- ! slow, lethargic movement
- ! fatigue, loss of energy
- ! feelings of guilt/worthlessness

- ! diminished ability to think and concentrate
- ! recurring thoughts of death, or suicidal ideation

3. **Additional tips for interviewing a depressed adolescent.**

- ! Tune out the irritability. Don't take the young person's irritability -- a common sign of depression in that age group -- personally.
- ! Get the young person talking by letting him/her talk about what's on his/her mind. This reduces the impact of his/her depression on the interview and builds rapport. Again, it's crucial not to rush the young person onto another topic because you're anxious about covering everything on your agenda.

IV. Interviewing Younger Adolescents (roughly ages 11-13)

A. Facts about younger adolescents which can affect success of interview

1. Young adolescents are much shyer than older adolescents.
2. Young adolescents are more aware of adult power.
3. Young adolescents are not as advanced in their cognitive development.
 - a. Their memories aren't as reliable.
 - b. They embellish stories more often.
 - c. They provide less detail than older adolescents.
4. Young adolescents are much more suggestible. They are more reliant on the interviewer's statements, very interested in pleasing adults and very influenced by parents' and peers' thoughts on the matter.
5. Post event influences can have a big impact on younger adolescents' willingness to talk. For example, in sex abuse cases, younger children will often hesitate to talk after an initial report because the perpetrator, who could be someone they love, was removed from the household.

B. Implications for interviewing young adolescents

1. **Don't give subtle clues to young teens about your impressions about what happened, because of potential suggestibility.**
2. **Do facilitate recall by asking them who, where, what actions occurred, what feelings they had at the time. Use pictures you provide or that they draw to help the process.**
3. **Don't reward certain answers, either by body language or through words.** Acknowledge all answers in the same way so that the younger adolescent will not get the idea that certain answers are the right answer.
4. **Don't ask leading questions** for the same reasons outlined above.

v. Interviewing Adolescent Victims of Sexual Assault/Abuse

A. Why teenagers may be unwilling to disclose sexual assault/abuse.

1. Adolescents often have a fear of not being believed. For example, in date rape situations, perpetrators will often tell their victims, "It's just your word against mine."
2. Adolescents will feel extremely humiliated. Teens will view themselves as "damaged goods," and feel that others will stigmatize them if they disclose. This is especially true in situations where the teenager has experienced long-term, in-home abuse.
3. Teenagers are made to feel that they are responsible for the abuse.
4. Adolescents will feel pressure to not disclose the abuse to protect the abuser and keep the family together. The pressure can be internal, when the adolescent still loves the abuser, or from other members of the family.
5. Adolescents often believe that they can cope with the situation alone. They see getting help as a sign of weakness.
6. Adolescents may fear reprisal against them, and their family.

B. What leads teenagers to disclose sexual abuse.

1. Anger is the primary motivating factor for disclosure in the adolescent population. Disclosure in cases of in-home sexual abuse will usually be triggered by another family event, such as an argument about another issue. This has the unfortunate consequence of making these teenagers appear less credible, because they don't appear to be a victim but instead a rebellious, defiant teenager.
2. Teenagers will often be more difficult in interviews than children; they won't appear "cuddly" like younger victims and, therefore, pose a special challenge to the interviewer.
3. Medical concerns, including pregnancy, STDs.
4. Victim realizes implications of abuse. Some adolescents grew up with the abuse so they don't realize that there is some other way to be in a family until they come into contact with others who share their experiences.
5. Victim is asked about the possibility of abuse by someone outside the family.
6. Siblings are at risk.
7. Abuse becomes intolerable. There is an escalation in the frequency of abuse, or the abuse is taken to a more intrusive and hurtful level.
8. Abuser leaves the household.

9. Victim finds safe relationship with someone in whom they confide. But teens will be more likely to tell a peer than an adult.

C. **Additional strategies for establishing rapport when interviewing victims.**

1. **Communicate that you understand what the victim has gone through.** With younger children, a good way to start off an interview is to ask general questions, such as "What games do you like?", "What's your favorite subject in school?" However, if you start this way with a teenager, it will be an immediate turn-off. Instead, you must communicate to the teenager that you are concerned with his/her well-being. A good method is to focus on what the teenager has immediately been through: "I understand that the police brought you in yesterday. How are you feeling? Where did you spend last night? Did anyone explain to you why you were coming to see me today?"
2. **Don't judge the adolescent before the interview starts.** For all the reasons discussed above, teenagers may come into interviews hostile or completely closed off. Don't assume negative emotions are directed at you.
3. **Be empathic.** The victim needs to feel as though s/he has someone on his/her side.
4. **Reassure them that they have some control over the interview situation.** Give the interviewee some options (i.e., where they sit in the room, the order in which they discuss things, that they can take a break when they get to a hard part, that you can talk about something else for awhile when a topic gets too tough and come back later to it, etc.). Ask the interviewee if s/he would rather tell you what happened in his/her own words, or if it would be easier for him/her if you asked questions. Teens will usually say that it would be easier if you asked them questions, and in that way they give you permission to proceed with the interview.
5. **Remember the impact of individual development and trauma on the young person's understanding and processing of language.** Be simple and concrete if necessary. Have communication aids available. Ask the teenager to draw pictures to stimulate recall, and make it easier to tell the story.
6. **Consider gender issues.**
 - a. Gender issues can impact the dynamic of an interview. For example, teens may be hesitant to talk about sexual abuse/assault with an interviewer of the opposite sex.
 - b. Gender issues must be addressed by the interviewer, or else they will hang over the interview like a cloud. For example, in an interview by a woman of a male teen, the interviewer could say the following: "I know that some boys and young men aren't comfortable talking to ladies about stuff that happens to them. I just want to let you know that I talk about all sorts of things, and I'm used to hearing all sorts of words. Nothing is going to make me upset or make me think badly of you."

- c. It is also important to take into account how your reaction to victims of sexual abuse/assault may be shaped in part by differences in gender.

D. Strategies for gathering information

1. **Be direct in introducing reason for interview.** Don't start off an interview with a teenager asking "Do you know why you are here?" The teenager will simply respond, "Don't you know? If you don't know, why am I here?"; your credibility will be called into question. Teenagers will also question why they have to repeat a story that they have already told to others. The best way to start off an interview is to simply say: "I know that something happened and that the police were involved. I need to hear from you about what happened because you were the one there. I need to know because . . ." But remember to keep your introduction short and simple or you'll lose the teen's attention.
2. **Allow use of slang terminology for body parts and sexual acts.** Ask for clarification as rapport is established. It is best to allow the young person to talk for awhile and not interrupt, because of his/her hesitance to talk in the first place. You can always go back and clarify as the teenager becomes more comfortable.
3. **Do not correct grammar or vocabulary.**
4. **Take time out to address feelings.** Understanding and empathy are more effective than confrontation in getting teenagers to talk.
5. **Remember the impact of trauma and developmental level in the teenager's ability to understand and process language.** Be simple and concrete, and use communication aids.

E. Closing the interview

1. Be prepared to provide support and crisis intervention during and after interview.
2. Assess suicidal ideation. Determine the young person's support systems in the community.
3. Inform the young person about the next steps in the legal process. Don't assume that the young person understands legal terminology or the court system.
4. Ask the young person about his/her concerns about his/her health and body.
5. Make appropriate referrals for counseling and medical assistance.

Interactive Exercise**ROLE PLAY OF ADULT-JUVENILE INTERVIEWS
IN THE JUVENILE COURT SYSTEM**

(Note to trainers: see "Tips for Trainers" below for guidance on how to prepare for this exercise prior to the training.)

The purpose of this exercise is for participants to utilize the techniques discussed in this training to conduct simulated interviews with teenagers that are typical of the types of interviews the participants routinely conduct in their professional capacities.

- Step 1:** Break into small groups to conduct simulated interviews. Each group picks a member to play the part of the teenager (unless trainers can recruit local teenagers to play these parts, which is recommended) and a member to conduct the interview. Attached at Appendix C are the instruction sheets for the individuals doing the role plays. Provide the teenager with the instruction sheet for the interviewee, which contains some information about his/her role (i.e., respondent, victim, witness), the pertinent events that s/he witnessed and/or was involved in, and some family/social background; the teenager should be instructed to make up additional facts as needed as the interview progresses. Provide the interviewer and the rest of the small group with the interviewer's instruction sheet, which contains some basic information from the police report, a statement of where the case is in the chronology of court proceedings, and the purpose of the interview. Give the interviewers a time limit for the interview if not provided on the instruction sheet.
- Step 2:** Volunteers conduct interview in front of small group.
- Step 3:** Group provides feedback on the interview. Group should be instructed to use the worksheet attached at Appendix B as a guide for structuring their feedback.

TIPS FOR TRAINERS**Interactive Exercise on Role-Playing Adult-Juvenile Interviews**

Instruction sheets for participants to role play interviews of teenage witnesses and victims are attached at Appendix C. Trainers are greatly encouraged, however, to create their own role plays for use in this exercise. This requires some preparation prior to the training.

As a first step, gather some actual police reports from juvenile cases in your jurisdiction (with names struck out to protect confidentiality). You will provide the police report to the interviewer prior to the role play, along with a one-page statement of where the case is in the

chronology of court proceedings and the purpose of the interview the participant is to conduct (i.e., you are a prosecutor and you are interviewing a witness to an aggravated assault prior to his/her grand jury testimony).

The instruction sheet for the teenager should include an explanation of the events s/he witnessed and/or participated in, and some brief social/family/school information. The teenagers should be instructed to play the role however they like (i.e., they can be reluctant to talk, hostile, depressed, keep interrupting, etc.), and make up whatever information they need to as the role play progresses. The main point is that the teenager doesn't make the interview easy for the interviewer.

In creating these instruction sheets, trainers should consult the materials attached at Appendix C. The trainer-developed instruction sheets should contain the same level of detail as in the instructions in Appendix C.

If possible, trainers should arrange for facilitators to participate in the small group exercises, to facilitate the critique process and reinforce major themes discussed during the training.

Suggestions for the types of interviews that can be role played (depending on the interests of the participants):

- ! teen witness to an offense being interviewed by a prosecutor.
- ! teen victim of an offense being interviewed by a prosecutor.
- ! teen defendant being interviewed in cell block by appointed defense attorney prior to initial hearing.
- ! teen defendant being interviewed in detention by defense attorney prior to trial.
- ! teen defendant being interviewed by probation officer for disposition report.

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(Note to trainer: *trainer should consult the literature review included under separate cover for additional reference materials and suggestions for assigned readings for training participants.*)

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Appendix A
SCRIPTS FOR ROLE PLAYS

Interview of Adolescent by Probation Officer/Court Social Services Worker in Preparation for Disposition Hearing

(Note to trainers: the actors enacting this role play should use this script as a guide. It is not intended that they strictly follow the script.)

Interviewer: (fumbling through briefcase): Okay Marcus. I don't have very much time so we're just going to have to talk about as much as we possibly can today. You've got a hearing coming up and the judge is going to want to know some explanation of what's going on here with you.

Juvenile: What do ya want to talk about?

Interviewer: These papers say that. . .

Juvenile: (interrupting) Can I see those?

Interviewer: Oh no, you wouldn't . . . no, no.

Juvenile: (pointing to paper on desk) That one has my name on it. Can I see that?

Interviewer: These papers . . . this is just the police report. You were at 3:00 o'clock in the morning . . . (in judgmental tone) 3:00 in the morning on 11/1 you were arrested for driving a stolen vehicle. (in judgmental tone) First thing I'd like to know more about is what were you doing out at 3:00 in the morning?

Juvenile: I wasn't driving a car.

Interviewer: That's what the police report says. You were driving a car that was stolen at 3:00 in the morning. (in judgmental tone) Did your mother know you were out at 3:00 in the morning? Are you usually out at 3:00 in the morning?

Juvenile: I wasn't driving no car. I don't know. Can I see that? What does that say?

Interviewer: It says that the police officer arrested you for driving a stolen car.

Juvenile: When was that?

Interviewer: November 1st.

Juvenile: This year?

Interviewer: (with a little chuckle) November 1st this year.

Juvenile: I wasn't arrested in November.

Interviewer: Well you are in detention now. What were you arrested for?

- Juvenile: I was arrested before Thanksgiving.
- Interviewer: Right that was in November. And you were arrested for driving a stolen car.
- Juvenile: I wasn't driving no car. And that case was dismissed. You've got the wrong case. That case was dismissed. I wasn't driving no car, but the cop said that if I told him who was driving the car, the case would be dismissed. So if that's the case you're talking about that case was dismissed. Who are you???
- Interviewer: Well, are there other cases?
- Juvenile: Are you my public defender? My mom said she was going to send me a lawyer.
- Interviewer: No, I'm not your lawyer. I'm work with court social services and I'm here to talk to you about your next court hearing because I have to write a report. . .
- Juvenile: (interrupting) Am I going home at that hearing?
- Interviewer: I can't tell you what's going to happen at that hearing, but I think this is a really serious offense, driving a stolen car.
- Juvenile: I already told you I wasn't driving the car.
- Interviewer: Well the police report said that you were driving the car and that's what I've got in front of me. The question that we are going to be asked about in court are: why were you driving a stolen car? What were you doing out at 3:00 in the morning? How can you answer those questions?
- Juvenile: Who did you say you are?
- Interviewer: I work for the court, and I'm trying to get ready for this hearing. I have to write a report about you and about this offense.
- Juvenile: So you are going to tell them I can go home, right?
- (pause)
- Interviewer: Well, . . .
- Juvenile: Cause I don't like it here.
- Interviewer: I don't know
- Juvenile: You should tell them I can go home.
- Interviewer: Should I tell them you can go home when you are going to be out at 3:00 in the morning?
- Juvenile: I wasn't out at 3:00 in the morning.

- Interviewer: Well, this report says you were out at 3:00 in the morning.
- Juvenile: I won't be out at 3:00 in the morning. I'd be going to school
- Interviewer: Well that's another thing I wanted to ask you about. The police report says that you aren't going to school and you are 14 years old.
- Juvenile: (slightly hostile) Where are they getting that?
- Interviewer: That you're 14 years old?
- Juvenile: How does the cop know whether I'm going to school or not?
- Interviewer: Maybe the police interviewed someone at your school. Is it true you don't go to school. (While interviewer asks this, kid turns away from interviewer)
- Juvenile: I go to school.
- Interviewer: So why would they . . . ?
- Juvenile: (interrupting) I was going to school until they locked me up.
- Interviewer: Why would the police officer say that you weren't?
- Juvenile: I don't know. Must be the same reason that he said I was driving the car, I wasn't doing that either.
- Interviewer: Well, this isn't the court hearing about . . .
- Juvenile: (interrupting) What's court social services, anyway? I already told this story . . . I already talked to someone about this. Don't you have that there?
- Interviewer: No, what I've got is the police report, and you've got to get ready for a disposition . . . You've got to get ready so that the judge can make a decision about whether you're going to go to a group home.
- Juvenile: A group home?
- Interviewer: Yes . . .
- Juvenile: (interrupting): For what?
- Interviewer: For driving a stolen car.
- Juvenile: My mom wants me home, she says I can come home. She said she only didn't take me last time to scare me. But she wants me home so I'm going home next time. I'm not going to no group home. That doesn't make any sense.

- Interviewer: Well, it might make sense to the judge, who wants to stop young people from driving stolen cars, which can be very dangerous. Being out after curfew, driving a car that isn't yours, someone can get hurt. Did you think about that?
- Juvenile: No, no one got hurt. Besides the car wasn't stolen, it was my friend's car, we had the keys.
- Interviewer: What the people in your neighborhood are worried about . . .
- Juvenile: (interrupting): What people?
- Interviewer: Any person who might have been hurt because you were driving a stolen car, and the person who owned the car . . .
- Juvenile: (interrupting): Why do you keep saying I was driving? Who you going to believe? Can I see that? What's it say I was driving? What kind of car does it say?
- Interviewer: Well, let me see . . .(as she looks over police report). Well, I can't really . . .
- Juvenile: (interrupting) Because if it says a Toyota, that wasn't me.
- Interviewer: Well I can't really make it out. I can read the day of arrest, and the offense, which is driving a stolen car.
- Juvenile: All I know is that I should be going home. I don't know what you're talking about, I already talked to someone about this.
- Interviewer: And going back to school?
- Juvenile: What do you mean, going back?
- Interviewer: The police officer says you weren't attending school when you got arrested at 3:00 in the morning.
- Juvenile: (slightly hostile tone) He's not my teacher, he doesn't know. You should talk to my teacher. Talk to Mrs. Smith, she'll tell you I was there.
- Interviewer: The day before the stolen car . . .
- Juvenile: (interrupting) I was there that day too. What day was that?
- Interviewer: November 1st.
- Juvenile: Yeah, I was there that day too.

**Cellblock Interview of Adolescent-Respondent
by Defense Attorney in Preparation for Initial Hearing
Version #1**

(Note to trainers: the actors enacting this role play should use this script as a guide. It is not intended that they strictly follow the script.)

(Juvenile sits at a table and rests his head on the table. He looks tired and scared. Lawyer rushes in, sits next to the juvenile, and starts asking him questions.)

Lawyer: (fumbling through briefcase) Lock-up number 10?

Juvenile: Yeah.

Lawyer: You're number ten, right?

Juvenile: Right.

Lawyer: Okay. This is my card. (Drops card on the table) Blair Brown's my name, and I'm going to be your lawyer, okay? Now, we don't have much time to talk, alright? So you're going to have to answer all the questions I have, okay? I really want to get you out, but we don't have much time, okay? Alright. What's your name?

Juvenile: William, William Jackson.

Lawyer: William Jackson. What's your date of birth?

Juvenile: 1-19-84

Lawyer: How old's that make you?

Juvenile: 15

Lawyer: Now don't worry about what's going to be happening in court today, okay? That's what I'm going to be worrying about.

Juvenile: I've got to worry.

Lawyer: Well, what I mean is, don't open your mouth. Let me do all of the talking. And don't worry about what's going on because I'm the one who's going to be dealing with all of that. Okay?

Juvenile: Yeah, okay.

Lawyer: Alright, alright, umm, now what's your parents' names?

Juvenile: Do I have to tell you? I don't want to get my family in this.

Lawyer: (appearing annoyed) Well, look, if we're going to get you out of here today you're going to have to cooperate. And I really do want to get you out of here. But I need to know the names of your parents because its important to get your parents down here.

Juvenile: My father's deceased.

Lawyer: Your father's dead. Alright. What about your mother?

Juvenile: Melvern Jackson.

Lawyer: What's her name?

Juvenile: Melvern Jackson . . .

Lawyer: How do you spell Melvern?

Juvenile: M-e-l-v-e-r-n

Lawyer: Okay. What's her phone number?

Juvenile: 882-1904

Lawyer: Is she going to be home if I call her right now?

Juvenile: She could. She might.

Lawyer: (appearing annoyed and serious) Where else would she be if I called her right now? I need to get in touch with her.

Juvenile: At work.

Lawyer: What's her work phone number?

Juvenile: You want it?

Lawyer: Yeah, I need it, I need it. We're going to get you out of here, okay? I need this information.

Juvenile: Okay. 312-0160.

Lawyer: Where's she work at?

Juvenile: UVC

Lawyer: She know you're here?

Juvenile: I don't know.

Lawyer: Well, I'm going to tell her you're here. Okay?

Juvenile: (in a concerned tone of voice) You don't have to tell her.

Lawyer: Well, I have to tell her. Because we have to get you out of here and the only way to get you out of here is to get your mother here.

Juvenile: Alright. As long as you don't tell my stepfather.

Lawyer: (appears surprised) Oh, you also live with a stepfather?

Juvenile: Yeah.

Lawyer: What's his name?

Juvenile: I don't like to discuss it.

Lawyer: Well, I got to have this information to get you out of here. What's your stepfather's name.

Juvenile: His name's Bill Martin.

Juvenile: Bill Martin? He lives at the same phone number?

Juvenile: Yeah.

Lawyer: Well, if I can't reach your mother, I'm going to get him down here. Okay?

Juvenile: If you got to do that.

Lawyer: You got any brothers and sisters?

Juvenile: Yeah.

Lawyer: (still rushing through the questions) What are their names and how old are . . . Well I don't have time to go into that . . . Umm, now you don't have any prior convictions, right?

Juvenile: No, I don't.

Lawyer: (in a suspicious tone) Alright, well, I know that's what your saying, but the computer says that you do have prior convictions. (In an annoyed tone of voice) Now look, if I'm going to get you out of here, you're going to have to tell me the truth about everything. Alright?

Juvenile: Yeah.

Lawyer: And if you tell me that you don't have prior convictions when you have prior convictions, it's not going to help at all because I'm going to get up there and not

think you have any prior convictions. The computer says that you have priors, and I just want to confirm that. Now you do have prior convictions, right?

Juvenile: No, I don't. The computer made a mistake.

Lawyer: (in a sarcastic and annoyed tone) Oh, the computer made a mistake? Well, I've been dealing with that computer a lot and I've never heard of it making a mistake.

Juvenile: It did.

Lawyer: Okay, the computer made a mistake. Well, anyway, we'll deal with that at the hearing. Umm, the other thing that's important in getting you out of here, besides your parents being here, is you going to school. If you're going to school, you have a better chance of getting out. So you are going to school, right?

Juvenile: Yeah.

Lawyer: What school you go to?

Juvenile: Draper High School.

Lawyer: Draper?

Juvenile: Yeah. What you going to call my principal or something?

Lawyer: Well, no because you tell me that you been going to school everyday. And I don't want to tell that principal anything. Umm, but you're not involved in any sort of activities at school, right?

Juvenile: No, it don't interest me.

Lawyer: Okay. And you're not working anywhere, right?

Juvenile: No.

Lawyer: Okay. Now, I want to talk about what went down when this robbery occurred. You're charged with a robbery and, you know, if I'm going to help you get out of here, I'm going to need to know what I'm dealing with. I'm going to need to know the sorts of things the cop is going to say, so you tell me, when you were taking that purse from the lady, exactly what happened?

Juvenile: Well, while the police were taking me over to the car, the lady was complaining to him. She said I grabbed her and took her purse and started running. That's what she said...

Lawyer: (interrupts) Right. When you took the purse, what direction were you coming from?

Juvenile: I don't know. I didn't even pay attention to that.

Lawyer: Okay.

Juvenile: (in a concerned tone) Hey, my jacket. You know, they got my jacket. You know, my jacket cost a lot of money.

Lawyer: Right.

Juvenile: I'd like to see my jacket back.

Lawyer: We really don't have time to be dealing with your jacket. What we really need to deal with is what went down when this robbery occurred.

Juvenile: That's a Polo Jacket- Ralph Lauren, okay?

Lawyer: (in a sarcastic tone) Well it may be the world's most expensive jacket but what's important is not your jacket, alright? What's important is getting you out of here.

Juvenile: Yeah, okay.

Lawyer: Alright, so lets get back to what happened when you committed this robbery. Do you think the lady got a good view of you?

Juvenile: No, she didn't because she said she saw my arms.

Lawyer: (in an annoyed tone) Well, I don't want to know what she said. I want to know what you think was going on.

Juvenile: No . . .

Lawyer: You don't think she got a good view of you when you were ripping off her purse?

Juvenile: (interrupting) Not at all. Not at all.

Lawyer: Now, you didn't make any statements to the police about what happened, right?

Juvenile: No.

Lawyer: Good. We're starting from a good position if you didn't make any statements to the police. Now, you don't have any problems with drugs, right?

Juvenile: You supposed to ask this?

Lawyer: Well, if you don't have any problems with drugs, it's going to help you get out.

Juvenile: (Interrupting) Well, I smoke here and there.

Lawyer: Well, what do you mean "here and there"? Do you use drugs a lot?

Juvenile: It's not no habit or anything. I use it to have a good time.

Lawyer: Like everyday?

Juvenile: No, every other day.

Lawyer: (appearing annoyed) Well, it sounds like a problem to me. I think that to help you out, I'll raise this at the hearing . . .

Juvenile: (interrupting) I'm doing fine right now.

Lawyer: (interrupting) No. No. I want to help you out so at the hearing, I'll raise this drug problem with the judge and try to get him, as a condition of you getting out of here, to get some treatment in a drug program, to make it part of the order. And that'll help you out.

Juvenile: Alright

Lawyer: Good.

Juvenile: Where will it be? Do I have to catch the bus or anything?

Lawyer: (appearing annoyed) Don't worry about these details. We don't have time to talk about these details. I want to get you out of here.

Juvenile: Okay.

Lawyer: Alright. Look, we don't have anymore time, and I've covered all the important points, so I'm just going to go. I'll see you in court. Okay.? Bye-bye.

(Lawyer rushes out of the door.)

Juvenile: Hold on for a minute. Excuse me?

**Cellblock Interview of Adolescent-Respondent
by Defense Attorney in Preparation for Initial Hearing
Version #2**

(Note to trainers: the actors enacting this role play should use this script as a guide. It is not intended that they strictly follow the script.)

(Juvenile sits at the table appearing tired and scared. Lawyer walks in calmly and sits next to the juvenile).

Lawyer: William Jackson?

Juvenile: Yeah.

Lawyer: (in a friendly tone) Hi, William. How are you doing? My name's Blair Brown. I'm going to be your lawyer. This is my card for you to hold onto. (Hands card to juvenile) Do you go by William or do you go by another name?

Juvenile: My nickname's Potts.

Lawyer: Potts? Do you want me to call you that or do you want me to call you William?

Juvenile: Doesn't matter.

Lawyer: Okay, well, I'll call you Potts. Look, I'm going to be your lawyer, and it's important for you to know that anything that you tell me is just between me and you.

Juvenile: You saying I can trust you.

Lawyer: Well yeah, that's right (smiling). What I'm saying too is that anything you tell me is a secret between me and you. And I can't tell anyone else unless you give me your permission. Okay? Now, I'm going to write down some of the things we talk about today, to help me remember some of the things you told me because they're very important.

Juvenile: Okay.

Lawyer: How are you feeling?

Juvenile: Fine. Worried.

Lawyer: Worried? Well, unfortunately, we don't have much time to talk right now. So there's some information about you I'm going to have to get. But we'll have plenty of time after today to sit down and talk a lot more.

Juvenile: Okay.

Lawyer: What's your date of birth, Potts?

Juvenile: 1-19-84.

Lawyer: Okay, I'm going to tell you what is going to happen today so you will know what to expect. Alright? After we talk, at some point this morning, they're going to bring you upstairs, and you'll be put in the courtroom. There's a good chance that they're not going to let me beyond that courtroom to talk to you again. Okay?

Juvenile: Yeah.

Lawyer: And so the first time you'll see me again is when they bring you out in front of the judge. Now, the only thing that the judge is going to decide today is whether or not you're going to get out of here, today.

Juvenile: Am I going to get out of here today?

Lawyer: I don't know. A lot depends on whether I can confirm some of the information that you give me, and a lot depends on what the recommendation to the judge is. I'm going to try as hard as I can to get you out. All I care about is getting you out. And that's what I'm going to be working on today. So when they bring you upstairs and bring you out, it's going to be important what you look like and the sorts of things that you say and do.

Juvenile: Alright.

Lawyer: So I don't want to tell you how to act, but it's real important. When you go in there, take your hat off and keep your hands out of your pocket, and you look at the judge.

Juvenile: (interrupts) I can't chew bubble gum?

Lawyer: No, don't chew any gum. Okay? The judges are very old-fashioned, and they don't like stuff like that. Look at the judge, and it's going to be a woman.

Juvenile: One of them . . .

Lawyer: (interrupts) Well, this one isn't so bad. And you say 'yes ma'm,' you know, things like that.

Juvenile: (interrupts) yes ma'm?!

Lawyer: These judges like that. They're going to help you get out. Okay?

Juvenile: Well, I'm not going to say that anyway.

Lawyer: Well, give it a try because it's going to help you out. Once we get up there, there's going to be a report by the social worker. She's going to make a recommendation as to whether or not you're going to get out. And the prosecutor, those are the people who sometimes are trying to lock you up. They'll also ask the judge...

Juvenile: (interrupts) I don't like them. I don't like them.

Lawyer: Yeah, well, that's who we're fighting in this case, but I'm on your side, so we'll be fighting them. Don't say anything to them. And then I'm going to get a chance to say some good things about you. And I'm going to be asking the judge to let you out and let you out today.

Juvenile: Oh, you going to do your best.

Lawyer: Right.

Juvenile: Okay.

Lawyer: And the judge, based on what he hears and also on the stuff about your prior record, is going to make a decision on whether you get out. Now, just in case you don't get out today, they're going to send you over to the Children's Center. And we don't know if that's going to happen yet, so don't get worried and assume that's going to happen because it may not, and I'm going to try to keep that from happening. So if you go to the Children's Center, I'm going to be out there tomorrow to see you and talk about the case.

Juvenile: We're going to go over this again?

Lawyer: Well, some of the information we don't have to go over, but we don't have a whole lot of time to talk about what you're accused of today. That's going to have to wait until later. What's important today is finding out information about you because that's the sort of stuff that's going to help you get out. Okay?

Juvenile: Okay.

Lawyer: Now, what I usually do, even before I meet you, is go upstairs and check to see on what your prior record is because that's real important as far as getting you out, and the computer says you have two prior convictions: one for unlawful entry and one for disorderly conduct. Is that right? Have you been to court here before?

Juvenile: Yes, I have.

Lawyer: It also says you're not on probation anymore. Is that right?

Juvenile: Right.

Lawyer: So do you see a probation officer anymore?

Juvenile: No.

Lawyer: What was your probation officer's name? Do you remember?

Juvenile: Robert Taylor.

Lawyer: When was the last time you saw him?

Juvenile: About a week or so.

Lawyer: Because your probation ended a week ago. Is he going to say good things about you if I ask him a question, you think?

Juvenile: Could.

Lawyer: He might? Okay. The other thing that's really important as far as helping you get out is to make sure that your parents are here. Who are you living with?

Juvenile: I'm living with my mother and my stepfather.

Lawyer: Okay, what's your mother's name?

Juvenile: Lavern Jackson.

Lawyer: Lavern Jackson?

Juvenile: uh-huh.

Lawyer: How can I reach her?

Juvenile: She might be at home or at work.

Lawyer: Why don't you give me both numbers, and I'll try to get a hold of her.

Juvenile: My home number is 592-1905

Lawyer: And work?

Juvenile: 882-3160.

Lawyer: Where does she work?

Juvenile: UVC. If you reach her, its an emergency. O.K.? Because she won't be able to get out of work if it's not an emergency.

Lawyer: Okay. I'll explain what the situation is. Does she know that you're locked up?

Juvenile: Yeah she knows.

Lawyer: Did you talk to her last night?

Juvenile: Yeah.

Lawyer: Did she say whether she was coming down to court or not?

Juvenile: No, she didn't say. She might be there, though.

- Lawyer: In case she can't come, is there any other family member who might be able to come down?
- Juvenile: Probably my sister. (In a concerned tone) Don't call my stepfather.
- Lawyer: Okay. What's your sister's name?
- Juvenile: Shirley Jackson.
- Lawyer: How old is she?
- Juvenile: She's 21.
- Lawyer: How can I reach her?
- Juvenile: She's at work.
- Lawyer: What's her number at work?
- Juvenile: 681-1200
- Lawyer: Okay, and you mentioned your step-father.
- Juvenile: Yeah.
- Lawyer: What's his name?
- Juvenile: Bill Martin.
- Lawyer: Why don't you want to me to call him?
- Juvenile: He... Me and him don't get along. I had a problem with him.
- Lawyer: Okay. That's something that, if you want, you and I can talk about and I want to be able to resolve that. Unfortunately, we don't have time to go into that now. But you and I can talk about that and maybe we can try to get help for both of you. Are you going to school right now?
- Juvenile: Yes.
- Lawyer: What's the name of your school?
- Juvenile: Draper High School.
- Lawyer: Now, the social workers are going to check on whether you're going to school or not so if I call the school, what do you think they're going to tell me? Do you think they'll say you're there everyday?
- Juvenile: Not everyday but I come.

Lawyer: What do you think they'll say about how often you go?

Juvenile: Yeah, I go about three times a week.

Lawyer: You have any teachers who, if I call, will say good things about you?

Juvenile: No, none of them like me.

Lawyer: Any counselors?

Juvenile: Ms. Davidson.

Lawyer: Would she say good things about you if I called her?

Juvenile: Yeah, me and her get along okay.

Lawyer: Are you involved in any sort of activities at school?

Juvenile: No.

Lawyer: Sports or anything?

Juvenile: No.

Lawyer: Do you work anywhere right now?

Juvenile: No, nowhere.

Lawyer: Alright, we don't have a whole lot of time today to go into what you've been charged with and exactly what happened, but you are accused of robbery of taking a lady's purse. And what I want to talk to you about in the few minutes that we have is what happened when you were arrested. Okay. Just tell me what you were doing when the cops came to pick you up.

Juvenile: Like I said, while I was coming over to the car, the lady was complaining to the cops. She said that I put my hands inside her car and reached for her pocketbook.

Lawyer: Okay. Let me just stop you for a second. When did you hear her saying this?

Juvenile: While the cop was taking me over to the car. I was handcuffed.

Lawyer: Okay, so you heard the lady say that somebody's hand or arm came through the window.

Juvenile: Yeah.

Lawyer: Of the car?

Juvenile: Uh-huh.

- Lawyer: Let's step back just a couple of minutes, and tell me what you were doing when you were arrested.
- Juvenile: I was out on the streets just having fun.
- Lawyer: Okay, where was this?
- Juvenile: Umm. 8th Street and South East
- Lawyer: And what happened?
- Juvenile: Well, I was over there playing ball with my friends. Police just came over and picked me up.
- Lawyer: Was anybody else arrested with you?
- Juvenile: No. Nobody.
- Lawyer: Did you tell the police anything?
- Juvenile: No, I was waiting for a lawyer.
- Lawyer: Okay. Do you remember filling out that little card?
- Juvenile: Yeah, I remember.
- Lawyer: Do you remember how you answered it?
- Juvenile: (sounding annoyed) No, I don't care.
- Lawyer: (appearing surprised) You don't care how you answered it?
- Juvenile: Yeah, that's what I said. I don't care because I think that was wrong what they did.
- Lawyer: Okay. We're going to have to go into what exactly went down when you were arrested a lot more when I learn more about the case next time we talk. Now, there's good chance that the police officer who arrested you will take the stand at the detention hearing and say some things. And some of them might not be true . . .
- Juvenile: (interrupts) A lot of them won't be true.
- Lawyer: Okay, and you're going to have to be tough in there, and even though that cop is lying, you're just going to have to let him talk and not get angry. It's going to be hard to do, but we're going to be real cool. And I know you're going to want to also tell your side of what happened, but today's not the day for that. It'll only come back to hurt us if you got up there and start talking about your story about just walking around.

Juvenile: Right.

Lawyer: So we're going to use this and try to find out as much as we can about their case. OK? Now, one thing that's going to be important is exactly what you look like today.

Juvenile: You're in front of me. You can tell.

Lawyer: Well, I can't see everything. I can see you have on a white cap. Did you have all this on when you were arrested?

Juvenile: Yeah.

Lawyer: Okay, did you have anything else on that you don't have now.

Juvenile: (sounding concerned) Umm, they took my jacket.

Lawyer: A jacket?

Juvenile: A Ralph Lauren jacket.

Lawyer: A Ralph Lauren jacket? What color was it?

Juvenile: Blue. It was very expensive.

Lawyer: Okay, did they give you a receipt for that?

Juvenile: No.

Lawyer: Well look, there may be some things I can do to try to get that jacket back. It's possible they're holding it for evidence, and we might not be able to get it until the end of this case. But if they're not, I can semi-investigate it down to the precinct or make some calls to help you get it back.

Juvenile: I'd appreciate that.

Lawyer: Let's get back to what you were wearing. You got a blue shirt on and what color are your pants?

Juvenile: Blue.

Lawyer: You got blue jeans on?

Juvenile: Uh-huh.

Lawyer: Okay, and what about your shoes?

Juvenile: They're sandals.

Lawyer: Sandals?

Juvenile: Yeah.

Lawyer: Okay.

Juvenile: Tell me something.

Lawyer: Yeah?

Juvenile: At court, can you get my parents in?

Lawyer: I'm going to try real hard to get your mother there. If I can't get your mother...

Juvenile: (interrupts) That's all you have to get. Try to get my mother. That's all. Don't worry about anyone else.

Lawyer: If I have a lot of trouble reaching her, it's ok if I get you sister there? It's really important.

Juvenile: Yeah, my sister but not my stepfather.

Lawyer: Okay, not your stepfather. We don't have much time, so are there any other questions that you have before I go?

Juvenile: No, I don't.

Lawyer: Okay, keep your spirits up. (pats juvenile on the arm) Alright? Because we have a real good shot at getting you out of here.

Juvenile: I hope so.

Lawyer: Okay. Keep my card. Take care. See you later.

(Juvenile and lawyer shake hands)

Juvenile: Alright.

Lawyer: OK. Bye-bye.

Juvenile: Nice talking to you.

APPENDIX B

SMALL GROUP EXERCISE WORKSHEET

Critiquing Adult-Juvenile Interviews in the Juvenile Court System

Answer the following questions about the interview/discussion that you just witnessed:

1. How did the interviewer start the interview/discussion? How, if at all, did interviewer convey the purpose of the interview/discussion to the young person?

2. How would you describe the young person's demeanor during the interview/discussion (i.e., uncooperative, cooperative, hostile, friendly)? To what extent, if at all, do you attribute the young person's overall demeanor during the interview to the following factors: the interviewer's technique; the current situation s/he is in; the young person's own disposition/personality.

3. (If the young person appeared hostile in the interview/discussion): How, if at all, did the interviewer attempt to defuse the young person's hostility?

4. (If the young person appeared not to be paying attention to the interviewer): How, if at all, did the interviewer attempt to capture the young person's attention?

5. What questions/concerns did the young person express during the interview/discussion? How, if at all, did the interviewer address these questions and concerns?

6. Did the young person become emotional during the interview/discussion? How, if at all, did the interviewer respond to the expressed emotions?

7. Analyze the composition of the interviewer's questions. Did the interviewer ask any:

- leading questions?

- questions that required only a yes-or-no answer? If so, did the interviewer ask any follow-up questions to elicit more information?

- questions that sounded judgmental (either in language or tone).

8. How would you reword these questions to get the necessary information?

9. Describe the young person's body language during the course of the interview/discussion. What, if anything, did the young person's body language indicate to you about his/her feelings about the interviewer? About the subject of the interview/discussion?

10. Describe the interviewer's body language. What, if anything, did the interviewer's body language indicate to you about his/her feelings about the young person? Did the interviewer make eye contact with the young person?

11. What conclusions, if any, did you draw about the young person from the interview/discussion? (If juvenile was defendant in juvenile court proceeding): Did you make any assessment about the young person's amenability to treatment based on the interview?

12. How, if at all, did the interviewer react to any unexpected information that came out during the interview?

13. Describe any other poor interview techniques you observed. What would you have done differently and why?

14. Describe any other good interview techniques you observed.

APPENDIX C

INSTRUCTION SHEETS FOR INTERVIEW ROLE PLAYS

The following instruction sheets are included in this appendix:

1. Instruction Sheet for State's Attorney/Interviewer for James Branch interview.
2. Instruction Sheet for Public Defender/Interviewer for James Branch interview.
3. Instruction Sheet for James Branch.
4. Instruction Sheet for State's Attorney/Interviewer for Tamykia Stevens interview.
5. Instruction Sheet for Tamykia Stevens.
6. Instruction Sheet for State's Attorney/Interviewer for Maria Flores interview.
7. Instruction Sheet for Maria Flores.
8. Instruction Sheet for State's Attorney/Interviewer for Angela Sutton interview.
9. Instruction Sheet for Angela Sutton.

Role Play of Interview of James Branch

Instruction Sheet for State's Attorney/Interviewer

You are the prosecutor assigned to the case of People v. Michael Porter. Mr. Porter, age 22, is charged in the stabbing death of a 19-year-old male named Pernell Jones. According to police reports, James Branch, a 14-year-old male, was a witness to the stabbing. James is coming into your office today for an interview. You are preparing to bring the case to the grand jury for an indictment. Your purpose in this interview is to determine what James Branch witnessed and whether you will have him testify before the grand jury.

You know the following information from the arrest report and a brief phone conversation with one of the investigating detectives: On XYZ date, a Monday, the police were called to the Riverside Hospital about a possible homicide. Uniformed officers responded to the call. When they arrived at the emergency room at approximately 6:00 PM, hospital personnel informed them that Pernell Jones had been brought to the ER by two teenage boys; the boys were being held by the hospital security guard in the ER waiting room. One of the boys was James Branch. James told the officers that they had been at a party at someone's house that afternoon when Michael Porter took a knife from his jacket and stabbed Pernell Jones. James did not know Michael's address but said that he lived in an apartment somewhere on 17th Street off of Castor Avenue near a 7-11 convenience store. James also told the police that the party was at the house of a girl named Chantel. James said he didn't know Chantel's last name; he just went to her house with Freddy when they heard there was a party. James gave police general directions to Chantel's house. Except for Pernell, Michael, and Freddy, James did not know anyone else at the party. James and Freddy had driven the wounded Pernell to the ER in Freddy's car. Pernell died shortly after they arrived at the ER. Freddy (full name Federico Alvarez) gave the officers basically the same story.

The police located Michael Porter later that evening, and arrested him. He refused to give a statement. Police obtained a search warrant for Michael Porter's apartment, but did not find the knife. The police also located Chantel Davis's house; when they were admitted they saw a blood stain on the carpet. Ms. Davis thus far has refused to talk to the police. They have not yet found the murder weapon.

You know from the detective that both Pernell Jones and Michael Porter are drug dealers in the same neighborhood. Pernell Jones has some juvenile adjudications for possession with intent to distribute (PWID) marijuana and cocaine, but no adult arrest record. Michael Porter similarly has a juvenile record of adjudications for drug distribution offenses; at age 18 he was convicted on a PWID cocaine charge and was recently released after serving a three-year prison term. You have no further information regarding the relationship between the different parties involved in this event.

James had one prior arrest for possession marijuana which was not papered, and an adjudication for unauthorized use of a vehicle – passenger. James successfully finished a six-month probation for the UUV charge earlier last year.

ROLE PLAY OF INTERVIEW OF JAMES BRANCH

Instruction Sheet for Public Defender/Interviewer

You are the public defender assigned to represent Michael Porter in the case of People v. Michael Porter. Mr. Porter, age 22, is charged in the stabbing death of a 19-year-old male named Pernell Jones. According to police reports, James Branch, was one of the witnesses to the stabbing. Your client told you that James Branch is a teenager who lives in his neighborhood, and gave you information as to how you could find him. Today you've tracked James Branch down (you found him hanging out in front of a neighborhood grocery store just like your client said he would be), and James has agreed to talk to you. The two of you go to a bench in a park across the street to talk. Your purpose in this interview is to determine what James witnessed in order to assess the strength of the government's case and to figure out a theory of defense.

You know the following information from the arrest report: On XYZ date, a Monday, the police were called to the Riverside Hospital about a possible homicide. Uniformed officers responded to the call. When they arrived at the emergency room at approximately 6:00 PM, hospital personnel informed them that Pernell Jones had been brought to the ER with stab wounds in the chest; Mr. Jones died shortly after arrival. The two teenage boys who brought Mr. Jones to the hospital – James Branch and Federico Alvarez, both age 14 – told police that they had been at a party that afternoon when Michael Porter took a knife from his jacket and stabbed Mr. Jones. Later that evening, police located Michael Porter at his home at 134 17th Street, Apt. 3E, where they arrested him. Mr. Porter did not give a statement. Later the police obtained a search warrant and searched Mr. Porter's house, but they did not find any evidence to the stabbing. Police also later determined that the stabbing took place in the home of Chantel Davis at 341 Castor Avenue; when the police went to that address they saw a blood stain on the carpet. The police have not found the murder weapon.

You checked the court records, and Pernell Jones has no adult record. Because James Branch and Federico Alvarez are both juveniles, you were not able to access their court records; you have no idea whether either of them has a juvenile record. Your client Michael Porter has a juvenile record of adjudications for drug distribution offenses; at age 18 he was convicted on a PWID cocaine charge and was recently released after serving a three-year prison term.

You know the following from your client: When your client was recently released from prison, he returned home with hopes of getting back together with his old girlfriend, Chantel Davis. Unfortunately, he found out that Ms. Davis was seeing Pernell Jones. Your client describes Pernell Jones as a neighborhood guy who deals marijuana and sometimes cocaine; both James and Freddy work for him. Mr. Porter still decided that he wanted to approach Chantel Davis to see if they had any chance. About a week before the stabbing, Mr. Porter saw Ms. Davis on street near her home; he approached her and they began talking. While they were talking, Mr. Jones came up, pushed your client, and told him to stay away from Ms. Davis. The two "exchanged words" and at one point Mr. Jones patted his coat pocket and indicated verbally that he carried a gun. Your client left the area, but a few days later (the day of the stabbing) he saw Ms. Davis again on the street. Ms. Davis invited your client (continued on next page) to her house later that day. But when he arrived there, he was surprised to find a house full of people including Mr. Jones. Mr. Jones shouted at your client, and made a move towards his pocket. Your client, believing that Mr. Jones was reaching for his gun, took out his pocket knife

and lunged at Mr. Jones' chest. When Mr. Jones fell to the floor, your client ran out of the house in a panic. The police later found him in his family's apartment and arrested him.

ROLE PLAY OF INTERVIEW OF JAMES BRANCH

Instruction Sheet for James Branch

You are playing the role of James Branch. Today you are going to be interviewed by a state's attorney about the stabbing of Pernell Jones by Michael Porter. You received a subpoena to testify before a grand jury, but the police officer who gave you the subpoena told you that the state's attorney only wants to talk to you today about what you saw. (Alternatively, a man introducing himself as Michael Porter's attorney has approached you on the street. He says that he wants to ask you a few questions about what happened that day, and you've agreed. You go to the bench in a nearby park to talk.)

You are 14 years-old. Feel free to make up any information you want about your family, where (and if) you go to school, what you like to do, etc., if asked by the interviewer. At age 13 you were arrested for possession marijuana, but the charges were dropped. Two months later you were arrested for riding in a stolen car; you were placed on six months probation which you finished last year.

On XYZ date, the following occurred: You and your friend Freddy were hanging out (and cutting school) when Pernell Jones came by and invited you to Chantel's house for a party. Chantel is Pernell's girlfriend and you know her only through Pernell. When the three of you arrived at Chantel's house about six other people were already there, most of whom you know by sight and name but little else. Pernell, Chantel, and the others are a few years older than you and Freddy. Pernell sells cocaine, and on occasion you and your good friend Freddy have helped him with sales. People were drinking beer and passing around some joints, and you joined in. About an hour later, Michael Porter showed up at Chantel's door. You know Michael Porter from your neighborhood; he is around the same age as one of your older siblings. Michael used to date Chantel before he went to prison, and he got out recently. You know from Freddy that Michael threatened Pernell a week earlier if he didn't stop seeing Chantel. When the doorbell rang that afternoon, someone went to open the door. Michael pushed his way through the partially-opened door, went up to Pernell, and stabbed him in the stomach. Everyone ran except for you, Freddy, Chantel and Pernell, who was on the floor bleeding. Pernell carries a gun. You and Freddy removed the gun from Pernell's pocket and gave it to Chantel before you drove Pernell to the hospital. You assume that Chantel hid the gun, but you have not spoken with her since the day of the stabbing. You do not know what Chantel has told the police.

Once you got to the hospital the police came and questioned you about the stabbing. You told the police only minimal information. You told them that you went to Chantel's house with Freddy when you heard there was a party, and that you saw Michael Porter come in and stab Pernell. The only people you knew at the party were your friend Freddy, and Pernell, who's an acquaintance from the neighborhood. You told them where they could find Michael's and Chantel's houses. You didn't say anything to them about how you know Pernell.

(continued on next page)

You're scared of Michael Porter. You saw what he did to Pernell, and that was just because Pernell was dating his old girlfriend. You didn't tell your family that you saw the stabbing or that the police had questioned you about it. Your family would be furious that you were hanging out with Pernell after being repeatedly warned not to do so. You're worried that they won't let you visit your cousins in Atlanta this summer if they find out.

At some point well into the interview, admit to taking the gun off of Pernell and giving it to Chantel (don't admit it right away; let the interviewer work for it). Otherwise feel free to make up any additional information as needed during the interview. Also, you can choose to play the role in the interview however you want. For example, you can be cooperative but confusing in your account of what happened. Or you can completely backtrack on the story you originally told the police and say that you ran into the house when you heard people screaming, you found Pernell already on the floor bleeding, and it was Chantel who told you that Michael Porter had come into the house and stabbed Pernell.

ROLE PLAY OF INTERVIEW OF TAMYKIA STEVENS

Instruction Sheet for State's Attorney/Interviewer

You are the state's attorney prosecuting the case of In the Matter of Marquis Stevens. Marquis, age 16, is charged with simple assault for punching his mother, Angela Stevens. Today is the trial. Mrs. Stevens is in court but she is now refusing to testify. Ms. Stevens says that Marquis has learned his lesson from being in the detention center for the last two weeks, and now he wants him home with her. Mrs. Stevens has brought her daughter, Tamykia Stevens, age 15, to court today. You know that Marquis has been arrested two prior times for beating on his mother, but his mother in the past has refused to pursue the case. This is the closest you've gotten to getting Mrs. Stevens to testify. You know from the arrest reports that Tamykia was a witness to the assault, which took place in the Stevens home. Tamykia is sitting in the hallway outside the courtroom where you are assigned; you escort her to a witness room to talk. You have about 10 minutes to figure out if Tamykia would be a good witness and, if she would be, to encourage her to testify against her brother.

You know the following information from the case file and from a conversation with a counselor from the local Victim Services Agency (VSA) who accompanied Ms. Stevens to court today: On XYZ date, at approximately 9:30 PM, police received a 911 call from a neighbor stating that there was a domestic disturbance at 384 Eagleton Road, Apt. 1E. When police arrived on the scene, Mrs. Stevens answered the door. Mrs. Stevens was bleeding from her nose, which was swollen. Mrs. Stevens told the officers that her son Marquis had punched her repeatedly in the face before fleeing the apartment, and that she wanted to press charges. Listed as a witness in the arrest report was Tamykia Stevens. The police took Mrs. Stevens to the hospital, where she was diagnosed with a broken nose. Photographs were taken of Mrs. Stevens at the hospital. The police later that night arrested Marquis, who they found at the home of a friend. The police indicated that there was no sign that Marquis was intoxicated at the time.

At the detention hearing, Ms. Stevens said that she didn't want Marquis at home with her; the judge ordered that Marquis be placed in the county juvenile center pending trial. Marquis has no juvenile record except for the two arrests in the last year for assaulting his mother; as noted above, his mother later refused to pursue the charges.

You know from the VSA counselor that Mrs. Stevens has sought their help in the past when Marquis has beaten her. At one point, the agency referred the family to a counselor, but she does not know if they ever followed up on it. The counselor is worried because the abuse is apparently escalating – this is the worst that Mrs. Stevens has been injured since VSA began working with her about a year ago. As far as the counselor knows, Marquis has never hurt or threatened Tamykia.

ROLE PLAY OF INTERVIEW OF TAMYKIA STEVENS

Instruction Sheet for Tamykia Stevens

You are playing the role of Tamykia Stevens. You are going to be interviewed today by a state's attorney about your brother Marquis Stevens, 16, beating your mother, Angela Stevens, on XYZ date. Your mother decided to press charges and Marquis was arrested and detained at the county juvenile center. Today is Marquis' trial and you and your mother have arrived at court. Your mother, however, is now saying that she doesn't want to go ahead with the trial. She says that Marquis has learned her lesson after being in the detention center for the last couple of weeks and she now wants him home.

You are 15 years-old. You live with your mother and your brother in an apartment in a working-class neighborhood. Feel free to make up any information you want about where you go to school, what you like to do, etc., if asked by the interviewer.

On XYZ date, you were home with your mother at around 9:30 PM when your brother arrived home from work. Marquis has a job at a local hardware store, and he helps support your family. He gives money to your mother for food; once in a while he gives you money to buy clothes. When Marquis arrived home he went straight to the kitchen to look for his dinner, which he always does. He came out of the kitchen and starting screaming at your mother, something about not liking the fish cakes she had left for him for dinner. Your mother started yelling back that she wasn't his servant and the next thing you knew, Marquis was punching her in the face. You ran and jumped on Marquis' back and yelled for him to stop, which Marquis did. He then slammed out of the house. You went to get some ice for your mother's face who was hysterical and in pain. You were comforting your mother when the police came to the door, saying that they had gotten a call about a domestic disturbance. Your mother told the police that she wanted to press charges, and you all went to the hospital where you learned that Marquis had broken your mother's nose.

You are really torn up about the situation. Your brother can be really sweet to both you and your mom, and he has never laid a hand on you. He is very generous with his money. You also understand how your brother could be really angry at your mother – before your father left four years ago he used to regularly beat up on Marquis. You suspect that deep in his heart Marquis is angry at your mom for not doing something to stop it. But you are sick and tired of all the fights and the pain. Your brother has hit your mother before, but never this bad. Your mother is backing out of testifying, partly because she needs Marquis' income to support you and herself and partly because she loves Marquis. Marquis called your mother last night from the detention center and you got on the extension to listen without them knowing; Marquis was crying, begging your mother to let him come home and promising never to hit her again. Part of you wants your mother to testify so that Marquis will get sent away. But another part of you misses Marquis and wants him to come home.

ROLE PLAY INTERVIEW OF MARIA FLORES

Instruction Sheet for State's Attorney/Interviewer

You are the prosecutor assigned to the case of People v. Manuel Mendez. Mr. Mendez, age 20, is charged with statutory rape of Maria Flores, age 14. According to police reports, Ms. Flores does not want to cooperate in the prosecution. She is coming to your office today for an interview. Your purpose in this interview is to convince Ms. Flores to testify.

You know the following information from the report filed by Child Protective Services (CPS), the police report, and a conversation with the detective who interviewed Ms. Flores and her parents. On XYZ date during the school day, 14-year-old Maria Flores visited the school-based clinic; she was complaining of nausea and fatigue. After a brief examination, the nurse, Sancha Dorton, discovered that Maria was approximately 15-20 weeks pregnant. Maria did not know that she was pregnant. Upon questioning, she identified her 20-year-old boyfriend, Manuel Mendez, as the father. She begged the nurse not to tell her parents. She reported that her father was very strict, and had forbidden her from seeing Manuel. Maria said she was afraid her father would try to make her have an abortion when he found out.

The same afternoon, Ms. Dorton reported the pregnancy to CPS. An emergency response worker from CPS contacted Maria's parents to arrange for an interview later that evening. During the interview, the worker disclosed the pregnancy to Mr. and Mrs. Flores in their daughter's presence. Mr. Flores became enraged and began cursing at his daughter, calling her a "whore" and threatening to kill her and Manuel. Mrs. Flores remained silent during the entire interview, and simply turned to her husband when the worker asked a question. Maria was unable to respond to the worker's questions. She cried throughout the interview, and was visibly afraid of her father. Concerned about Mr. Flores' threats and Maria's safety, the worker removed Maria from her home and arranged for her to remain temporarily in the local children's shelter.

The worker contacted the police who arrested Manuel after a brief interview. Manuel admitted that he had an intimate relationship with Maria, and claimed that he wanted to marry her. When he learned of Maria's pregnancy, he seemed happy and said he wanted to raise the child with Maria. He was cooperative and polite, and very concerned about Maria's welfare.

A fingerprint check revealed that Manuel was arrested at age 14 for vandalism (graffiti), and completed a community service project. He dropped out of school at age 16, and is currently unemployed. He lives with his mother, who is an invalid. They live off her social security income. Although Manuel has tattoos associated with a local gang, he denies gang involvement and is not known by police as a gang member. The police arrested Manuel and he is in custody awaiting a preliminary hearing on the statutory rape charge.

ROLE PLAY INTERVIEW OF MARIA FLORES

Instruction Sheet for Maria Flores

You are 14 years-old and live with your parents and younger brother. You attend high school and have average grades, although your grades have been slipping this year. Your father is an alcoholic, and is physically and emotionally abusive toward you, your brother, and your mother. Your mother is afraid of your father and is unable to protect you and your brother. You would have run away a long time ago, but you feel that you need to protect your mother and your brother.

You met Manuel Mendez (age 20) over a year ago at a party. You are deeply in love with him, and you want to spend your life with him. He is the first person who has ever really cared for you. Your father has forbidden you from seeing Manuel. Your father says that Manuel is too old for you and accuses Manuel of gang activity. You believe that your father just doesn't want you to be happy. He doesn't know Manuel and has only met him once.

Manuel is unemployed, but he assures you that he is not a gang member. You believe him. He lives with his mother and can't find work. You have been skipping school and sneaking out at night to see Manuel. You have had sexual relations with him several times over the last several months. He has asked you to marry him and promises to wait for you. You were surprised to learn that you were pregnant because Manuel had assured you that he had timed your sexual encounters to avoid pregnancy. Because he is older and more experienced, you trusted his judgment. You want to have the baby and raise it with Manuel.

You are relieved to be away from your father, and you spend your time fantasizing about marrying Manuel and raising your child together. You would do anything to protect Manuel, and you refuse to cooperate with his prosecution.

Feel free to make up any additional facts about your life or the events in question as needed during the course of the interview.

ROLE PLAY OF INTERVIEW OF ANGELA SUTTON

Instruction Sheet for State's Attorney/Interviewer

You are the prosecutor in the case of People v. James Nelson. Mr. Nelson, age 38, has been charged with sexual abuse of his 13-year-old niece, Angela Sutton. Angela, who has already been interviewed by the school principal, a Child Protective Services worker, and a forensic interviewer is coming with her mother to your office for an interview. Your purpose in this interview is to determine whether you have enough evidence to prove the charges and to determine whether Angela is able to testify effectively.

You know the following information from a report written by the forensic interviewer and a brief telephone conversation with Angela's mother. On XYZ date, Angela disclosed to a friend that her uncle Jim had been sexually molesting her since she was 9 years-old. The friend told her mother, who reported it to Angela's teacher. The teacher notified the principal, Mr. Thomas, who questioned Angela. At first, Angela denied that anything had happened, and then dissolved into tears, saying she was too embarrassed to talk about it.

Mr. Thomas called Child Protective Services, and a social worker interviewed Angela and her parents that evening at their home. Again, Angela initially denied that anything happened and accused her friend of making the whole thing up. With prodding from the worker, however, she eventually confirmed that Uncle Jim had "touched her privates with his privates," although she had trouble providing details. Angela's parents seemed suspicious of her, and asked her repeatedly if she was just trying to get attention. Mrs. Sutton, in particular, seemed protective of her brother and unable to believe that he was capable of sexual abuse. She kept saying that the whole thing was a misunderstanding.

CPS arranged for a forensic expert to interview Angela on tape. The interview was observed by a police detective and a developmental psychologist who were seated on the other side of a one-way mirror. Angela again confirmed that her uncle had "touched her privates." She said that it happened more than 10 times and convincingly described where the incidents took place. However, she was too upset and embarrassed to describe exactly what the uncle had done to her. She also seemed to have some difficulty understanding the interviewer's questions. The psychologist observed that Angela did not seem to have any vocabulary for describing the relevant body parts. The forensic team concluded that Mr. Nelson had molested Angela repeatedly over a four year period. However, they were doubtful about the chances for a successful conviction given Angela's inability to talk about the molest or to provide details.

Angela's pediatrician also conducted a physical examination. The results were consistent with repeated vaginal penetration.

ROLE PLAY OF INTERVIEW OF ANGELA SUTTON

Instruction Sheet for Angela Sutton

You are 13 years old, and live with your younger sister (5 years old) and your parents. You are a reserved child, and you have trouble academically. In particular, you have trouble following verbal directions. You read at a level two years below your grade.

When you were 9 years old, your Uncle Jim started pressuring you to orally copulate him. He told you that you were his favorite child, and that your activities had to be a secret because the other cousins would be jealous if they found out. Although you were resistant at first, you eventually agreed to his demands. You wanted his attention, and you were afraid he'd tell your parents and you would get in trouble. After about a year, he began penetrating you vaginally – first with his finger and then with his penis. You were very resistant, but he told you that he would kill you with his gun if you didn't "cooperate" or if you told anyone. You believed him.

You have tried very hard to act like everything was "normal" because you think the whole thing is your fault, and you know your parents would be very angry at you if they found out. You told your friend, Jackie, when your uncle threatened to "do the same thing" to your little sister if you stopped cooperating.

You regret having told anyone, and you are terrified to help the police put your uncle in jail. You feel guilty and ashamed, and you're afraid the social worker is going to take you away from your family. You're also afraid that your Uncle Jim may come and kill you. Your mother has been crying every day, your father is furious, and your sister is having nightmares. Your parents think you are lying or that you seduced your uncle. You are also extremely embarrassed, and refuse to go to school. You are convinced that everyone knows what you've been doing. You are fairly unsophisticated, even for a 13-year-old, and do not know the terminology for body parts or sexual activities (i.e., you do not know or use words such as copulate, penetration, penis or vagina). You do not want to be interviewed again. The lady from the team told you that, if you told them everything, no one else would have to ask you any more questions. You just want the whole thing to be over with.

*MENTAL HEALTH ASSESSMENTS
IN THE JUSTICE SYSTEM:
How to Get High-Quality
Evaluations and What to Do
With Them in Court*

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Lourdes M. Rosado, Editor

AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

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Juvenile Law Center is a non-profit public interest law firm that advances the rights and well being of children in jeopardy. Founded in 1975, JLC is one of the oldest legal services firms for children in the United States. JLC uses a range of strategies -- including individual advocacy, reform of state and national law and policy, and training of public defenders and lawyers for children -- to improve the juvenile justice and child welfare systems. The children we serve include abused or neglected children placed in foster homes, delinquent youth sent to residential treatment facilities or adult prisons, and children in placement with specialized health and education needs. JLC works to ensure that children and youth are not harmed by -- but instead receive appropriate care from -- the systems that are supposed to help them.

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Youth Law Center is the leading national legal advocacy program working on juvenile justice issues. For the past 22 years, YLC staff have worked with defense attorneys, prosecutors, judges, and probation officials in virtually every state throughout the nation. In addition to authoring a major text, *Representing the Child Client*, and more than two dozen articles, book chapters, and other publications on the representation of minors, YLC staff have conducted literally hundreds of trainings and presentations throughout the country on delinquency-related matters, conditions of confinement, liability, alternatives to detention, and coordination of services.

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This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM

June 2000

Preface

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*

Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*

Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*

Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*

Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a "tool kit" containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can be assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer -- is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

Executive Summary

The goal of Module Three is for juvenile court personnel to become better-informed consumers of mental health evaluations. Juvenile court professionals routinely request mental health evaluations to inform critical decisions, such as whether a child is competent to stand trial, his/her mental state at the time of the offense, and what treatment and programming would best serve the child. Often, however, we receive evaluations that are difficult to decipher and raise more questions than they answer. After completing this training, participants will know what they can do to ensure that mental health professionals produce high-quality evaluations that will better aid court personnel in key decision-making.

As a first step, the trainer will “demystify” the mental health field and assessment process. Participants will learn, for example, about the DSM-IV (what does “Axis III” mean anyway?), the appropriate psychological tests for adolescents (and what the tests can and can not tell us), and those mental health disorders that are most prevalent among the juvenile justice system population.

Participants then learn step-by-step guidelines on requesting and reviewing a forensic evaluation, including:

- ! How to assess the qualifications of a mental health professional to conduct the needed forensic evaluation, including whether the evaluator understands the legal question you are trying to answer and the relevant law and psychological factors.
- ! How to write a court order that will guide the evaluator in producing a useful evaluation, including answers to developmental questions (i.e., where is the juvenile in his/her cognitive, moral and identity development and what areas of growth remain?) that are critical for determining a young person’s competence, his/her danger to the community and/or amenability to treatment.
- ! What information and history is most relevant to answering the legal issue at hand.
- ! The minimum contents of a good evaluation.
- ! Criteria for judging the quality of an evaluation, including the degree to which the examiner evaluated relevant mental states, capacities, and knowledge and their relationship to the psycholegal issue to be answered, and the appropriateness and validity of any tests or instruments administered.

Participants acquire information and skills by engaging in a number of interactive exercises, including writing court orders for evaluations, analyzing evaluations, and examining a mental health professional in court. Participants also will receive materials that they can use in their daily practice, such as an outline for assessing the qualifications of a mental health professional prior to hiring him/her and a checklist of developmentally-sensitive questions that an evaluation should answer.

Table of Contents

I. Introduction	1
A. Goal of this module	1
B. Key themes in this module	1
II. Legal Contexts in Which a Mental Health Evaluation May be Indicated	3
A. Competence to Confess/Waive Miranda Rights	3
B. Waiver to Adult Court	3
C. Competence to Proceed	3
D. Mental State at the Time of the Offense/Sanity	4
E. Disposition/Sentencing	4
III. De-mystifying Mental Health Assessments	5
A. Professions and Their Distinctions	5
B. Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)	5
C. Disorders by Category	6
D. Conduct Disorder Diagnosis in Juvenile Delinquency Cases	7
IV. Psychological Assessment and Testing	9
A. Basic Information	9
B. Focus of Testing	9
C. General Measures	10
V. Ensuring Developmentally-Sensitive Mental Health Assessments	14
A. Determine the young person's competence	14
B. Examples of Questions that a Developmentally-Sensitive Mental Health Assessment Should Answer	14
VI. How to Think About, Request, and Review a Forensic Evaluation	16
A. Distinguish Between Therapeutic Evaluation and Forensic Evaluation.	16
B. Pre-Evaluation Preparation	16
C. Assessing the Evaluator	18
D. Post-Evaluation Review of the Evaluation	19
Bibliography	26
APPENDIX A	A1
APPENDIX B	B1
APPENDIX C	C1
APPENDIX D	D1
APPENDIX E	E1
APPENDIX F	F1
APPENDIX G	G1
APPENDIX H	H1

I. Introduction

A. Goal of this module

The goal of this module is to educate juvenile court personnel on what mental health professionals should be doing when they serve as consultants to the court and how they should be doing it, so that as consultants they produce mental health evaluations that aid court personnel in key decision-making. Participants should leave this training as better-informed consumers of mental health evaluations.

B. Key themes in this module

1. Court personnel have a right to demand a high quality product from the mental health consultant. It is the mental health professional's obligation to ensure that the consumers of the information understand the information and can use it.
2. There are key differences between an evaluation conducted for therapeutic purposes and one conducted for forensic purposes. In general, a therapeutic evaluation is an evaluation voluntarily initiated by the youth or parent for purposes of identifying treatment needs. A forensic evaluation is any evaluation that is done for use in court or to assist decision-makers in a court proceeding.
3. When seeking forensic evaluations, court personnel must be specific about the questions the evaluation is expected to answer and the purposes for which it will be used.
4. There are a number of factors to consider when hiring a mental health consultant. More important than the prestige of a professional's graduate training is his/her experience doing the specific type of juvenile forensic evaluation requested (i.e., is the child amenable to treatment? Is the child competent to stand trial?), familiarity with the key legal issues for which these evaluations are requested, and training in developmental issues.
5. The mere presence of a psychological disturbance does not mean that it is related to the legal issue at hand. The mental health professional has to make the connection. Most psychological tests were developed for therapeutic purposes and not specifically to be used in forensic contexts; therefore, inferences have to be made about how they apply to the question at hand. It is best if legally relevant psychological conditions can be assessed directly by administering tests that were specifically designed to answer the psycho-legal questions at issue. The more inferences an evaluator needs to draw in order to reach a conclusion about a legally relevant condition, the more that red flags should go off in the consumer's mind.
6. Lawyers and judges should generally refrain from attacking the validity or reliability of the findings of a mental health evaluation without consulting a mental health expert because of the technical knowledge involved. "Validity" can refer to "external" or "internal" validity. External validity refers to whether the findings can be generalized beyond the specific sample studies. Internal validity refers to whether the interpretation of the findings is real, or whether there are alternatives that have not been ruled out. Validity can also mean concurrent validity (e.g., in the case of an IQ test, whether it correlates with other established measures of intelligence); predictive validity (whether it predicts things it should predict, like success in school); or face validity (does test on its face measure what it purports to measure).

“Reliability” refers to the accuracy of the instrument, i.e., the confidence one has in the replicability of the test results. For example, an IQ test is reliable because people’s scores on it don’t fluctuate day to day. One can have a reliable test that isn’t valid (e.g., using a measure of head size as a test of intelligence). Each of these concepts has a different meaning and is used for different reasons.

II. Legal Contexts in Which a Mental Health Evaluation May be Indicated

A. Competence to Confess/Waive Miranda Rights

1. Legal Issue (*Miranda v. Arizona*, 1966): was the confession knowing, voluntary & intelligent?
2. Factors that might suggest referral for evaluation:
 - a. youth
 - b. limited intellectual functioning
 - c. poor verbal skills
 - d. difficulty communicating with client
 - e. history of poor academic achievement
 - f. under influence of substances at time of interrogation
 - g. history of emotional and/or behavioral problems
 - h. interrogation in absence of parents if one or more of the above factors exist

Interactive Exercise:

Elicit from participants a list of the different purposes for which they request mental health assessments. Ask participants to describe what is typically said in the order requesting the evaluation, including what information is provided to the mental health professional to guide the evaluation. Trainer will return to this list later in the class to discuss how his/her evaluation – both the methods and tests used to gather and analyze information, as well as the final product delivered to court – would differ depending on the stated purpose for which the evaluation was requested. Trainer will also work with participants on specific language for orders requesting evaluations which will better convey to the evaluator the purpose for which the evaluation is being obtained.

B. Waiver to Adult Court

1. Legal Issue: Whether the child presents a risk to the public and whether he/she shows a likelihood of reasonable rehabilitation (i.e., is the child amenable to treatment)?
2. Factors that might suggest referral for evaluation:
 - a. history of emotional/behavioral problems
 - b. history of violence
 - c. significant delinquency history
 - d. nature of the instant alleged offense
 - e. young age
 - f. history of abuse/neglect

C. Competence to Proceed

1. Legal Issues:
 - a. Is the child competent to stand trial? (Is the client able to consult with his/her lawyer with a reasonable degree of rational understanding, and does he/she have

a rational, as well as factual understanding of the proceedings?-- *Dusky v. U.S.*, United States Supreme Court, 1960)

- b. Is the child competent to enter a plea?
 - c. Is the child competent to be sentenced?
2. Factors that might suggest referral for evaluation:
- a. difficulty communicating with client about the case
 - b. age, in particular for younger adolescents
 - c. limited intellectual functioning
 - d. history of poor academic achievement
 - e. history of emotional/behavioral problems
 - f. being tried in adult court

D. Mental State at the Time of the Offense/Sanity

1. Legal Issue: At the time of the offense was the child's ability to distinguish between right and wrong, or appreciate the nature and consequences of his/her actions, impaired due to mental disease or defect? (Note to trainer: trainer should use the language for the sanity test in his/her jurisdiction.)
2. Factors that might suggest referral for evaluation:
 - a. age, in particular for younger adolescents
 - b. limited intellectual functioning
 - c. history of poor academic achievement
 - d. history of emotional/behavioral problems
 - e. third-party accounts alleging unusual/bizarre/disorganized behavior by the client at or around the time of the offense

E. Disposition/Sentencing

1. Legal Issue: What are the client's treatment and programming needs given his/her involvement in the juvenile justice process?
2. Factors that might suggest referral for evaluation:
 - a. offense committed under influence of substances or history of substance abuse suggested
 - b. history of emotional/behavioral problems
 - c. history of abuse/neglect
 - d. history of poor academic achievement
 - e. limited intellectual functioning
 - f. history of violence

III. De-mystifying Mental Health Assessments

A. Professions and Their Distinctions

1. Psychiatrists (MDs/Doctors of Osteopathy) are physicians and the focus of their training is on psychopathology and its treatment. They are authorized to prescribe medication. They have a particular expertise with respect to: distinguishing physical disorders with emotional manifestations from psychiatric disorders, psychopharmacological treatment, and neurological impairment.
2. Psychologists (PhDs/PsyDs) are doctoral level psychologists and the focus of their training is assessment and treatment of psychopathology. They have a particular expertise with respect to: psychological testing and standardized assessment of psychopathology, intellectual functioning, behavioral functioning, academic achievement, and verbal and behavioral therapies and interventions.
3. Clinical Social Workers (MSWs) have masters level social work training and the focus of their training is on assessment and treatment of psychopathology, with an emphasis on social and family systems as they affect the individual. They have a particular expertise with respect to: social and family systems as they affect the individual, and social services and programs available for persons with emotional/behavioral problems.

B. The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)

1. **Overview:** DSM-IV is a manual published by the American Psychiatric Association. It lists the diagnostic criteria for, and prevalence rates of, mental disorders, which reflect a consensus of those in the field. This is a classification system that aids in the collection of statistical information about mental disorders and in the diagnosis and treatment of those disorders. It is used by psychiatrists and psychologists, and it is routinely accepted by courts.
2. **DSM-IV** is organized to allow for assessment and description of disorders. When psychiatrists or psychologists conduct evaluations and rely on DSM-IV, they classify the disorders that people have, allocating the disorder to five different domains. Each domain is called an "axis." For purposes of juvenile court practitioners, the first two axes are usually the most important.
 - a. **Axis I looks at Clinical Disorders**, which includes Depression, Anxiety Disorders, Schizophrenia, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder. It also includes other conditions that may be a focus of clinical attention, including physical abuse of child, sexual abuse of child, parent-child problems, borderline intellectual functioning.
 - b. **Axis II looks at Personality Disorders**, which are more ingrained, long-standing aspects of a person's personality that are typically not expected to change over time. Children typically should NOT receive personality disorder diagnoses because their personalities are still developing. Examples include antisocial

personality disorder and borderline personality disorder. Also included in Axis II is mental retardation, which may be relevant in many cases.

- c. **Axis III: General Medical Conditions Relevant to Emotional/Behavior Functioning.** Examples include seizure disorder, head injury.
 - d. **Axis IV: Psychosocial and Environmental Problems.** Examples include educational problems, occupational problems, housing problems, and problems related to interactions with the legal system.
 - e. **Axis V: Global Assessment of Functioning (GAF).** The examiner's judgment of the examinee's overall level of functioning ranging from 0 to 100. This information is useful in planning treatment and measuring its impact.
- C. **Disorders by Category.** It is important to note that DSM-IV does not classify people. Rather, it classifies disorders that people have. It is also important to note that one does not give a diagnosis by category, but rather by specific disorder. Note: trainer does not have to go through all of these if time does not permit. Most important to flag those disorders prevalent among children in the juvenile justice system. (See Note following #15, next page.)
1. Disorders usually first diagnosed in infancy, childhood, or adolescence. Examples include: Mental Retardation, Learning Disabilities, Attention-Deficit and Disruptive Behavior Disorders, Pervasive Developmental Disorders.
 2. Delerium, Dementia, and Amnestic and other Cognitive Disorders.
 3. Substance-related Disorders. Examples include: Alcohol Dependence or Abuse, Cocaine Dependence or Abuse, Polysubstance Dependence.
 4. Schizophrenia and other Psychotic Disorders. Examples include: Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder.
 5. Mood Disorders. Examples include: Major Depressive Disorder, Bipolar Disorder-Manic, Dysthymic Disorder.
 6. Anxiety Disorders. Examples include: Panic Disorder, Posttraumatic Stress Disorder, Obsessive-Compulsive Disorder.
 7. Somatoform disorders. Examples include: Pain Disorder, Hypochondriasis, Somatization Disorder, Conversion Disorder.
 8. Factitious Disorders.
 9. Dissociate Disorders. Examples include: Dissociative Identify Disorder, Dissociative Amnesia.
 10. Sexual and Gender Identify Disorders. Examples include: Gender Identity Disorder of Childhood or Adolescence, Exhibitionism, Voyeurism, Pedophilia.

11. Eating Disorders. Examples include: Anorexia Nervosa, Bulimia Nervosa.
12. Sleep Disorders. Examples include: Sleep Terror Disorder, Nightmare Disorder, Primary Insomnia.
13. Impulse Control Disorders. Examples include: Pyromania, Tricotillomania, Kleptomania.
14. Adjustment Disorders. Examples include: Adjustment Disorder with Depressed Mood, Adjustment Disorder with Anxiety.
15. Personality Disorders (TYPICALLY NOT DIAGNOSED UNTIL AGE 18 OR ABOVE).
Examples include: Antisocial Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder.

(Note to trainer: In reviewing the above disorders, pay particular heed to those that are most prevalent in delinquency populations: **Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, Substance Abuse and Dependence, Affective disorders, and Posttraumatic Stress Disorder.**)

D. **The Conduct Disorder Diagnosis in Juvenile Delinquency Cases.** Thomas Grisso, in *Forensic Evaluations of Juveniles* (1998), pays particular attention to diagnosis of Conduct Disorder. Because the prevalence of Conduct Disorder as a diagnosis in delinquency cases is so high, trainers should alert the class to the following three pitfalls, cited verbatim, that are identified by Grisso:

1. Some clinicians have a tendency to stop the diagnostic process when they find that the youth meets the formal criteria for Conduct Disorder [thus missing other problems a youth might have.] . . . This ignores the fact that Conduct Disorder is often comorbid with one or more other psychiatric disorders. The job is not to find “a diagnosis” but to discover and describe the youth’s psychological condition. Rarely is this job completed by establishing a diagnosis of Conduct Disorder.
2. Clinicians should recognize that not all youth who meet the formal criteria for Conduct Disorder– even perfectly– should be given a diagnosis of Conduct Disorder. . . . DSM-IV commentary points out . . . that “the Conduct Disorder diagnosis should be applied only when the behavior in question is symptomatic of an underlying dysfunction within the individual and not simply a reaction to the immediate social context” . . . This requires that the clinician explore the causal relationship between the criterion behaviors and (a) the youth’s personality as well as (b) the social and cultural conditions in which the youth’s past criterion behaviors occurred. In at least some instances, youth who meet all of the formal criteria for Conduct Disorder should not be given the diagnosis.
3. Clinicians who are unaccustomed to diagnostic work with adolescents should very carefully identify the relation of Conduct Disorder to Antisocial Personality Disorder. [Grisso cites examples of false claims by testifying mental health professionals, such as: children with Conduct Disorder become adults with Antisocial Personality Disorder; or Conduct Disorder is the adolescent version of Antisocial Personality Disorder; or Antisocial Personality Disorder is what youths with Conduct Disorder become– “after

all, according to DSM-IV criteria, an adult can be APD only if he was CD in adolescence." . . . The majority of youths who can be diagnosed Conduct Disorder "remit by adulthood." [citing DSM-IV]

IV. Psychological Assessment and Testing

A. Basic Information

1. Although psychological tests vary in their types and purposes, generally speaking they all can be described as standardized ways of assessing various aspects or abilities of a person (e.g., mood, intelligence, quality of thought process, adaptive behaviors, memory, knowledge, visual motor coordination) which allow for comparing that person to others.
2. Tests assess skills, abilities, or traits that are measurable. Those attributes that are measurable are called "constructs," which may or may not be relevant, or may be indirectly related to, the question(s) at issue in court. For example, an instrument that measures competence to stand trial will measure constructs of "appreciation," "understanding" and "ability to communicate," which together inform the judge who has to decide whether the youth's capacities for appreciation, understanding and ability to communicate meet the legal standard for competence.
3. Many of the tests that are widely administered to children (and that are reviewed below) do not directly answer the relevant legal questions.
4. A few psychological tests have been designed for forensic purposes and specifically assess psycholegal constructs (e.g., Grisso's Miranda Waiver measures, Competence Screening Test, MacArthur Competency Assessment Tool-Criminal Adjudication, Competency Assessment for Standing Trial-Mental Retardation.)
5. No matter what test is being used, practitioners should know basic information about the test's validity. [Trainer should review matters highlighted in the Introduction, B.6.] Basic questions include:
 - a. What does the test purport to assess? (E.g., intelligence is not the same thing as competency to proceed).
 - b. For what purposes has the test been demonstrated to be valid?
 - c. Is it appropriate to use with children? Have norms been developed for children? Was the test developed specifically for children? For children involved in the juvenile and/or criminal justice systems?
 - d. Is there any reason to believe that the test is biased with respect to race or gender?
 - e. Has the most recent version been employed? Why or why not?

- B. **Focus of testing.** Consumers should ensure that the mental health professionals conducting the evaluations are familiar with the instruments most relevant to the legal questions at issue.

1. **Competence to Waive Miranda Rights.** In 1966, in *Miranda v. Arizona*, the U.S. Supreme Court required procedural safeguards to protect the rights of an accused person to be free from compelled self-incrimination when they are being questioned while in custody. An accused can “waive” (give up) Miranda rights and give a statement to police, but such waivers must be knowledgeable and voluntary. Psychologist Thomas Grisso has developed a standardized assessment of a youth’s competence to waive Miranda rights. (The instruments used to conduct the assessment, *Instruments for Assessing Understanding and Appreciation of Miranda Rights*, are discussed thoroughly in Module Six: *Evaluating Youth Competence in the Justice System*.)
2. **Competence to Stand Trial.** In 1960, the U.S. Supreme Court, in *Dusky v. United States*, adopted the legal standard of competence that is followed in the states. The Dusky standard asks “whether he [the defendant] has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him.” Tests for competency include the MacArthur Competence Assessment Tool -- Criminal Adjudication (MCAT-CA) and the Interdisciplinary Fitness Interview. It should be noted, however, that these tests have only been validated with adults; they have not been validated for juveniles. (Competency to stand trial is discussed thoroughly in Module Six.)

C. General Measures

1. Overview

- a. These measures were developed to diagnose patients in order to provide appropriate treatment or therapy.
- b. Because these general measures were not developed specifically to be used in forensic contexts, inferences have to be made about how they apply to the question at hand. However, when something can be assessed directly, it must be done that way. For example, if the judge wants to know whether a child has the cognitive abilities to understand Miranda warnings, it would be useful to have the results of one or more of the intelligence tests listed in the next paragraph. Red flags should go off in the consumer’s mind when a huge leap must be made in order to answer the legal question, for example, taking the results of an achievement test and inferring that a child a) had the capacities to waive rights, and b) that those capacities were not interfered with by personality or emotional problems.

2. Types.

a. Intelligence (cognitive) testing.

- (1) A cognitive evaluation can be conducted by either a clinical, counseling or certified school psychologist.
- (2) The two most commonly administered intelligence tests are:

- (a) **WAIS-III** (Wechsler Adult Intelligence Scale-III). The WAIS-III assesses capacity for intelligent behavior of adolescents and adults ages 17-74 (Harrington, 1986). It consists of two major scales: Verbal and Performance, each of which contains six subtests. IQ scores are derived for each of these scales as well as a composite Full Scale IQ score. The WAIS-III is available in Spanish.
 - (b) **WISC-III** (Wechsler Intelligence Scale for Children- Third Edition). The WISC-III assesses mental ability in children ages 6-16. It is used to measure a child's capacity to understand and cope with the world (Harrington, 1986). It consists of two major scales: Verbal and Performance, each of which contain six subtests. IQ scores are derived for each of these scales as well as a composite Full Scale IQ score. The WISC-III is available in Spanish.
- (3) For these intelligence tests, a score of 100 is the average, with a standard deviation of 10 points. Accordingly, the following IQ ranges apply:

Very Superior	130 and above
Superior	120-129
High Average	110-119
Average	90-109
Low Average	80-89
Borderline	70-79
Mentally Retarded	69 and below

Ranges of Mental Retardation

Mild	56-69
Moderate	41-55
Severe	26-40
Profound	0-25

- (4) There are other less widely used intelligence tests that may be employed as part of the evaluation. The IQ ranges for the following tests and the normative samples upon which they are based are different than the Wechsler scales. Thus, an IQ number derived from these tests may have slightly different meaning than one from the WAIS-III or WISC-III. It is preferable to have a client evaluated using either the WAIS-III or WISC-III, depending upon the client's age. These less widely used intelligence tests include:
- (a) The Slosson Intelligence Test (SIT)
 - (b) Kaufman Brief Intelligence Test (KBIT)
 - (c) Stanford-Binet Intelligence Scale: Fourth Edition (SB:FE).

b. Academic achievement tests.

- (1) Academic achievement tests are often administered in conjunction with intelligence tests. This allows the examiner to determine whether an individual suffers from a learning disability.
- (2) Such tests include the Wide Range Achievement Test-Third Edition (WRAT-III), the Wechsler Individual Achievement Tests (WIAT) and the Woodcock Johnson Psycho-educational Battery-Revised (WJEB-R).
- (3) The results of these tests will include a grade-equivalent score and a standard score. The standard score can be compared to the IQ scores (Verbal, Performance, Full Scale) to determine if there are significant differences in level of functioning.

c. **Emotional/personality functioning tests.**

- (1) Court evaluations will also usually include some measures designed to provide an index of a client's emotional/personality functioning. These can include both highly structured self-report measures and loosely structured "projective" techniques.
- (2) Clinical psychologists typically have more training in the administration and interpretation of these types of tests than either counseling or school psychologists.
- (3) Commonly employed measures of emotional/personality functioning include:
 - (a) **Beck Depression Inventory (BDI).** The BDI is a 21-item inventory that measures the degree of depressive symptoms found in adolescents and adults. Scales for this inventory include: sadness, pessimism, sense of failure, suicidal ideas, social withdrawal and work difficulty, etc. (Harrington, 1986).
 - (b) **MMPI-A** (Minnesota Multiphasic Personality Inventory- Adolescent Edition). The MMPI-A (used with children and adolescents up to age 18) is a standardized questionnaire that elicits a wide range of self-descriptions scored to give a quantitative measurement of an individual's level of emotional adjustment and attitude toward test-taking (Groth-Marnat, 1984). The MMPI-A has a total of 13 scales, 3 of which relate to validity, and 10 which relate to clinical or personality indices. An individual's score is based on these 13 different categories of responses and is represented in graph form on a profile sheet. This score can be compared with the scores obtained from different normative samples (Groth-Marnat, 1984).
 - (c) **Rorschach Psychodiagnostic Test.** The Rorschach evaluates an individual's personality (usually ages 10 to adult), as one is asked to interpret what one sees in ten inkblot cards. This technique is based on the assumption that an individual's responses are rooted in aspects of personality unique to him or her. Extensive scoring systems have been

developed, and an individual's responses can be compared to normative samples (Harrington, 1986), although this method is considered controversial by some.

V. Ensuring Developmentally-Sensitive Mental Health Assessments

A. To determine the young person's competence, risk for reoffending or amenability to treatment, it is often helpful for the court to know qualitative answers to developmental questions -- where the juvenile is in his/her cognitive, moral, and identity development and what areas of growth remain. (These are the areas of adolescent development that we discussed at length in Module One.) Specifically, qualitative answers to developmental questions:

1. **Assist us in determining the young person's level of culpability for the offense in question, and his/her intent at the time of the offense.**
2. **Help us to determine the young person's amenability to treatment and clarify the young person's needs so that an appropriate disposition/sentence can be designed that rehabilitates the young person while also protecting the community.**

a. **Determining amenability to treatment.** Knowledge of where a young person is developmentally can assist the court in making a more informed determination regarding amenability to treatment; such knowledge allows the court to examine whether services provided in the past were appropriate for the young person's needs. For example, in the context of a transfer hearing, a determination that the services provided did not address the young person's unique developmental needs suggests that the young person may still be amenable to treatment -- the young person was not resistant to treatment but instead was not provided with right to type of treatment -- and should remain in juvenile court. By contrast, a finding that a young person has received developmentally-appropriate services in the past suggests that he/she is may not be receptive to treatment and therefore should be transferred to adult court.

b. **Fashioning developmentally-sensitive dispositions and sentences.** Disposition plans and sentences must specifically address the developmental needs of the individual. It is not enough to state in a disposition order, for example, that a young person should receive counseling while on probation. Instead, a disposition plan must specify what particular services a young person will receive to help him/her learn, for example, to walk away from provocative situations, or to succeed in some area and not rely on negative peers for approval.

B. **Examples of questions that a developmentally-sensitive mental health assessment should answer.** *See Appendix E for a full list of questions.*

1. Maturity of Thought

- a. At the time of the offense, to what extent was this young person anticipating outcomes? Reacting to threat? Minimizing consequences? Seeing only one choice?
- b. Could this young person foresee the consequences of his/her actions?

- c. Was this young person able to plan like an adult, and under stress, did he/she react similar to or different from an adult if things did not occur as planned?
2. **Moral Values**
 - a. What is this young person's understanding of fairness, rights, and responsibility?
 - b. Does this young person consider loyalty a higher moral principle than conventional views of right and wrong?
3. **Empathy**
 - a. Is this young person capable of empathy? Are this young person's adolescent bravado and/or his/her view of the offense as accidental being interpreted as a lack of remorse?
4. **Prior Trauma**
 - a. Is there evidence of prior trauma? Of serious child abuse or neglect? What connections, if any, exists between his/her trauma and the offense?
 - b. How does this young person's past trauma impact his/her cognitive processes, if at all? His/her perception of threat?
5. **Learning Issues**
 - a. Does this young person have a history of school problems or learning disabilities? If yes, what connections, if any, exist between this young person's history of school problems or learning disability, and the offense?
 - b. What connections, if any exist between this young person's learning problems and his/her cognitive processes? His/her perception of threat?
6. **Purposes Served by Delinquency**
 - a. To what extent is this young person's delinquency driven by a need for approval?
7. **Amenability to Treatment**
 - a. Does the young person want to change? Does the young person have a desire for approval that could lead to change?

VI. How to Think About, Request, and Review a Forensic Evaluation

A. Distinguish Between Therapeutic Evaluation and Forensic Evaluation.

1. Therapeutic Evaluation

- a. Initiated by the client (or guardian in the case of a minor).
- b. Voluntary.
- c. For purposes of identifying treatment that will improve the client's overall behavioral adjustment, psychological functioning and welfare.
- d. Confidential and privileged (via psychotherapist-client relationship).

2. Forensic Evaluation

- a. Initiated by a third party (an attorney or the court).
- b. Can be compelled over the objection of the examinee.
- c. Purpose is to assist the court in answering a legal question or questions (e.g., competence, treatment/placement to be initiated as part of disposition, mental state at the time of the delinquent act/sanity). Sometimes the court's specific purpose is to help the child's well being (e.g. disposition evaluations), while in other cases the child's well-being is largely irrelevant to the question the evaluation seeks to answer (e.g., waiver evaluations).
- d. Not confidential because not obtained in the context of a therapeutic relationship, but evaluations requested by the examinee's attorney may be privileged (via the attorney-client privilege).
- e. The format and process of forensic evaluation is controlled by more specific, focused professional standards than are general mental health evaluations. *(Note to trainer: Full citations for these standards are attached at Appendix G.)*
 - (1) Specialty Guidelines for Forensic Psychologists (1991), adopted and promulgated by the American Academy of Forensic Psychology and the American Psychology/Law Society.
 - (2) Ethical Guidelines for the Practice of Forensic Psychiatry (1989), adopted and promulgated by the American Academy of Psychiatry and Law.

B. Pre-Evaluation Preparation

1. Identify the law and the relevant psychological factors that are relevant to the legal issue and discuss with the evaluator. Examples:
 - a. Competence to proceed.

- (1) Child's capacity to understand and appreciate the charges and penalties that he or she is facing.
 - (2) Child's ability to understand the legal process.
 - (3) Child's ability to work with his or her attorney by way of providing relevant information, discussing case options, etc.
 - (4) Child's understanding of how the hearing process works and ability to participate in the process.
- b. Waiver to adult court.
- (1) Violence risk the child presents as affected or suggested by a number of factors including violence history, mental health history, substance abuse history.
 - (2) Available treatments that might bring about significant change in this child's delinquent behavior, given emotional, behavioral, and other problems the child is experiencing. The child's treatment history and success or failure.
 - (3) the child's emotional and intellectual maturity.
2. List mental states, capacities, abilities, behaviors, knowledge, skills that are relevant to the legal questions or issues. Examples:
- a. Competence to proceed.
- (1) Communication abilities (both receptive and expressive).
 - (2) Basic intellectual abilities along with clear and deliberate thinking.
 - (3) Emotional appreciation of the significance of the proceedings.
- b. Waiver to adult court.
- (1) Social/emotional/behavioral problems as they impact the child's history of delinquent behavior.
 - (2) The child's history of treatment for these difficulties.
 - (3) The child's (and significant others') motivation to treatment/rehabilitation.
 - (4) The child's support systems.
 - (5) Available treatment for the child in juvenile versus adult criminal court systems.

3. Gather any relevant information about the child that might bear on the particular psycholegal issues at question and provide to the examiner (e.g., school records, psychiatric record, arrest reports, depositions, witness/victim reports, family accounts or reports).
- C. **Assessing the Evaluator.** *(Note to trainer: trainer should hand out and review the "Outline for Assessing an Expert Witness" attached at Appendix C.)*
1. Ensure that an examiner is appointed who understands the relevant law and psycholegal factors that are at issue (you should not have to do this for an experienced examiner).
 - a. *(Note to trainer: trainer should show overhead attached as Appendix D.)* Mental health professional needs to know the question the court is trying to answer (box A). Otherwise, he/she won't know what to assess. He/she also needs to know both clinical (box B') and forensic assessment (box C') instruments, because failure to use the latter could lead to significant errors.
 - b. Do not assume that simply because a person has conducted a number of evaluations he or she knows the law, or he/she is good at what he/she does. **Few psychologists and psychiatrists receive formal forensic training.** Therefore, don't assume that simply because a professional went to a good school that he/she knows forensics.
 2. Absent extenuating circumstances (e.g., you are practicing in a remote area in which only one qualified mental health professional is available), ensure that the examiner HAS NOT previously been involved with the child in any kind of treatment or therapeutic capacity.
 - a. As noted above, forensic evaluation is a different enterprise than treatment.
 - b. Involvement with an individual in both a forensic and therapeutic context arguably constitutes a dual relationship, which is discouraged by the two leading professional organizations in this area – The American Academy of Forensic Psychology/American Psychology-Law Society and the American Academy of Psychiatry and Law.
 3. Ensure that the examiner has relevant clinical knowledge. The examiner's experience with and knowledge of children in the courts is more important than the examiner's degree. Many mental health professionals do not get a great deal of exposure to children in their training. An examiner should be familiar with the following substantive areas:
 - a. Child and developmental psychology.
 - b. Child psychopathology.
 - c. Mental retardation.

- d. Treatment options within the juvenile justice and mental health systems in the jurisdiction.
- D. **Post-Evaluation Review of the Evaluation.** *Note to trainer: trainer should hand out and review the checklist of "Minimum Criteria for a Good Forensic Evaluation" attached at Appendix I.*

1. Minimum Contents of a Good Forensic Evaluation.

- a. Inclusion of relevant identifying information (e.g., who referred for evaluation, whether completed via court appointment or confidential/ex parte, examinee's involvement with the legal system).
- b. Statement of legal question(s) to be addressed.
- c. Identification of all sources of information relied upon (e.g., review of medical or school records, interview with examinee, testing, parent interview, review of police reports). Note: in some jurisdictions, this is required by statute or court rules.
- d. Description of relevant mental states, capacities, abilities, knowledge, and/or skills that are relevant to the legal question at hand.
- e. Description of the relationship between the mental states, capacities, abilities, knowledge, and/or skills assessed and their causal connection to the youth's abilities or issues about which the court is interested.
- f. Information that contextualizes the conclusions.
- g. Information qualifying the conclusions drawn. What external limitations (i.e., in the testing conditions, the tests themselves, the amount of time evaluator was given to interview the relevant parties, in the amount of background information that the evaluator was able to collect and review, etc.) should be taken into account when relying on the evaluator's conclusions?
- h. Specific recommendations for intervention (when appropriate) with a reasonable attempt to identify interventions that are available in the community.

2. Steps in Reviewing an Evaluation

- a. Ensure that the examiner correctly understood the relevant law and psychological factors that were at issue and addressed them accordingly.
- b. Determine if examiner failed to consider or obtain any relevant information.
 - (1) Did the examiner obtain a thorough personal and social history?
 - (2) Did the examiner tell you how the child's particular history interacts with other clinical measures and techniques used?

- c. Consider the degree to which the examiner evaluated and described relevant mental states, capacities, abilities, behaviors, knowledge, or skills and **their relationship and their connection with or relationship to the psycholegal issues of interest**. Statements such as “The child is depressed” or “The child has limited intelligence” are not particularly helpful because they only provide half the information needed. They don’t link the child’s adjustment or capacity with the behavior that brought the child to the attention of the court. Follow up such “half answers” with questions, i.e., “How does the child’s depression play out in terms of the child’s deliberate behavior, and what implications does that have for interventions?” or “How does the child’s limited intelligence affect the child’s interactions with his attorney?”

(1) Consider how “direct” the examiner was in his/her examination.

(2) Your wariness about the utility of the report in helping you resolve the legal question should increase as the level of inference employed by the examiner increases. (See discussion of inferences on next page.)

- d. Assess whether you need to consult an expert on the particular condition or mental illness diagnosed by the expert evaluator.

- e. Assess appropriateness and validity of any techniques, tests, or instruments used.

(1) General Test Validity²

Review questions raised in Part IV above, entitled “Psychological Assessment and Testing.”

(2) Appropriateness.

- (a) What is the relationship between the capacities assessed by this test and the psycholegal question at issue? The examiner has to explain the relationship, and should be discouraged from using statements like, “The child has borderline IQ and therefore the child is incompetent to proceed.”

²Attorneys wishing to obtain an independent review of the test(s) used can consult some references. First, the various volumes of the *Mental Measurements Yearbook* (published by University of Nebraska Press and available in any good library) publishes reviews of hundreds of tests. Second, forensic evaluation books (the best being *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Attorneys* published by Guilford Press) address the reliability and validity of specific forensic measures and the appropriateness of using more general tests in the context of forensic evaluation. Keep in mind that the former two publications are written by and for psychologists, and they may be dense reading.

- (b) What kinds of inferences did you have to make to go from your assessment of the psychological construct to the legal question? For example, compare:
- i) Considerable level of inference moving from psychological construct assessed to psycholegal issue
 - a) The examiner believes that the adolescent was incompetent to proceed because she obtained an IQ of 78 (borderline intellectual functioning).
 - b) The examiner believes that the child was sane at the time of the offense because her MMPI-A profile is flat and suggests no significant psychopathology.
 - ii) Lesser degree of inference
 - a) The examiner believes that the adolescent is incompetent to proceed based on her responses to the Competence Screening Test and the Florida Juvenile Competency Assessment Procedure.
 - b) The examiner believes that the child was sane at the time of the offense because interview and third party data indicate that the child's behavior was purposeful and not affected by any symptoms of mental disorder. (In certain situations, a battery of tests may not be useful to the legal question, and therefore basing an assessment on such third-party data may be more appropriate.)
- (c) Are there any measures available which assess these relevant psycholegal constructs more directly?

Interactive Exercise: John Doe**Part A
Analysis of Psychological Evaluation**

The purpose of Part A of this exercise is to help participants develop a system for analyzing a psychological report under severe time pressures.

- Step 1: Break the participants into small groups. (If at all possible, make sure that there is representation from each of the professions – judges, prosecutors, defense attorneys and probation officers – in each group.) Randomly assign each group the role of judge, prosecutor or defense attorney. Ask each group to select one individual to act as a recorder and reporter for the group. Hand out the packet attached as Appendix A to this module, which includes: (1) a one-page description of Doe’s current legal status; (2) a copy of the court order requesting the evaluation; (3) a summary of Doe’s court-ordered psychological evaluation; (4) a worksheet for this exercise; and (5) DSM-IV criteria for Adjustment Disorder with Conduct Disorder.
- Step 2: Give the participants 20 minutes to read the court order, the one-page description and the evaluation, and complete Part A only of the worksheet as a group.
- Step 3: Reconvene as a large group to discuss the evaluation and specifically the groups’ responses to the questions in Part A of the worksheet. Trainers should be prepared to comment on the following:
- ! The stated goals of the evaluations: Are they idealistic? Realistic? Not helpful for the purposes of this hearing?
 - ! The areas of the evaluation that groups selected to concentrate on in their examinations to support their goals. What are potential traps or pitfalls of going into these areas? Where might the questioner get bogged down during the examination? How can these traps be avoided without giving up the quest for information?
 - ! The groups’ strategies to deal with the areas of the evaluation that are less helpful. What are the potential traps or pitfalls of going into these areas?

- ! The pros and cons of making a record versus making a point: should you aim to be inclusive and attack all weaknesses in the evaluation, or should you concentrate on those few elements that support your goal?

Part B

Examination of Mental Health Professional

The purpose of Part B of this exercise is to help participants develop the skill to formulate questions that will: (1) illuminate the nexus between the diagnosis in an evaluation and the supporting components of the evaluation; and (2) reveal whether the evaluator's route to diagnosis was based on adequate information and skilled interpretation.

- Step 1: Break the participants into pairs. (Again, ask participants to team up with a person from a profession not their own so that each pair is multi-disciplinary.) Randomly assign pairs the role of judge, prosecutor or defense attorney.
- Step 2: Ask participants to review the DSM-IV criteria in their information packet and then complete Part B of the worksheet.
- Step 3: Reconvene as a group. Trainer should prep a participant in advance of the role play, or select an experienced member of the class, to act the part of the professional who prepared the evaluation. Participants shall question the professional on the stand at the disposition hearing. Trainer will critique the questions during the course of the exercise and make suggestions on how to fine tune them. Trainer will also be prepared to comment on the following after completion of the psychologist's testimony:
- ! Whether weaknesses in the evaluation arose from: (1) the psychologist's failure to correctly interpret background information; and/or (2) the psychologist's failure to cast a wide enough net to capture relevant information; and/or (3) lack of court guidance about what specific issues s/he should concentrate on.
 - ! Whether more information and/or skilled interpretation would have led to a different diagnosis, i.e., a more precise diagnosis.

- ! Whether a diagnosis that considered substance abuse was adequately considered (trainer can introduce concepts of “dual diagnoses” or “co-morbidity”).
- ! Whether the psychologist chose tests that covered the range of issues needed to be addressed at the disposition hearing. What does each test measure? Do the chosen measurements leave any gaps?
- ! If inadequate measures were chosen, was this due to the psychologist’s failure to choose appropriate measures, or lack of guidance from the court?

Part C

Writing Court Orders for Mental Health Evaluations

The purpose of Part C of this exercise is to practice how to draft a court order that will give the best possible guidance to the psychologist about the issues s/he should address in the evaluation and the report to the court.

- Step 1: Break the participants into the same small groups as they did for Part A of the John Doe exercise.
- Step 2: Ask participants to go back in time and assume that they are in court on the day that John Doe entered his guilty plea. The judge asks the parties to draft an order for a psychological evaluation for John’s disposition. Participants should write out a sample order and submit it to the trainer.
- Step 3: Trainer critiques orders that the groups submitted.
- Step 4: Trainer should then return to the list generated at the beginning of the class of the different purposes for which mental health evaluations are requested in juvenile court. Trainer will discuss how his/her evaluation – both the methods and tests used to gather and analyze information, as well as the final product delivered to the court – would differ depending on the stated purpose of the evaluation. Trainer will discuss specific language and information that should be included in the court order for the different types of evaluations requested.

Interactive Exercise: Analyzing Evaluations

Part A

Trainer should give out and review with the group the more thorough psychological evaluation of John Doe, attached at Appendix B. Trainer should discuss/ elicit from participants the following:

- ! In what ways is this a stronger evaluation as compared to the summary that was used in the earlier exercise?
- ! What relevant information is still missing from this evaluation?
- ! What statements and/or omissions should you question the evaluator about?

Part B

Prior to the training session, trainer should arrange for participants to submit mental health assessments from their own cases in juvenile court. (Names of all relevant parties should be deleted for confidentiality reasons.) Or the trainer may use the sample evaluations attached at Appendix B. At the session, the trainer will go through selected evaluations to (1) help participants understand the information that is typically in an evaluation; (2) suggest questions that the participant could have posed to the mental health professional in order to clarify any ambiguity and/or seek additional information; and (3) elicit from participants the strengths and the weaknesses of each evaluation.

Bibliography

(Note to trainer: trainer should consult the literature review included under separate cover for additional reference materials and suggestions for assigned readings for training participants.)

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APPENDIX A

Materials for John Doe Exercise

Includes:

1. One-page description of John Doe's current legal status
2. Court order requesting evaluation
3. Summary of John Doe's court-ordered psychological evaluation
4. Worksheet
5. DSM-IV criteria for Adjustment Disorder with Disturbance of Conduct

JOHN DOE'S CURRENT LEGAL STATUS

Today is John Doe's dispositional hearing in juvenile court. Several weeks ago, John entered a plea to the charges of unauthorized use of a vehicle and possession of marijuana. John is fourteen years old. The facts of the case are as follows: He was apprehended by the police while driving recklessly. John drove his vehicle right at the police car and came to a screeching halt, just short of a head-on impact. The officer grabbed John from the vehicle. He then lunged at the officer and attempted to escape, but the attempt was thwarted. John was charged with unauthorized use of a vehicle, possession of marijuana (which was found in the car), and resisting arrest (which was later dropped).

This is not John's first contact with the juvenile court. He was previously charged with possession of an illegal substance and was placed into a diversion program for a period of six months. He attended three counseling sessions, but then stopped going; however, the charge was not reinstated by the government. At the time that John was apprehended on the current charges, he had run away from home and was staying at the home of a different friend or acquaintance each night.

The presiding judge ordered a psychological evaluation and for the psychologist to be present in order for counsel to interview him/her. The judge (and the training participants) have not yet seen the evaluation, as it just came into court. Counsel asks for a continuance in order to evaluate the report. The judge asks the psychologist if he could be present for a hearing in one month. The psychologist informs the judge that he will be out of the country for the next six months on a teaching fellowship and will be unavailable. The judge orders the disposition to go ahead. Counsel will have a brief recess to go over the assessment in order to determine what questions to ask.

Please read the attached court order and summary of the psychological evaluation. Then turn to the worksheet and discuss and complete Part A only of the worksheet as a group.

COURT OF COMMON PLEAS OF LINCOLN COUNTY
FAMILY COURT DIVISION – JUVENILE BRANCH

IN THE MATTER OF : J -4287-9X
 : :
 John Doe, : Judge Schiff
 : :
 a Minor : Disposition: February X, XXXX

ORDER

IT IS HEREBY ORDERED this XX day of December, XXXX, that Court Social Services shall arrange for the Respondent, John Doe, to undergo a mental health evaluation in preparation for Respondent’s disposition. A copy of said evaluation shall be provided to the Court and to counsel no later than one (1) week prior to Respondent’s disposition.

IT IS SO ORDERED.

Schiff, J.

SUMMARY OF PSYCHOLOGICAL EVALUATION OF JOHN DOE Mary Smith, Ph.D.

Sources of Information Utilized: Clinical Interview, Telephone interview with Louise Doe, Mental Status Examination, Wechsler Intelligence Scale for Children-R, Wide Range Achievement Test-R, Draw-A-Person, Incomplete Sentence Blank (High School Version).

Background Information: John is currently enrolled in the 9th grade at Lincoln Middle School. He lives with his mother and younger brother Jeremy. John's parents have been separated for the past year and his father currently lives outside of Atlanta with his girlfriend. Ms. Doe reported an unremarkable medical and psychological history for the first 12 years of her son's life. She indicated that, over the past year, John has shown a pattern of troubled behavior including lying, skipping school, talking back to her, staying out late, and sleeping late, sometimes missing school. She reported that John had no academic or significant behavioral problems through 8th grade (he was a B/C student). In 9th grade his grades began to suffer, and he received all Ds and Fs on his most recent report card. He has been suspended twice, once for fighting with another student and once for threatening a teacher. Ms. Doe believes that her son has experienced other difficulties that she is unaware of and she attributed this lack of knowledge to her busy work schedule (she has worked 4PM to midnight at a convenience store since her husband left the home).

Clinical Interview: John was cooperative with the evaluation process. He admitted to stealing the car ("it was a joyride") and claimed that he found the drugs in his possession in the car's glove box. He admitted to trying marijuana and alcohol in the past but stated that he did not use any drugs on a regular basis because it interfered with sports. John admitted to skipping school and stated that he wanted to drop out and get a job. He cited his prior record of acceptable grades as evidence that he was able to do school work if he wanted to. He acknowledged difficulties with his mother but attributed them to her being over-worked and him trying to "be a teenager." John reported a prior arrest for loitering and indicated that he was placed on community control. Records of this arrest were not available.

Test Results and Interpretation: John's WISC-R Full Scale score of 98 places him in the average range of intellectual functioning. Analysis of his verbal and performance scores suggests that his verbal and non-verbal abilities are equally developed, and he shows no particular strengths or weaknesses with respect to these abilities. John's performance on the WRAT-R suggests academic achievement lower than that expected given his intellectual abilities. John's performance on the Spelling, Arithmetic, and Reading subtests places him in 80th, 72nd, and 40th percentiles, respectively, when compared to same age peers. John's responses to the Draw-A-Person Test and Incomplete Sentence Blank suggest underlying feelings of anxiety and insecurity for which he is trying to compensate at this time, perhaps related to his parents' separation and divorce.

Provisional Diagnosis: Axis I: Adjustment Disorder with Disturbance of Conduct, Rule out Reading Disorder, Axis II: No Diagnosis, Axis III: No Diagnosis, Axis IV: Educational Problems, Problems with Primary Support Group, Axis V: 80-Current (Transient symptoms resulting from psychosocial stressors)

Recommendations: John Doe is a 14 year old boy who shows a recent history of some delinquent behavior that coincides with his parents' separation and related family stressors.

While John maintains that he is not particularly affected by these family events, results of psychological testing suggest a young man who is emotionally challenged by his parents' separation and is responding by acting out, perhaps as a way of challenging these feelings or gaining attention. His use of defense mechanisms such as repression and denial, however, minimize his ability to draw these connections. Individual or group therapy is recommended so that John can focus on his parents' divorce, and how that has affected him and his behavior. Psychotherapy at this juncture is considered to have a positive prognosis, given apparent development of superego functions, and positive object relations predating the parents' separation and divorce.

SMALL GROUP EXERCISE WORKSHEET

John Doe Exercise

Part A

Complete the following questions as a group:

What will be the goal of your examination of the mental health professional who prepared the evaluation? Reach a consensus in your group about the goal of your examination. (If you can't reach consensus, then report on the separate goals, but work hard to reach consensus.)

Which areas of the evaluation support your goal?

Which areas of the evaluation are less helpful to your goal? What are your strategies for dealing with this less helpful information?

What are the weak areas in the evaluation? Why do you consider them weak?

What additional sources of information, tests, etc., do you think the psychologist should have considered before making her diagnosis?

What relevant questions are left unanswered by this evaluation?

SMALL GROUP EXERCISE WORKSHEET

John Doe Exercise

Part B

Review the DSM-IV criteria in your packet and complete the following with your partner:

Formulate 1-3 questions intended to elicit from the psychologist how the **tests** that were administered to John Doe bear on the adjustment disorder diagnosis.

Formulate 1-3 questions for the psychologist about how the **background information** on John relates to the diagnosis.

Formulate 1-3 questions for the psychologist about how the **clinical interview** with John relates to the diagnosis.

DSM-IV DIAGNOSTIC CRITERIA FOR ADJUSTMENT DISORDER WITH DISTURBANCE OF CONDUCT (DSM-IV 309.3)

Diagnostic Criteria for Adjustment Disorders (309.X)

1. The development of emotional or behavioral symptoms in response to identifiable stressor(s) occurring within three months of the onset of the stressor(s).
2. These symptoms or behaviors are clinically significant as evidenced by either of the following:
 - a. marked distress that is in excess of what would be expected from exposure to the stressor.
 - b. significant impairment in social or occupational (academic) functioning.
3. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
4. The symptoms do not represent Bereavement.
5. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

- a. Acute: if the disturbance lasts less than six months.
- b. Chronic: if the disturbance lasts for 6 months or longer.

Adjustment orders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(c) can be specified on Axis IV.

With Disturbance of Conduct (309.3)

This subtype should be used where the predominant manifestation is a disturbance in conduct in which there is a violation of the rights of others or of major age-appropriate social norms and rules (e.g., truancy, vandalism, reckless driving, fighting, defaulting on legal responsibilities).

APPENDIX B

Sample Mental Health Assessments for Use With Exercise on Analyzing Assessments

Includes:

1. Second John Doe evaluation
2. Josh Adams evaluation
3. Paul Prentiss evaluation

PSYCHOLOGICAL EVALUATION OF JOHN DOE

NAME: John Doe
CASE NO: J-4287-9X
DATE OF BIRTH: 1/3/84
AGE: 14
EDUCATION: 9th grade

DATE OF EVALUATION: 1/8/98
DATE OF REPORT: 1/14/98

IDENTIFYING INFORMATION/REASON FOR REFERRAL/NOTIFICATION

John Doe is a 14 year-old white adolescent who was referred for evaluation by the Honorable Susan Schiff. John had been arrested for possession of marijuana and auto theft and Judge Schiff ordered a psychological evaluation to determine any treatment or placement needs that John might have at this time.

Accordingly, John was interviewed and tested on January 8, 1998. Prior to initiating the evaluation its nature and purpose were explained to John and his mother, who accompanied him to the evaluation. John and his mother were informed that the evaluation was for purposes of making treatment and placement recommendations with respect to the current case, that the evaluation was not confidential, and that any information they revealed might be included in a report, which would be provided to his public defender, the state attorney, and the judge. John and his mother understood this notification and agreed to participate in the evaluation process.

SOURCES OF INFORMATION

The following sources of information were relied upon in completing this evaluation:

Clinical Interview with John Doe (1/8/98, 1.0 hours)

Administration of Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A, 1/8/98)

Interview with Louise Doe, John's mother (1/8/98, .50 hours)

Review of arrest/incident reports (1/6/98)

Review of John's DJJ record (1/8/98)

Telephone interview with Lloyd Samuels, John's school counselor (1/9/98, .25 hours)

Review of John's school records at Riverdale High School

RELEVANT HISTORY

John is the oldest of two boys born to and raised by his parents. Jeremy, his younger brother, is 10 years old. John currently lives with his mother and younger brother. Mr. Doe moved to Atlanta one year ago after announcing his intention to divorce.

Ms. Doe indicated that, over the past year, John has shown a pattern of troubled behavior including lying, skipping school, talking back to her, staying out late, and sleeping late,

sometimes missing school. She reported that John had no academic or significant behavioral problems through 8th grade (he was a B/C student). In 9th grade his grades began to suffer, and he received all Ds and Fs on his most recent report card. He has been suspended twice, once for fighting with another student and once for threatening a teacher.

Ms. Doe first reported that she was not aware of her son having any problems with alcohol or drugs. More detailed questioning, however, indicated that Ms. Doe had found John drinking beer in the home on a few occasions but she clearly minimized the significance of this, stating it was inevitable that children will experiment with alcohol. Ms. Doe reported not being aware of any drug use on her son's part, however, and she denied any history of emotional or behavioral problems prior to the past two years. Ms. Doe reported being unaware that John had been ordered to participate in substance abuse treatment but rather, believed that he was ordered to receive counseling, which, she believed, was being provided by Mr. Samuels. Ms. Doe acknowledged that John may have experienced other difficulties that she is unaware of and she attributed this lack of knowledge to her busy work schedule (she has worked 4PM to midnight at a convenience store since her husband left the home).

A report by John's school counselor, Mr. Samuels, was generally consistent with comments offered by Ms. Doe. Mr. Doe corroborated Ms. Doe's report of her son's academic achievement, and he indicated that testing with the school psychologist did not identify any intellectual limitations or learning difficulties. Mr. Samuels, however, perceived a pattern of escalating intimidating behavior with peers at school, and noted that the incidents for which John was suspended were quite serious. Mr. Samuels also reported that other students had reported John to be using drugs at school, but John denied this on interview. Mr. Samuels also voiced concerns about Ms. Doe's involvement with her son as she had not responded to two requests for a meeting to discuss his repeated absences, poor academic performance, and acting-out behavior.

Records provided by the Department of Juvenile Justice indicate that John had previously been arrested for possession of a controlled substance and ordered to undergo substance abuse counseling. Arrest records obtained by this writer indicate that John initially fled from police when observed driving a stolen car. After being stopped, John allegedly lunged at officers and tried to escape before being apprehended. Officers at the scene reported that John appeared to be under the influence of drugs or alcohol at the time of his arrest.

BEHAVIORAL OBSERVATION & CLINICAL INTERVIEW

John and his mother were interviewed in this writer's office. They arrived promptly for their appointment. John is a tall, lean young man who came to the evaluation casually but neatly dressed, wearing jeans, tennis shoes, and a white t-shirt. When interviewed with his mother, John appeared angry, and frequently contradicted his mother, even about minor and irrelevant issues. He was more cooperative and less disagreeable when interviewed alone. Overall, John was cooperative with the evaluation process.

When interviewed, John was oriented to time, place, and person (i.e., he knew when it was, where he was, and who he was). He spoke at a normal rate and tone. His speech was logical and goal directed and his responses to questions were typically informative although at times, his responses appeared guarded. The above indicates that the structure and form of his thought process was not in any way impaired. Similarly, the content of John's thought process

was not considered to be impaired insofar as he did not voice any unusual ideas or beliefs (i.e., delusions). John also denied experiencing other symptoms indicative of major mental disorder (i.e., hallucinations).

John's attention and concentration appeared unimpaired as indicated by his ability to remain involved in the interview process. He was considered to be a good historian overall, but, as is described in more detail below, he appeared to be somewhat guarded and defensive, and there were some indications that he intentionally withheld information from this examiner that he thought might be detrimental to his case.

In order to further assess John's current adjustment and functioning, he was administered the MMPI-A, a structured, self-report measure of behavior and psychopathology. Validity indices of the MMPI-A indicate that John responded to the inventory items in a reliable and consistent, although somewhat defensive manner, perhaps in an attempt to present himself in a positive light. Thus, while valid, the MMPI-A profile produced by John may underestimate his current difficulties to some degree.

Teenagers who obtain MMPI-A profiles similar to that produced by John show a disregard for social standards and are likely to display impulsive and acting out behaviors. They may experience school-related, legal, and family problems as a result of the above. As compared to their peers, they are more focused on their own needs and interests, to the exclusion of others. Although they may make a good first impression on others, their self focus is likely to prevent establishment of enduring relationships. Significant family difficulties, frustration with parents, a desire to leave home, and feelings of being misunderstood are also suggested by John's MMPI-A profile.

Testing with the MMPI-A also portrayed John as experiencing a moderate level of distress, which may be characterized by feelings of depression and anxiety. There remains the possibility that these reported symptoms are, in part, related to his current circumstances and involvement with the legal system. Indeed, the MMPI-A profile suggests the possibility that John may engage in a pattern of behavior whereby he acts out impulsively followed by expression of remorse and regret. The MMPI-A profile also suggested the possibility of drug and/or alcohol abuse.

As noted above, John was judged to be somewhat guarded during the interview, and he selectively revealed information to this writer. For example, John admitted to stealing the car, describing it as a joyride, and claimed that he found the drugs in his possession in the car's glove box. While John maintained that he did not use drugs he was unable to explain why he took them from the glove box. John claimed that the arresting officers were guilty of police brutality and he admitted to attempting to strike one officer, but only in self defense. He denied being under the influence of any substances when arrested. John admitted to trying marijuana and alcohol in the past but stated that he did not use any drugs on a regular basis because it interfered with sports. Contrary to his mother's report, John denied ever using alcohol in the home with friends.

John was also less than forthcoming about his contact with the juvenile justice system. Apparently unaware that this writer had access to his juvenile justice record, John reported a prior arrest for loitering and indicated that he was placed on community control. As noted below, however, John was previously arrested for possession of a controlled substance. When

confronted with this inconsistency, John at first claimed that it was a mistake and he became angry, asking this examiner if he was calling him a liar. John then acknowledged the incident but claimed that he had forgotten about it, and he maintained that he had been wrongfully accused.

John admitted to skipping school and stated that he wanted to drop out and get a job. He cited his prior record of acceptable grades as evidence that he was able to do school work if he wanted to. He acknowledged difficulties with his mother but attributed them to her being over-worked and him being a teenager.

John was willing to talk about his parents' separation. He reported being angry with his father and described him as taking advantage of his mother. John sees himself, his brother, and mother as suffering financially as a result of his father's departure.

Overall, John did not see himself as having any significant difficulties. He portrayed his recent academic difficulties as fleeting and he downplayed the significance of the behavior leading to his suspensions. He claimed that he only fought after another student instigated the fight, and he denied threatening his teacher but claimed that she harbored negative feelings towards him because he had challenged her in class before. John denied any emotional or psychological difficulties at this time or in the past. He portrayed difficulties with his mother as minor and largely the result of her over-concern. He denied recent or current use of alcohol or drugs and described his involvement with the juvenile justice system as resulting from nothing more than mistakes or poor judgment, which would not occur again.

DIAGNOSTIC IMPRESSION

The diagnostic picture at this time is somewhat unclear, largely as a function of inconsistencies between John's self-report and accounts offered by third parties. Overall, however, information provided to this writer suggests that John has a substance abuse or dependence problem at the current time. Specific substances that John may be abusing are unclear but may include alcohol and marijuana, and there remains the possibility that other substances may be involved. Additionally, John appears to have developed a constellation of behaviors characterized by rule and norm breaking, with little concern for the impact of his behavior on others. Accordingly, the following provisional diagnoses are offered:

Axis I: Conduct Disorder, Adolescent Onset, Moderate Polysubstance Abuse, Rule out Polysubstance Dependency

Axis II: No Diagnosis

Axis III: No Diagnosis

Axis IV: Educational Problems, Problems with Primary Support Group, Problems Related to the Legal System

Axis V: 55-Current

SUMMARY AND RECOMMENDATIONS

John Doe is a young man with a two year history of increasingly problematic behavior that is characterized by intimidating and aggressive behavior towards peers and adults, theft, academic underachievement, and substance abuse.

Given the above, John is in need of intensive treatment at this time. First, although John maintains that he is not abusing substances at this time, information provided to this writer suggests that placement in an intensive substance abuse treatment program is indicated. Following completion of either a residential or intensive outpatient program, John will need intensive follow-up and monitoring that includes random drug testing.

Additionally, John will also benefit from structured supervision by and contact with DJJ. John may also benefit from involvement in individual therapy. There may be some concern about John's peer group at this time and some restrictions with respect to this may be indicated. Involvement in prosocial activities (e.g., organized sports or clubs) will be helpful and should be considered as part of his intervention plan. If John does leave school, stable employment or participation in an alternative training or educational program is indicated.

The relationship between John's recent behavioral difficulties and his parents' marital difficulties is unclear, but John may benefit from having the opportunity to discuss these and related issues. Reports by John's mother suggest that she might benefit from parent training or individual therapy.

Positive prognostic indicators include John's relatively good adjustment until the past two years, his history of academic achievement, and his mother's support and involvement. Factors that prove to be of some concern regarding positive changes on John's part include his unwillingness to acknowledge what appear to be clear problems (e.g., his substance use), his tendency to minimize the severity of some of his behavior, and the pattern of increasingly criminal behaviors. Certainly, without significant intervention, John is at risk for continued and more serious delinquent/criminal activities.

Thank you for this opportunity to serve the court. As always, if you have any questions about my evaluation, please do not hesitate to contact me.

Respectfully submitted,

Mary Smith, Ph.D
Licensed Psychologist

REPORT OF PSYCHOLOGICAL EVALUATION OF JOSH ADAMS

Name: Josh Adams
Date of Evaluation: 4/18/2002
Age: 13 years
Date of Birth: 9/15/1988
Referral Source: Linda Attorney
Evaluator: Lawrence Henderson, Psy.D

REASONS FOR REFERRAL:

Josh Adams was referred for a psychological evaluation by his attorney to assist in understanding and treating a variety of serious behavioral concerns. Results of this evaluation were to be used to inform specific treatment and placement plans for Josh.

RECORDS REVIEWED:

Psychological Evaluation by Gordon Humphrey, Ph.D. (2/21/2002)
Pediatric Neurology Outpatient Notes, Jack Marshall, M.D., Lang Medical Center (1/31/02)
Pediatric Cardiology Outpatient Notes, Joseph Bellows, M.D., Lang Medical Center (1/18/02)
Records from Mountain View Academy Intermediate Secure Treatment Facility, *including*:
 Psychiatric Assessment by Miles Wilson, M.D. (3/12/02)
 Individual Service Plan Six Month Review (3/4/02)
 Individual Service Plan Three Month Review (1/4/02)
 Individual Service Plan (9/30/01)
Psychiatric Evaluation by Steven Butler, M.D. (9/14/01)
Psychological Evaluation by Charles Lundy, M.A. (9/17/01)
Records from Juvenile Court of Milwaukee, Wisc., *including*:
 Transcript of Detention Hearing (9/7/01)
 Juvenile Petition (9/6/01)
 Written Statement of Josh Adams and Signed Waiver (9/5/01)
Records from Child & Adolescent Clinic, *including*:
 Psychological Evaluation by Charles Lundy, M.A. (9/29/00)
 Psychological Re-Evaluations by Charles Lundy, M.A. (11/24/99, 3/20/00)
 Psychiatric Evaluation by Gary Ginsburg, M.D. (8/30/99)
 Psychological Evaluations by Diane Snyder, M.A., and Roger Santiago, Ph.D. (6/4/98, 9/19/98)
 Psychiatric Evaluation by Trude Bianco, M.D. (5/28/98)
 Psychological Evaluations by Katherine Hollimon, M.A., and Paulette Miller, Ph.D. (10/29/95, 1/25/97)
 Psychiatric Evaluations by Sarah Hurwitz, M.D. (9/20/95, 10/4/96)
 Psychiatric Evaluation by Steven Fitzmartin, M.D. (11/11/95)
Records from Elmhurst Hospital, *including*:
 Discharge Summaries by John Richman, M.D. (11/26/93, 9/25/94, 8/13/95, 10/11/97)
 Psychiatric Assessment by Michael Dalton, M.D. (9/14/97)
Records from First Milwaukee Hospital, *including*:
 Discharge Summary by Michael Dalton, M.D. (5/10/97)

Social Service Discharge Summary by David Morgan, M.A. (5/10/97)
History and Physical Report by Angie Simmons, M.D. (4/30/97)
Records from Presbyterian Hospital, *including*:
Discharge Summary by Mina Patel, M.D. (7/26/96)
Social Assessment by Don Meadows, M.S. (7/8/96)
History and Physical Record by Jonathan Ebert, M.D. (7/4/96)
Records from Children's Hospital of Milwaukee, *including*:
Discharge Summary by Robert Silver, M.D. (12/20/95)
Diagnostic Summary by Donna Crouse, M.S.W. (12/16/95)
Psychiatric Update by Robert Silver, M.D. (12/15/95)
Biopsychosocial Summary by Donna Crouse, M.S.W. (11/30/95)
Psychiatric Evaluation by Robert Silver, M.D. (11/11/95)
Records from Various Schools, *including*:
Notices of Recommended Assignment (5/3/95, 11/21/96, 7/23/01)
Individualized Education Programs (9/8/95, 12/1/00, 6/8/01)
Comprehensive Evaluation Reports (10/6/99, 6/3/01)

EVALUATION METHODS:

Collateral Interview via Telephone with Josh's Mother, Evelyn Drake
Collateral Interviews via Telephone with Mountain View Academy Counselor, Joe Merna;
Unit Supervisor, Matthew Simmons; and Group Therapy Facilitator, Sue Stotland
Achenbach Child Behavior Checklists, Completed Separately by Mr. Merna and Mr. Simmons
Clinical Interview with Josh
Bender Visual-Motor Gestalt Test
Projective Figure Drawings
Thematic Apperception Test (TAT)
Rorschach Inkblot Method (Attempted)
Minnesota Multiphasic Personality Inventory – Adolescent Version (MMPI-A)

BACKGROUND INFORMATION:

Identifying Data and Family History

Josh Adams is a thirteen year-old Caucasian male who is currently being held in residential placement at the Mountain View Academy in Woodside, WI. Josh entered this placement on 9/28/01, after being arrested for Indecent Assault earlier that month. Prior to his arrest, he was living with his mother, step-father, and sister Samantha (age four). Josh's arrest stemmed from charges that he had been engaging Samantha in sexually inappropriate behavior on multiple occasions over a roughly two-month period of time.

Josh was born in Ohio but has lived in north-central Wisconsin since he was approximately eighteen months old. His parents divorced when he was very young, and he has had little or no contact with his biological father. In available records (e.g., see evaluation by Dr. Ginsburg, 8/30/99), his father has been described as a "very hyperactive individual ... known to be quite aggressive [and] ... in and out of jails." According to Josh's mother, his father had a history of alcohol abuse, as did Josh's paternal grandfather and four of the father's siblings.

According to records, Josh's mother also has a remote history of poly-substance abuse but has been substance free for roughly twelve years. Records indicate that this contributed to an early history of physical neglect for Josh, but this has reportedly not been a concern since he was a young child. According to records, the family history also includes alcohol abuse in Josh's maternal grandfather and other maternal relatives. Mrs. Drake denies any additional family history of substance abuse or other mental health concerns.

History of Presenting Problems

On 9/6/01, Josh was charged with Indecent Assault. According to police records, Josh admitted to "[touching Samantha's] genital area with his penis many times during the months of May 2001 and June 2001." In conjunction with the current assessment, Mrs. Drake offered the evaluator the following account of events leading to her son's arrest: Approximately one year ago, Mrs. Drake observed Samantha "grinding against people" in a sexualized manner, and when she asked her daughter what she was doing, Samantha replied, "playing the 'oh baby game.'" Samantha then told her mother that, on more than one occasion in the home, Josh had laid on top of her and "rubbed against her." According to Mrs. Drake, Samantha added that this generally took place with both of their clothes on, but that once he had taken her underwear off. Mrs. Drake subsequently reported Samantha's comments to authorities in an effort to seek services for both children. A medical exam of Samantha revealed a "broken hymen but no proof of penetration." She was referred for outpatient psychotherapy, which Mrs. Drake states is currently continuing. During a psychological evaluation of Josh conducted shortly after his arrest, (see report by Psychological Evaluation by Charles Lundy, M.A. (9/17/01)), Josh reportedly provided a very similar account of the sexual incidents but added that "he had his pants down" during at least one of these incidents. In the report of a subsequent psychiatric evaluation by Dr. Butler, M.D. (9/14/01), there is additional mention of "oral genital contact," but this is not discussed in any other records, and Mrs. Drake and Josh both assert that this is an error, denying any knowledge of such contact.

Since being placed at Mountain View Academy, Josh had exhibited extremely poor adjustment. Staff members describe him as "really struggling," as he has demonstrated "constant" defiance and oppositional behavior to varying degrees throughout his placement. One staff member suggested that Josh "needs more" structure and support than this placement can provide because he refuses to comply with staff to improve his behavior. He reportedly requires verbal redirection on a frequent basis throughout the day, as well as numerous "assists" from staff to physically redirect or control his behavior. At times, he appears unable to focus and has difficulty staying on task to complete assignments. Additionally, staff members and records describe Josh as manipulative and provocative, apparently deriving pleasure from "setting off staff to see what they'll do." He reportedly tells "blatant small lies to instigate" conflict among peers and staff. However, staff members each reported there have been no significant incidents of aggressive or violent behavior during his placement, and there have been no known incidents of sexually inappropriate behavior (in terms of physical contact, verbalizations, or gestures). Staff further report that one area where Josh has made progress is in groups, including sex offenders group, where he has acknowledged and discussed the sexual offending behavior that prompted placement. Although he initially was reluctant to disclose, he has since reportedly maintained consistent acknowledgment of his sexual behavior and has worked on relevant treatment goals. According to his group facilitator, Grace Stotland, Josh has expressed concerns that he may repeat that behavior upon discharge to his home.

Josh has an extensive history of behavioral and emotional concerns and corresponding mental health interventions, which began shortly before his fourth birthday. This includes approximately eleven psychiatric hospitalizations, beginning at age five, each in response to out-of-control, violent, or otherwise destructive behaviors. Voluminous records are available for specific details of these hospitalizations, but presenting problems at the time of various admissions have included the following: labile mood and tantrums; threatening his mother with a knife; threatening to hurt his mother and her unborn child (Samantha) during her pregnancy; attempting to stab his step-father with a barbecue fork; trying to set fire to a cot at home; being cruel and malicious to a cat; fighting with peers and school staff; urinating on peers and on property when angered; stealing. Records also indicate an early childhood history of anxious behaviors, including chewing his hands, and enuresis and encopresis as late as age six. There is a documented history of early psychotic symptoms, but these are not clearly delineated in available records. Josh has been followed for mental health services through the Child & Adolescent Clinic since he was nearly four, and numerous interventions have been offered in the community. He has participated in individual therapy, intensive home-based family counseling, wrap-around services in the home and school, and partial hospitalization. Most recently, he was placed into residential care through Bethany Christian Services in 1997 for approximately nine months (exact dates unavailable), then discharged to his home with wrap-around services and related interventions. Josh has been assigned numerous diagnoses, most often including Attention-Deficit/ Hyperactivity Disorder, Conduct Disorder, and Bipolar Disorder. He has been prescribed an extensive array of medications to address these conditions, including various psychostimulants, antidepressants, mood stabilizers, and antipsychotics. None of these medications have proven effective over time, with the exception of Tegretol and Dexedrine. The former was discontinued because of a negative allergic reaction. The latter has been discontinued in the past, because it suppressed Josh's appetite and weight. However, at the time of this assessment, he was taking Dexedrine spansules (10 mg twice daily) plus Remeron (30 mg, ½ tab at bed time) to counteract those negative effects. He had been taking this combination of medications since 10/27/01, after multiple prior medication adjustments at Mountain View Academy.

Developmental and Medical History

Josh's perinatal history was marked by multiple complications. According to records, during the pregnancy his mother used alcohol, cocaine, heroin, and Thorazine. He was born full-term (at seven pounds, six ounces) but was delivered via unplanned Caesarian section due to fetal distress. At the time of delivery, Josh suffered from meconium asphyxiation (i.e., swallowing his own feces). He was separated from his mother following the delivery, due to medical complications both were experiencing, and he had limited contact with her throughout the hospitalization. Josh was able to leave the hospital after two weeks, but his mother remained there for over a month. Following these initial insults, Josh reportedly showed no significant medical difficulties as a young child. All developmental milestones were reached within age-expectable limits.

In September 1994 (age six), Josh was evaluated for Fetal Alcohol Syndrome (FAS) at Children's Hospital of Milwaukee, in light of his prenatal history and ongoing problems with hyperactivity and poor behavior control. At that time, FAS was ruled out. In November 1994, a neurological evaluation revealed an abnormal EEG, suggesting that some form of neurological dysfunction might be contributing to Josh's behavior control problems. However, recently he was referred for an updated neurological evaluation and cardiology exam. These procedures,

which were both performed at the Lang Medical Center in January, 2002, revealed no abnormal findings.

Josh states that he is currently in good physical health, with no significant medical limitations. He describes a variety of minor injuries he sustained from various childhood accidents, but he denies any serious head trauma, loss of consciousness, or seizures. Records indicate a history of surgical procedures in 7/93 and 6/94 to realign both eyes due to strabismus. There is no other significant medical history.

Academic History

Prior to his current placement, Josh last attended public school as a seventh grader at Dorset Middle School. Records indicate that at that time, he was enrolled on a part-time basis in an Emotional Support classroom. He has a long history of special education services to address his behavior problems in the classroom, but records describe a history of earning high marks. Josh has reportedly never repeated a grade.

Achievement testing conducted through the school district for his most recent Comprehensive Evaluation Report (6/3/01) revealed fifth grade math and reading levels, as well as middle school level performance in other subject areas. These scores reflect slight delays in academic areas relative to Josh's intelligence, which has recently been found to be at least average. Specifically, during a recent psychological evaluation by Dr. Humphrey (1/21/02), Josh earned a WISC-III Verbal IQ in the Average range and Performance IQ in the High Average range. Earlier testing of cognitive abilities (in 9/92 and 10/95) produced discrepant results, reportedly due to poor attention and/or cooperation during those test sessions. On the basis of early test results, Josh has been diagnosed in the past with Borderline Intellectual Functioning, but this appears to be a gross underestimate of his true abilities, in light of more recent results.

Juvenile History

Josh has no charges prior to his current arrest.

Substance Abuse History

Josh denies any use of alcohol, marijuana, or any other drugs throughout his life. There is no indication in available records to suggest he has used any of these substances.

Psycho-Sexual History

The sexually inappropriate behavior that prompted Josh's current placement is described above. Records indicate no known sexually assaultive or inappropriate behavior committed by Josh prior to the above-mentioned contact with his sister, with the exception of an earlier history of being removed from his school bus "on occasion" for making "sexually lewd comments to female drivers." No further information is available about those incidents.

Josh's history is significant for at least one incident of sexual victimization. Specifically, when he was approximately eight years old, he was reportedly touched on the genitals on multiple occasions by an older male peer while placed out of the home. In earlier records (see

psychiatric assessment by Dr. Dalton, 9/14/97), there is mention of a separate incident of "inappropriate sexual stimulation by a [male] van aide" when Josh was age five. This incident was never confirmed. There are no other known incidents of sexual abuse. Josh denies having any direct exposure to sexual behavior, including witnessing sexual activity or nudity in person. At the same time, according to records, (see psychiatric assessment by Dr. Miles Wilson, M.D., 3/12/02), Josh has had some limited exposure to soft pornography with friends. This was characterized by Dr. Wilson as "within the realm of normal adolescent curiosity." During the current assessment, Josh acknowledged such exposure to pornographic videos and magazines, but he categorically denied any other instances of participating in sexual activity of any kind. He denied having any girlfriends, minimized having any sexual interest in females, and denied having engaged in any intimate or sexual contact with peers.

Behavioral Observations and Clinical Interview

Josh was seen jointly by two evaluators at Mountain View Academy on one day for a morning and afternoon session totaling approximately six hours to complete clinical interviewing and psychological testing. At that time, he presented as an attractive, dark-haired latino male whose small stature made him appear slightly younger than his stated age. At the time of the assessment, he was dressed in casual, clean, appropriate attire and had adequate hygiene. Josh had reportedly taken his morning dosage of medication approximately one hour prior to the start of the assessment, which clearly impacted his behavior as noted below. At all times, Josh was alert and fully oriented. He generally presented little evidence of excessive restlessness or distractibility throughout both lengthy sessions. However, nearing lunch time, he did become increasingly distracted and less focused, so that he was unable to complete certain test exercises. Subsequently, he was administered his midday dosage of medication, and this had a dramatically positive effect on his ability to focus throughout the afternoon. Josh's gross motor abilities were judged to be intact, with no problems with gait, balance, or posture. Fine motor skills were also intact. Speech, receptive language, and expressive language were all age-appropriate, with no major impediments preventing communication with the evaluators. During much of the assessment, Josh's speech was rapid and voluminous, though not pressured. His mood was bright, with a normal range of affect. Josh acknowledged feeling depressed but had difficulty articulating his exact experiences. He denied any present suicidal or homicidal ideation. He denied a variety of psychotic symptoms upon direct questioning. His thought content and thought processes were normal.

Josh met the evaluators with no reluctance and quickly became engaged in active conversation. He arrived carrying several paperback books and related that he often reads up to ten books at a time. He described various personal interests with a fair amount of knowledge and depth. Shortly into the session, he openly bragged about his intelligence, his memory, and other assets, including his ability to "outsmart" doctors. He also boasted happily about numerous assaults he had carried out at Mountain View Academy (staff later refuted the fact that Josh had been involved in five major assaults, as he had claimed). In response to questions in most areas, Josh appeared open, honest, and matter-of-fact. In contrast, however, he appeared more reluctant and cautious in answering questions about the sexual behavior that prompted his admission. With encouragement and prompting, he eventually related an in-depth account of one incident of sexual contact with his sister. He provided a careful and extremely detailed description of events leading up to his actual sexual behavior, but then claimed to have difficulty remembering information about the actual sexual contact. With continued prompting and support, he finally provided an account that was highly similar to events described above

and in available records, with two exceptions: by his current report, Josh rubbed on top of Samantha on only one occasion; and, during that occasion, there was no removal of clothes. Later, when he was confronted with records that were inconsistent with his account, and Josh adhered to his story and could provide no explanation for such discrepancies. At other times during the clinical interview, Josh provided contradictory statements about other topics, and when questioned for clarification, he appeared unconcerned about these inconsistencies.

When he was presented with formal testing exercises, Josh generally took a highly invested approach, working slowly and deliberately, reworking his products, and offering comments that suggested he was very concerned with the quality of his responses. Over time during the morning session, he became increasingly frustrated and less able to focus, which seriously reduced his level of effort. This appeared to be related to a combination of the ambiguous nature of certain testing exercises (which prevented Josh from controlling the quality and content of information he was providing) and the wearing off of his morning medication. During the remainder of the assessment, Josh was highly verbal and productive, providing rich information that suggested relatively high levels of intelligence and imagination. Notable during the evaluation was some extreme slowness, which at times appeared intentional and controlling (e.g., to prolong the evaluation and to avoid other tasks). Overall, data collected during this evaluation appear to be valid indicators of Josh's levels of functioning.

Evaluation Results

This assessment finds Josh to be currently functioning better than in the past but still experiencing significant behavioral, interpersonal, and emotional concerns that are causing discomfort for himself and the people around him. Behavior checklist results provided by two Mountain View Academy staff members provide a snapshot of Josh's current functioning. Showing average to above-average agreement, these staff members endorsed significant problems across several of the broad areas assessed, with an emphasis on externalizing or acting-out problems. Based on the verbal reports of staff, Josh's current behavior is characterized by "constant" disobedience, as well as a variety of provocative, instigating, and attention-seeking behaviors directed toward peers and staff, which collectively make him extremely difficult to manage over time.

Despite these widespread difficulties, it is notable that staff report relatively little overt physical aggression, except for incidents that took place earlier during his placement. Although he is currently demonstrating difficulties managing his behavior in many areas, this actually represents an improvement relative to his long history of repeated, serious, out-of-control behaviors. Available information indicates the presence of a serious Attention-Deficit/Hyperactivity Disorder (ADHD), composed of both hyperactive-impulsive symptoms and difficulties focusing attention and concentration. These symptoms are in addition to longstanding entrenched conduct-disordered behaviors that have made Josh difficult to manage in any setting. It is possible that an underlying mood disorder (e.g., bipolar disorder) accounts for some of Josh's volatility and other symptoms, but at present his negative behaviors seem best explained by the presence of both severe ADHD and conduct disorder stemming in part from his exposure to difficult environmental factors, discussed in more detail below. In contrast to the pattern of behavior documented throughout his childhood, it is notable that he is currently described as usually being in control of himself, acting in defiant and oppositional ways only to a degree that he needs to gain attention or intervention. One component that appears to be working effectively at present is Josh's current medication regimen. Based on behavioral

observations during this assessment, as well as other available information, it is obvious that his medication is allowing Josh to maintain a comparatively high level of focused concentration and behavioral control, which is in contrast to his functioning in the absence of medication.

Also notable about Josh's current presentation is the complete absence of sexual aggression or sexually inappropriate behavior, according to reports provided by all staff members and by Josh. All available information portrays his sexual contact with his sister as a relatively isolated series of behaviors, rather than being indicative of an emerging pattern of deviant sexuality. Although his acts could be seen by observers as such, at present it would be inaccurate and detrimental to Josh to label him as a child with deviant sexual interests or behaviors. Instead, his sexual acting-out appears to be symptomatic of pervasive impulse control problems and other concerns described in this report. Josh has demonstrated a life-long pattern of maladaptive, impulsive behaviors, and as he has approached puberty and adolescence, it is not surprising that some of these behaviors have been expressed through sexual acting out. Josh remains at risk of acting out sexually as he did prior to placement, as long as he remains at risk of more generalized acting out. Treatment is most likely to be effective in reducing his risk of sexually inappropriate behavior by viewing this area of functioning as one component of much larger behavior control problems that need to be alleviated.

Josh's longstanding conduct problems appear largely attributable to two main sources. First is the presence of an ADHD condition rooted in low-grade, diffuse neurological impairment, which hinders his ability to focus and control his behavior effectively unless medication and other intensive interventions are in place. Second is the presence of attachment deficits associated with Josh's experience of multiple important separations and losses throughout his childhood (e.g., separation at birth from his mother during a critical bonding period; inconsistent attachment, as well as reported neglect during his earliest months of life; absence of his biological father; and repeated separations from family due to the need to place him outside the home on numerous occasions).

Josh's attachment difficulties continue to impact his ongoing behavior in a number of ways. First, he exhibits strong needs for connection, including tactile closeness, but has not developed age-appropriate strategies for getting those important needs met. It is notable that some of his acting-out behaviors appear geared toward eliciting attention and physical contact from others. In fact, one staff member commented that Josh has been observed acting "out of control" just long enough and seriously enough to warrant an "assist" from staff, then stopping himself as if he has "gotten what he wanted." Josh's provocative behavior elicits emotionally charged attention from others, but usually this attention is highly negative. Although he may be capable of positive, mutually enjoyable exchanges, he has not learned to connect with people in these ways on a consistent basis. Instead, he often seeks closeness or attention in indirect, maladaptive ways. Josh has been repeatedly described as manipulative, but it should be noted that at least some of his "manipulative" behaviors appear aimed at gaining important interpersonal connections, rather than simply representing efforts to control or con others.

Another consequence of Josh's chronic, repetitive separations and losses is the presence of strong negative emotions that he has difficulty identifying and expressing appropriately. One of these powerful emotions is anger, which certainly has contributed to violent behavior in the past. Much of Josh's earlier aggression was directed toward close family members, who were

the target of poorly controlled rage. More recently, with a high level of structure and support, Josh has not shown such serious aggression. Instead, he continues to act out his anger through oppositional and passive-aggressive behaviors directed toward authorities. Other negative emotional experiences for Josh involve feelings of sadness, loss, and emptiness. These are difficult for him to identify and articulate effectively, so he is often prone to act them out through irritable, frustrated behavior directed toward the people around him. Josh's comments during the clinical interview, as well as his responses to a lengthy self-report inventory, reveal the presence of various low-grade anxious and depressive experiences. He appears to be internalizing negative experiences because he has not developed effective strategies for coping with them. It is important to note this tendency to internalize, as it clearly causes Josh discomfort and distress that could go unnoticed by the people around him, as they are often forced to focus on his overt acting-out behaviors.

Josh is a bright child with notable strengths, including a creative imagination, varied interests, and solid verbal skills. (Intellectual abilities were not formally tested during this assessment, but recent testing and current behavioral observations suggest average to high average potential.) While these are obviously strengths, Josh's ability to function at a high level in some areas may actually be problematic for him at times. That is, despite his high intelligence and other strengths, he experiences longstanding serious problems in other important areas (i.e., behaviorally, interpersonally, and emotionally). He is acutely aware of these problem areas and the fact that they are preventing him from living up to his ample potential. This appears to be highly distressing to him. Josh's responses to a thorough self-report inventory portray him as an individual who, along with mild depressive and anxious features, often feels alienated and alone, misunderstood by others and uncomfortable around them. He may avoid direct social contact with people at times because he is suspicious of them or is afraid of being rejected. He is intensely sensitive to perceived slights or maltreatment from other people, and he may retaliate behaviorally when he feels he has been put down. He often sees himself as a victim, which presents problems in interpersonal situations and causes him to avoid blame for his part in interpersonal conflicts.

Summary

Josh Adams is a thirteen-year-old male referred for a psychological evaluation to assist in placement and treatment planning, in light of recent (nearly one year ago) sexually inappropriate behavior directed toward his sister for a period of approximately two months. In addition to this behavior, which prompted legal charges and residential placement, he has a life-long history of extensive behavior management problems, which have required varied and intensive treatment interventions throughout his childhood. The current evaluation finds that, despite his highly structured, supportive, and controlled setting, Josh continues to demonstrate serious behavior management problems in the form of constant oppositional and defiant behaviors. Notably, he currently displays a complete absence of sexually inappropriate activity and a relative absence of the kinds of explosive, physically aggression behavior documented in the past. Information from all sources indicates the presence of underlying ADHD, barely controlled throughout his childhood but now attenuated to some degree by his current medication regimen. In addition, Josh exhibits longstanding behavioral symptoms associated with a conduct disorder, partly rooted in early and repeated separations and losses. These experiences continue to impact his functioning and are played out in his daily interactions. For example, he demonstrates socially delayed interpersonal skills, including a tendency to use inappropriate strategies for seeking out emotional and physical contact from others.

Additionally, he experiences powerful negative emotions that he cannot fully identify or articulate, and this contributes to his likelihood of acting out in an effort to externalize these experiences. Josh is acutely aware of his serious behavioral and emotional difficulties, because they are in stark contrast to his notable strengths in other areas, and this awareness is causing him a great deal of discomfort. Self-report measures reveal the presence of mild anxious and depressive features, as well as a prominent sense of interpersonal isolation and alienation. Josh appears to genuinely want to change his behavior for the better, but he simply lacks an understanding of how to do so. With regard to Josh's history of sexually inappropriate behavior, it is important to view this behavior as one symptom within a pervasive pattern of impulsive control problems, combined with a tendency to act in inappropriate ways to meet his needs for physical and emotional closeness. While there is no evidence to suggest Josh will display an ongoing pattern of sexually deviant arousal and behavior, he does remain at risk of acting out sexually as long as he continues to exhibit his larger pattern of difficult-to-manage behavior.

Diagnostic Impression

Axis I: Attention-Deficit/ Hyperactivity Disorder, Combined Type
 Conduct Disorder, Childhood-Onset Type, Severe
 Rule/Out Bipolar II Disorder

Axis II: Deferred

Axis III: No Diagnosis

Axis IV: Current Stressors = Severe: Legal involvement; Separation from family;
 History of multiple removals from home; Social conflicts with peers and
 adults; Absence of biological father

Axis V: Current Global Assessment of Functioning (GAF): 40

Recommendations

Josh has shown a life-long course of severe acting out behavior, which has repeatedly placed himself or others at risk of serious harm. While there have been periods of relative calm, even those times have not been problem-free. For example, Mrs. Drake reports that during roughly the year prior to Josh's current placement, he was "doing well" with "few aggressive outbursts;" however, it was during this period that he began sexually acting out with his sister for an extended period of time before finally being discovered. All available information suggests that if Josh is returned to the community at the present time, even with all the intensive resources available in his area, he would present a risk of acting out and risking harm to himself (e.g., causing re-arrest) or to others (e.g., making sexual contact with his sister again, which he has expressed worries about during his placement).

Because he presents this high level of risk, it is strongly recommended that Josh continue to be placed in a residential treatment facility that is designed to meet his needs, for a minimum of twelve months. This recommendation has not been made lightly, in light of Josh's and his mother's strong wishes for him to return home. There are serious concerns about the possible difficulties related to further separation from his family, especially given how prior separations have impacted his functioning. However, these important concerns are outweighed by the high level of risk Josh currently presents to his sister, himself, and others if placed into a setting any less restrictive than his current residential placement.

The goal of Josh's continued placement is the stabilization of his behavior through medication management and other critical mental health interventions. These include his participation in a controlled, structured milieu with specific interventions provided to help him develop the internal controls necessary to function appropriately in society over time.

An important component will include teaching Josh cognitive-behavioral strategies for building age-appropriate interpersonal problem-solving skills. In formal settings such as group therapy, as well as informally through the structured, therapeutic milieu, Josh's ability to delay behavior, think about possible consequences, and decide on the most appropriate alternative must be developed and constantly reinforced.

Josh also needs interventions designed to bolster his social skills and ability to relate to others in age-appropriate ways. In group therapy and in the overall milieu, positive interactions must be reinforced. At the same time, whenever possible it will be helpful to discourage and ignore Josh's efforts to engage people negatively (e.g., instigating peers; provoking staff to the point of receiving physical restraint). As Josh starts to escalate, the most effective intervention may be to remove him from any reinforcement, through time-out or seclusion, so his negative behavior cannot earn the contact and attention he is seeking at those times.

Josh would benefit from participation in regularly scheduled individual psychotherapy to address the emotional and interpersonal issues that continue to impact his behavior. His therapist can help him to identify negative emotions (e.g., anger, sadness) and to cope more effectively with them, instead of lashing out when he experiences these feelings. Josh's therapist must be a skilled professional with experience working with children with his types of background experiences and provocative behaviors. Josh is likely to provoke and frustrate his therapist, so this person must remain vigilant to his or her own reactions of anger, irritation, or even helplessness, so that these reactions do not hinder Josh's treatment.

Josh's current medication regimen appears to be having some positive impact on his ability to remain focused and control his behavior in his current setting. This is especially notable given his long history of multiple medication failures. Even if Josh experiences a change in treating physician or placement, it is strongly recommended that he remain on his current medications unless there are compelling reasons to make a change.

Placement in a facility geared toward sex offenders does not appear indicated at this time. Once Josh has met treatment goals in his current sex offender group, it would be in his best interest to treat his history of sexual acting-out as another manifestation of his acting-out and impulse control problems in all areas. Alleviating Josh's generalized conduct problems is expected to reduce his specific risk of sexually inappropriate behavior.

Staff's approach to Josh is critical to his behavioral adjustment. Some of his current defiant behaviors appear to represent a reaction to extremely behavioral expectations. Staff may find it helpful to "pick their battles wisely" with Josh and allow some flexibility over minor issues, insofar as this is possible in a residential setting. Allowing some flexibility without accepting manipulation of the rules is expected to have a positive impact on Josh's oppositional behaviors.

Another critical component of Josh's treatment is the involvement of his family prior to his release home. There must be regular contact between Josh and his family, including ongoing visits at the facility. Staff and the family must be unified in their approach to Josh's treatment in order to promote success. Throughout his placement, Josh should be allowed to step down

gradually to the community, by participating in regular home visits that eventually increase in frequency and duration. This step-down process may also require an intermediate placement prior to full return to the home from residential placement. These decisions can be made by the treatment team over time, depending on Josh's level of risk and his progress in placement.

The Abraham Lincoln Mental Health Residential Treatment Facility appears to be uniquely qualified to meet Josh's varied behavioral and emotional needs. Because this facility services both dependent and delinquent youths of a wide age range, there is a reduced risk of Josh's being placed solely among more serious, persistent delinquent offenders. Also, the facility provides an extensive step-down program that will be critical for Josh's long-term adjustment.

Prior to his return to the home, there must be intensive interventions already in place there, so there is no gap in services during that critical transition period. At that time, he will probably need intensive wrap-around services in the home and school to provide the high level of monitoring and behavioral support he requires. In the home these services will be especially crucial, as they will provide close monitoring of his behavior, and support to his parents in their efforts to monitor and discipline Josh. Continued enrollment in individual psychotherapy will also be beneficial on an outpatient basis, to continue progress that had been made in placement and to deal with new stressors that emerge in home and school. The treatment team working with Josh at that time will be able to make more specific recommendations as needed.

Lawrence Henderson, Psy.D.
Licensed Psychologist

Thomas Earle, Ph.D.
Licensed Psychologist

APPENDIX C

Outline for Assessing Expert Witness

For use as a handout.

*The attached worksheet was prepared by Antoinette Kavanaugh, Ph.D.,
Clinical Co-Director, Clinical Evaluation and Services Initiative, Chicago, IL
Tel: 312. 433.6850 Email: a-kavanaugh@nwu.edu*

Date: _____ Name of witness/potential
witness _____

AN OUTLINE FOR ASSESSING AN EXPERT WITNESS OR POTENTIAL WITNESS

Developed by Antoinette Kavanaugh, Ph.D.

For more information, call 312-433-6850

I. The Case

The redefined referral question (should be clear, concise and reference the legal issue at hand)

II. The Evaluation

A) What would your evaluation consist of?

B) What does my office need to provide at this point?

III. The Expert Witness

A) Training and supervised experience

a) Did you complete a post-doctoral program in forensic psychology or a forensic psychiatry fellowship? _____
i) If so, describe the program.

b) Have you had training in case law and forensic ethical guidelines? _____
i) If so, describe the training.

B) Independent work experience

a) Describe the clinical experiences you have with children/adolescents (ask about your client's age group).

b) Describe your experience conducting forensic evaluations, conducting forensic evaluations involving the legal issue at hand, and conducting forensic evaluations with children/adolescents.

Date: _____
witness _____

Name of witness/potential

C) Certification

- a) Are you licensed? _____ Since when and in what state? _____
- b) Psychiatrist - Are you board certified? _____
 - i) If so, in what area(s)? _____
- c) Psychologist - Are you a diplomat of the American Board of Professional Psychology? _____
 - i) If so, in what area(s)? _____

D) Relevant scholarly activities

a) Publications

b) Presentations

c) Workshops/conferences/lectures

d) Describe your university affiliations (e.g., when, which university, position, role/duties/responsibilities).

e) Describe the professional organizations that you are currently an active member of.

E) Knowledge of relevant psycho-legal issues

a) Can you explain the differences between a therapeutic and forensic evaluation?

b) Can you explain the difference between a treating witness and an expert witness?

c) How do you conceptualize the legal standard/issue at hand?

d) What is your opinion regarding providing an ultimate or penultimate opinion?

e) What does the literature say regarding this specific legal issue for people who are similar to my client (in terms of age, intelligence, and prior court history)?

IV. Logistics

YES NO

- | | | |
|---|-------|-------|
| A) Interested in this expert witness? | _____ | ___ |
| | | ___ |
| | | - |
| B) Requested a copy of CV/resume? | _____ | _____ |
| C) Discussed judicial opinion about ultimate issue? | _____ | _____ |
| D) Need to send expert witness relevant legal standard, statute, or case law? | _____ | _____ |
| E) Fees _____ | | |
| F) Asked to send letter of agreement? | _____ | _____ |

APPENDIX D

Conceptual and operational definitions for forensic assessment

For use as overhead.

APPENDIX E

Questions that a Developmentally-Sensitive Assessment Should Answer

This questionnaire is excerpted from "Expert Evaluations of Juveniles at Risk of Adult Sentences," by Marty Beyer in ABA CHILD LAW PRACTICE, Vol. 18, No. 2 (April 1999).

Strengths

1. What are this young person's strengths?

Maturity of Thought

1. How mature are this young person's thought processes?
2. At the time of the offense, to what extent was this young person anticipating outcomes? Reacting to threat? Minimizing? Seeing only one choice? Could this young person foresee the consequences of his/her actions?
3. Was this young person able to plan like an adult, and under stress, how did he/she react if things did not occur as planned?
4. If the young person was carrying a weapon, to what extent had he/she envisioned using the weapon to cause injury?
5. What else is informative about this young person's intent at the time of the offense?

Moral Values

1. What moral values was this young person brought up with in his/her family?
2. What is this young person's understanding of fairness, rights, and responsibility?
3. Does this young person consider loyalty a higher moral principle than conventional views of right and wrong?
4. How does this young person view the wrongness of the offense, and how does he/she explain if the offense was a violation of his/her moral values?

Relationships

1. Who is this young person most attached to?
2. Does the young person feel a sense of belonging?

Empathy

1. Who does this young person show the most empathy for?
2. What are the young person's feelings for his/her victim?
3. Are this young person's adolescent bravado and/or his/her view of the offense as accidental being interpreted as a lack of remorse?

Prior Trauma

1. What connections, if any, exists between his/her childhood trauma and the offense? How does this young person's past trauma impact his/her cognitive processes? his/her perception of threat?
2. Does this young person need help recognizing that he/she is not to blame for childhood neglect, physical or sexual abuse, or domestic violence? Does the young person need help getting out of a victim role?
3. How much loss has the young person experienced?
4. To what extent has the young person grieved these losses?
5. Is this young person unusually controlling because of early victimization?

Learning Style

1. What connections, if any, exist between this young person's history of school problems and the offense?
2. What connections, if any exist between this young person's learning problems and his/her cognitive processes? His/her perception of threat?
3. Is this young person primarily an auditory learner, a visual learner, or someone who learns best by doing?
4. Does the young person need to develop compensatory skills for difficulties in processing visual or spoken information?
5. What is this young person's current reading and math skill level?
6. What is this young person's school history, including most recent IEP objectives?
7. Does the young person require special teaching techniques or help to follow instructions or to organize material?
8. What specifically are the triggers of school behavior problems for this young person – does he/she have difficulty concentrating? does he/she feel picked on by teachers or students?
9. Is school nonattendance caused by boredom or being embarrassed by lack of skills?
10. Does this young person have sports/music/art or other special interests that should be built on?

Anger and Fears

1. Does this young person have an anger cycle or a fear cycle?
2. Does this young person overreact to perceived hostility from others?
3. Does this young person need to improve the ability to regulate specific behaviors?
4. Does this young person need to improve the ability to express him/herself in effective, non-aggressive ways?
5. In what ways, if any, was this young person's anger cycle or fear cycle operating during the offense?

Purposes Served by Delinquency

1. To what extent is this young person's delinquency driven by a need for approval?
2. What is this young person good at?
3. Does this young person have a positive view of him/herself in the future?
4. What type of vocational instruction and/or employment assistance would fit this young person's need for success?

Substance Abuse

1. What connections, if any, exist between this young person's substance abuse and the offense?
2. What is the extent of this young person's use of alcohol and drugs?
3. Does this young person use substances to relieve depression or numb feelings?

Services to Build Strengths/Meet Needs

1. Having identified the young person's strengths and clarified what additional areas of need remain for this young person, what are the specific services that would meet his or her emotional, educational, and other developmental needs and build on those strengths?
2. What setting is likely to have the identified services to meet these needs and build on those strengths?
3. What setting would not meet this young person's needs or would be harmful to this young person?
4. To what extent have services designed specifically to meet the young person's needs been provided in the past, through child protective services, mental health services, school, and/or the juvenile justice system?

Amenability to Treatment

1. Does the young person want to change? Does the young person have a desire for approval that could lead to change?
2. What is the prognosis for this young person if these services are provided (i.e., will there be a reduction in the likelihood of recidivism)?

APPENDIX F

Psychological Testing References

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APPENDIX G

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APPENDIX H

Checklist of Minimum Criteria for a Good Forensic Evaluation

For use as a handout.

CHECKLIST OF *MINIMUM* CRITERIA FOR A GOOD FORENSIC EVALUATION

Inclusion of relevant identifying information

- ___ Who referred for evaluation
- ___ Completed via court appointment or confidential/ex parte?
- ___ Examinee's age
- ___ Examinee's grade in school
- ___ Examinee's involvement with the legal system
- ___ Past record
- ___ Current charges
- ___ Examinee's current status
- ___ Identification/attribution of all sources of information relied upon
- ___ Dates/duration of all interviews and tests
- ___ List of procedures used/ tests administered to conduct evaluation
- ___ Reason for evaluation (i.e., competence evaluation, evaluation for treatment options, etc.)
- ___ Notification to child of reason for evaluation, lack of confidentiality
- ___ Statement of legal question(s) to be addressed

___ **Review of all relevant information/records**

- ___ Is there relevant information that evaluator failed to consider?

___ **Description of mental states, capacities, abilities, knowledge, and/or skills that are relevant to the legal question at hand.**

___ **Description of the relationship between the mental states, capacities, abilities, knowledge, and/or skills assessed and their causal connection to the youth's abilities or issues about which the court is interested.**

___ **Information qualifying the conclusions drawn.** An explanation of the external limitations (i.e., testing conditions, the tests themselves, amount of time evaluator was given to interview the relevant parties, amount of background information that the evaluator was able to collect and review, etc.) that should be taken into account when relying on the evaluator's conclusions.

___ **Specific recommendations for intervention** (when appropriate) including specific interventions that are available in the community.

*THE PATHWAYS TO YOUTH
VIOLENCE: How Child
Maltreatment and Other Risk
Factors Lead Children to
Chronically Aggressive Behavior*

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Lourdes M. Rosado, Editor

AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

ABA JUVENILE JUSTICE CENTER/NATIONAL JUVENILE DEFENDER CENTER
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Juvenile Law Center is a non-profit public interest law firm that advances the rights and well being of children in jeopardy. Founded in 1975, JLC is one of the oldest legal services firms for children in the United States. JLC uses a range of strategies -- including individual advocacy, reform of state and national law and policy, and training of public defenders and lawyers for children -- to improve the juvenile justice and child welfare systems. The children we serve include abused or neglected children placed in foster homes, delinquent youth sent to residential treatment facilities or adult prisons, and children in placement with specialized health and education needs. JLC works to ensure that children and youth are not harmed by -- but instead receive appropriate care from -- the systems that are supposed to help them.

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This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM

June 2000

Preface

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*

Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*

Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*

Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*

Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a "tool kit" containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can be assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer -- is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

Executive Summary

Module Four focuses on the developmental dynamics of violent offending – what causes the onset of violent behavior in children, and what causes chronic violent behavior to continue into adulthood. Studies have shown that many children who commit violent acts have experienced maltreatment, and were exposed to a number of “risk factors” that made them more susceptible to a cycle of chronic violent offending. But research also demonstrates that most children who face these risk factors do not become violent offenders. This indicates that there are “protective factors” that enable at-risk children to avoid engaging in anti-social behavior. Juvenile court personnel are in a unique position to intervene and break the cycle.

By participating in Module Four, juvenile court personnel will acquire knowledge that will help them to identify developmentally-appropriate interventions for young people who’ve committed violent acts. Specifically, participants will learn about:

- ! The relationship between child maltreatment and violent offending. Participants will learn about the developmental pathway from being a victimized child to victimizing others.
- ! Other risk factors – personal, in the family, and in the community at large – that can interrupt a child's normal development and lead the child to chronic violent behavior. These risk factors include living in poverty, in an unstable family situation, and in an overall “socially toxic” environment where there is a high incidence of drug and gun activity.
- ! The major points of onset of aggressive behavior in youth. Data shows that the onset of serious violence mostly take places between ages 12-18, thus providing us with a window of opportunity to intervene and “re-route” adolescents’ developmental pathways when we see them in juvenile court.
- ! The high correlation between association with delinquent peers and engaging in violent activity. This correlation has important implications for creating developmentally appropriate programs for teaching young people who have already engaged in violence to learn to deal with potentially threatening situations with non-violent action.
- ! Protective factors that help prevent children exposed to these risk factors from becoming chronic violent offenders, either directly or by virtue of buffering the child from the negative effects of risk factors.
- ! Existing model programs with proven track records of effectively treating youthful violent offenders.

Table of Contents

I. Introduction	1
A. Goals of this module	1
B. Where in the juvenile justice system do we consider risk and protective factors in decision-making?	1
C. Summary of Major Themes of This Module	2
II. Maltreatment of Children in the U.S.	3
A. Maltreatment: Definitions and Incidence	3
B. Observed Violence	5
C. Signs That a Child May Have Been Maltreated	6
D. Maltreated Children in the Juvenile Justice System	6
E. Adults in the Criminal Justice System Who Were Maltreated As Children	7
III. How Childhood Maltreatment Can Lead to Chronic Violent Behavior	8
A. Social Learning	8
B. Lack of Attachment and Positive Relationships	8
C. Scripts	9
D. Cognitive Deficiencies	9
E. Cognitive Problems Resulting from Chronic State of High Arousal	11
F. Mental Health Problems	11
G. Frustration-Aggression	11
H. Genetics	11
I. Temperamental Infants	11
IV. Guiding Principles for Structuring Interventions for Maltreated Children	12
V. Maltreatment Interacts With Other Risk Factors to Promote Violent Behavior	15
A. Culmination of Risk Factors	15
B. Interventions Must Address Multiple Risk Factors	15
C. Other Risk Factors for Violent Behavior	15
VI. Statistics on Violent Offending by Young People	27
VII. The Developmental Dynamics of Violent Offending	28
A. Three Major Points of Onset of Aggressive Behavior in Youth	28
B. Protective Factors that Intervene in Pathways to Chronic Violence	28
C. Structuring Developmentally Appropriate Interventions	29
VIII. Protective Factors	30
IX. Interventions for Violent Juvenile Offenders	35
A. Relationship Between Maltreatment and Other Risk Factors	35
B. Integrated, Developmentally-Appropriate Interventions	35
C. The "Blueprint Programs."	35
D. Selection Criteria	35
E. Blueprint Programs for juvenile offenders	36
F. Promising Programs for Juvenile Offenders	43

G. Limitations of Traditional Approaches to Reducing Juvenile Delinquency	44
Bibliography	46
APPENDIX A	A1
APPENDIX B	B1
APPENDIX C	C1
APPENDIX D	D1
APPENDIX E	E1
APPENDIX F	F1
APPENDIX G	G1
APPENDIX H	H1
APPENDIX I	I1

I. Introduction

A. **Goals of this module.** Participants shall learn about:

1. The risk factors -- personal, in the family, and in the community at large -- that can interrupt a child's normal development and lead the child to chronic violent behavior.
2. The link between family and community risk factors -- especially childhood abuse/neglect -- child development, and violent behavior.
3. The developmental dynamics of violent offending -- what causes the onset of violent behavior in children, and what causes chronic violent behavior to continue into adulthood.
4. The protective factors that help prevent children exposed to these risk factors from becoming chronic violent offenders, either directly or by virtue of buffering the child from the negative effects of risk factors.
5. Developmentally appropriate interventions for teaching young people who have already engaged in violence to learn to deal with potentially threatening situations with non-violent action.

B. **Where in the juvenile justice system do we consider risk and protective factors in decision-making?**

1. **Intake.** The intake person has several options, including releasing the juvenile to a parent, placing the juvenile in a community-based or other temporary residential setting, or confining the juvenile in the juvenile detention center. The intake person's knowledge of the particular juvenile's circumstances will play a large part in the decision. Risk and protective factors will be considered at this and at all junctures in the court process.
2. **Detention.** Again, judges may utilize information on the risk and protective factors in a young person's life in determining whether to release the juvenile or detain him.
3. **Juvenile or adult court.** An assessment of the risk and protective factors present in the young person's life would be useful to those responsible for making this decision.
4. **Adjudication.** Some jurisdictions (for example, Washington, D.C.) allow the judge to dismiss the charges against the youth for "social reasons" or in the interest of justice. See D.C. Super. Ct. Juve. R. 48(b). A dismissal of the charges pursuant to this rule is appropriate if, for example, the child is a first offender and is receiving adequate support in the home and in the community. Information about the young person's support systems and the risk factors s/he faces will inform the judge's decision-making as to whether such a dismissal is appropriate.
5. **Disposition.** Information about the young person's individual circumstances at home and in the community will assist all of the participants in the process in recommending appropriate disposition options.

C. **Summary of Major Themes of This Module**

1. Most juvenile violence results from the accumulation of a variety of risk factors, not just one factor. The accumulation of risk factors can have a tremendous influence on their involvement in violent activity.
2. Many children who engage in violent or otherwise delinquent acts have experienced maltreatment. Many have grown up in "socially toxic environments" (i.e., homes and communities where they are exposed to drugs, violence, crime, poverty, gangs, etc.).
3. However, most maltreated children and children who grow up in "socially toxic environments" do not commit violent or otherwise delinquent acts. Studies show that only about 14-26% of abused children go on to commit delinquent acts. This indicates that there are "protective factors" that enable these children to avoid engaging in anti-social behavior.
4. Programs and interventions that address multiple risk factors and are developmentally appropriate have the best chance of success with these young people.

II. Maltreatment of Children in the U.S.

A. Maltreatment: Definitions and Incidence

1. **Physical abuse.** This includes:

- a. Physical harm
- b. Confinement
- c. Bondage
- d. Sleep deprivation
- e. Intrusive control of bodily functions
- f. Sexual abuse
- g. Terrorizing behavior that accompanies the physical abuse, including:
 - (1) denial of the child's reality: "it didn't happen"
 - (2) enforcement of silence by threat of harm
 - (3) forcing acceptance of responsibility for the violence

2. **Incidence of physical abuse**

- a. According to the best study we have on the rate of child maltreatment, from 1986 to 1993 incidents of child abuse and neglect in the U.S. rose from 14 per 100,000 children to 23 per 100,000 children. These statistics refer to children for whom it has been documented that they have experienced harm. If the definition of abuse and neglect is expanded to include children who are at risk of imminent harm, the increase in reports is even larger, with the rate nearly doubling from 22 per 100,000 in 1986 to 42 per 100,000 in 1993. (Garbarino, LOST BOYS: WHY OUR SONS TURN VIOLENT AND HOW WE CAN SAVE THEM [hereinafter "Garbarino"] (citing Sedlak, A.J., & Broadhurst, D.D., THE THIRD NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS-3): FINAL REPORT. Washington, D.C.: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, (1996)))
 - b. One in three victims of physical abuse in the U.S. is a baby less than twelve months old. Every day a baby dies in the U.S. of abuse or neglect at the hands of his or her caregiver. (Karr-Morse, p. 13, citing THE STATE OF AMERICA'S CHILDREN. Washington, D.C.: Children's Defense Fund, (1996 and 1997))
 - c. Two thousand children are murdered by their parents through fatal child abuse and or neglect in the United States each year. (Garbarino, p. 40)
- #### 3. **Physical neglect.** A caretaker fails to exercise a minimum degree of care in meeting a child's physical needs.
- #### 4. **Emotional and psychological maltreatment.** Children need a secure attachment with a parent or parental figure for healthy development. The parent-child bond is instrumental for subsequent bonding with society and the social institutions therein. Bonding to a parent(s) or caretaker (forming a secure attachment) is an essential element in social development. Poor attachment reduces one's commitment to long-term goals (e.g. social, academic, economic). Emotional and psychological maltreatment includes the following:

- a. **Rejection.** Refusal to acknowledge the child's worth and the legitimacy of the child's needs. For example,
 - (1) abandonment
 - (2) the parent saying that she wished the child was never born or wished that she had an abortion, that she made suicide attempts upon learning that she was pregnant, etc.
 - (3) excluding child from family activities
 - (4) refusing the child's overtures of affection
 - (5) punishment for expression of emotions

- b. **Isolation.** Preventing the child from engaging in socializing behaviors, such as forming friendships, and inducing the child to believe s/he is alone in the world. This includes:
 - (1) leaving children and infants in a room unattended
 - (2) denying the child access to cherished loved ones
 - (3) prohibiting or failing to encourage the child from participating in clubs, after school programs, intramural sports, dating, music, etc.

- c. **Terrorizing.** Threatening the child with vague but sinister punishment, intentionally stimulating fear and creating a climate of unpredictable threat. Such behavior includes:
 - (1) extreme responses to child's behavior
 - (2) forcing child to choose between competing parents
 - (3) "parentifying" child
 - (4) threatening to reveal intensely embarrassing information
 - (5) humiliation
 - (6) episodes of rage alternating with affection
 - (7) verbally assaulting the child
 - (8) bullying
 - (9) setting unmeetable expectations and then punishing the child for not meeting them
 - (10) capricious enforcement of petty rules
 - (11) destruction of treasured objects, such as pets
 - (12) forcing false confessions

- d. **Ignoring.** Depriving the child of essential stimulation and responsiveness, stifling growth and intellectual development, being psychologically unavailable to the child, being preoccupied with oneself and unable to respond to the child's behavior, including:
 - (1) not noticing the child's presence or achievements
 - (2) not engaging in conversations at mealtimes and other times of interaction
 - (3) not intervening on child's behalf when child's need is evident, i.e., the child is being picked on or hurt by another party
 - (4) failing to follow up on child's requests for help in resolving problems
 - (5) concentrating on other relationships that displace the child as an object of affection
 - (6) showing no interest in the child's evaluations by teachers
 - (7) leaving child without emotionally-involved adult supervision

- e. **Corrupting.** Parental behavior that missocializes the child or reinforces deviant patterns, such as aggression, sexuality or substance abuse. Such behavior includes:
 - (1) offering drugs to or using drugs around the child
 - (2) exposing child to pornography, overt sexual behaviors or gratuitous violence
 - (3) ignoring or rewarding delinquent behavior such as truancy, drug and alcohol abuse

 - f. **Degradation.** Demeaning the child and minimizing his/her achievements or needs by:
 - (1) Use of derogatory terms
 - (2) public humiliation
 - (3) scapegoating
- B. **Observed Violence.** Observing violence -- as opposed to being the direct victim of violence -- also can severely traumatize a child.
1. **Observed in the Community.** An alarmingly high number of children witness acts of abuse and violence within their own homes and communities. A study of 1,035 inner-city youth age 10-19 found that those in the sample who had perpetrated violence had also been witnesses and victims. Another investigation of 536 inner-city children (in Grades 2-8) found that those who had witnessed a shooting or a stabbing were more likely to report their own involvement in fighting. **Implication:** Neighborhood violence affects children at a very young age -- first leading to aggressive behavior (i.e. fighting) and then to more severe acts of violence. (Becker & Rickel, p. 238 with cite Bell & Jenkins (1994)).

 2. **Observed Violence in the Home.**
 - a. Researchers have estimated that each year at least 3.3 million children in the U.S. are exposed to domestic violence between adult intimate partners; these numbers go as high as 10 million, depending on the individual study's definitions and methodologies.

 - b. Exposure to domestic violence includes watching or hearing the violent events, direct involvement (i.e., calling the police or trying to intervene), or experiencing the aftermath of violence (i.e., seeing bruises or observing that your mother is depressed).

 - c. Research also shows that childhood exposure to such domestic violence can cause children to:
 - (1) engage in aggressive behavior;
 - (2) suffer from emotional problems such as depression and anxiety;
 - (3) have lower levels of social competence and self-esteem;
 - (4) experience poor academic performance; and
 - (5) exhibit symptoms of post-traumatic stress disorder, including emotional numbing, increased arousal and repeated focus on the violent events.

 - d. Moreover, a 1998 study indicated that between 45%-70% of the children exposed to domestic violence were also victims of physical abuse, and 40% of

the child victims of physical abuse were also exposed to domestic violence. (Fantuzzo and Wohr, pp. 21-32)

C. **Signs That a Child May Have Been Maltreated.** The following observed behaviors may be associated with trauma:

1. High incidence of somatic complaints
2. High incidence of suicidal ideation and self-destructive behavior
3. Chronic physical complaints with unexplained cause
4. Harm to other children and/or animals as preparation for their own suicide and/or a behavioral re-enactment
5. Obsessive-compulsive behavior
6. Lack of future orientation, risk-taking, impulsivity
7. Lack of problem-solving skills
8. Learning problems and verbal impoverishment
9. Anxiety/phobias/panic attacks
10. Mood swings/disorders
11. Paranoia
12. Eating disorders
13. Nightmares/night terrors
14. Self-medication through drugs and alcohol
15. Regression to last level of cognitive development when under stress
16. Psychotic decompensation
17. Poor social skills
18. Volatile relationships
19. Hallucinations

D. **Maltreated Children in the Juvenile Justice System**

1. Research shows a demonstrable link between being abused and neglected in childhood and being arrested for delinquent and criminal acts, and committing violence generally. (Widom)
2. Various studies have shown that anywhere from 8% to 26% of children who have engaged in delinquent acts have been physically abused. (Policymaker's Guide and Garbarino)
3. Research shows a maltreated child is four to seven times more likely to commit a violent act than a non-maltreated youth. (Dodge)
4. Childhood victimization increases a child's risk of involvement in the juvenile justice system. The National Institute of Justice cites three studies from different parts of the country -- a metropolitan county in the Midwest, Mecklenburg County, North Carolina, and Rochester, New York -- that demonstrate that child maltreatment, specifically child abuse and neglect, leads to higher rates of delinquency. The odds are almost two times higher that an abused or neglected child will be arrested as a juvenile for a violent crime than non-maltreated children. (Widom)
5. Those abused and/or neglected children who are arrested at an earlier age are more likely to be repeat violent offenders. Being arrested does not necessarily deter juvenile violent crime. That's because the juvenile justice system is often ill-

equipped to deal with and treat the early childhood trauma and victimization that plays a role in these young people's violent acts.

6. Children who grow up in homes where they observe or experience maltreatment (i.e., considerable conflict, physical abuse, sexual abuse, inadequate supervision, physical or emotional neglect, parental abandonment, criminal activity, or drug/alcohol abuse) are at greater risk of becoming delinquents. (Policymaker's Guide)
7. One study in 1995 study found that 96% of surveyed children who had committed homicide had come from chaotic family backgrounds, usually including family violence (81%). 90% had been abused by a family member as a child; 100% had a history of serious school problems, including 86% who had failed at least one grade and 76% with documented learning disabilities (Karr-Morse, p. 182, citing Meyer, et al., *Psychopathological, Biopsychological Factors, Crime Characteristics and Classifications* in 34 JOURNAL OF AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHOLOGY 1483 (November 1995)).
8. A 1997 study found that experiencing physical abuse in the first five (5) years of life increases the likelihood of later developing clinically-significant conduct problems by about four-fold. (Dodge, p. 277)
9. Research shows that the absence of a caring father is associated with a greater likelihood of engaging in chronic bad behavior as a young person (Garbarino 45-6). (Garbarino writes: "Two patterns of father influence are most important in understanding the development of violent boys: (1) the presence of an abusive father and (2) the absence of a caring and resourceful father.")
10. A 1983 study of parent-child interaction found that 11% of the children who had a parent who was genuinely concerned for the child's welfare had committed serious crimes. By comparison, 20% of the abused and neglected children, and 50% of the rejected children had committed serious crimes. (The study defined an abused child as one subjected to frequent physical punishment; a neglected child as one who experienced little interaction with his/her parent(s); and a rejected child as one whose parents were frequently displeased with the child's behavior.) (Policymaker's Guide, p. 18, with cite to McCord 1983)

E. Adults in the Criminal Justice System Who Were Maltreated As Children

1. A study of inmates in a New York prison found that 68% of the sample reported some form of childhood victimization and 23% reported experiencing multiple forms of abuse and neglect, including physical and sexual abuse. (Widom and Weeks)
2. The same study found that violent offenders reported more childhood neglect (20%) than nonviolent offenders (6%). (Widom and Weeks)

III. How Childhood Maltreatment Can Lead to Chronic Violent Behavior

While there is no conclusive evidence that childhood maltreatment alone leads directly to later criminal activity, research indicates that multiple risk factors -- most notably childhood maltreatment -- can lead a child to commit delinquent acts and to later engage in criminal behavior as an adult. Childhood maltreatment increases the chances a child will become violent by interrupting normal emotional, social and intellectual development. The following describes ways in which childhood maltreatment can shape aggressive behavior.

- A. **Social Learning.** Children learn to use violence as a way to deal with day-to-day situations when they themselves are victims of violence and/or see others victimized.
 - 1. The family is the primary setting in which a child learns and develops an understanding of the social environment and one's place within that environment. The family is the place in which a child becomes socialized, where a child learns acceptable ways of thinking and acting. Abuse encourages the victims to use aggression as a means of solving problems and obtaining desired results. Children who have been traumatized by abuse believe in the legitimacy of aggression when faced with a perceived threat. The experience of abuse acts as a model for later actions.
 - 2. Trauma also leads to heightened threat awareness and perception of provocation. Trauma leads children to have a heightened startle response to external events.
 - 3. Social learning also takes place in the child's wider environment. While the first important influence on the child is the family, children and their families interact in a larger social system which includes schools and communities. Environmental risk factors are discussed in depth in Part V below.
- B. **Lack of Attachment and Positive Relationships.** Children experience rejection and abandonment when their relationships are characterized by insecurity and physical maltreatment. Rejected and abandoned children are unable to form secure emotional attachments first within their family and then within society as a whole. Because they have not been able to form intimate, trusting relationships, rejected children will often misinterpret the behavior of others as hostile and respond with aggression themselves. The following feelings and attitudes -- which result from abuse, rejection, abandonment and the consequent trauma -- are what prevent children from developing these critical relationships:
 - 1. Traumatized children develop a distrust of others, particularly adults. Children who are rejected or abandoned do not feel they can turn to adults for help -- they feel isolated and solely responsible for themselves.
 - 2. Traumatized children don't feel safe. Young people feel they are vulnerable and that adults and society cannot protect them. Therefore they develop alternative, often aggressive or violent methods, to protect themselves. They often join gangs in order to find a sense of safety and belonging.
 - a. In interviews with youth in prisons, young people say the reason they join gangs is because they feel that adults in their neighborhoods have no ability to make

them safe. When asked about his choice to join a gang, one juvenile replied "If I join a gang I'm 50% safe; If I don't join a gang, I am 0% safe." (Garbarino)

- b. Research shows that the best predictor of how children will fare in neighborhoods marked by violence is the extent to which they believe that key adults in their lives remain confident, competent, and in charge. When the key adults become unavailable, psychological terror sets in for these children. (Garbarino)
3. Children feel shame when they are mistreated, rejected or abandoned, and are likely to attribute the rejection to something lacking in themselves. Namely, they ask themselves "What's wrong with me that my parents don't want me?" "The shame of abandonment appears over and over again in the lives of kids who kill." (Garbarino, pp. 49 and 52)
 4. Abandonment and rejection often lead to feelings of pain and rage, increasing the chances a child will become violent.
 5. Rejected children are at a heightened risk for a host of problems ranging from low self-esteem, to truncated moral development, to difficulty handling aggression and sexuality.
 6. Rejected children have trouble learning the basics of empathy, sympathy, and caring. They become emotionally numb. Trauma leads to a sense of meaninglessness, hopelessness, and purposelessness. When children's psychological functioning (i.e., emotional and cognitive functioning) is overwhelmed by trauma, they often feel disconnected and isolated from the world around them. They have an inability to identify and use support systems. This feeling of separateness from the world leads to the feeling that life is without meaning, hope, or purpose. Children ask themselves, "What's the point?" and the answer is "Nothing." Such a sense of meaninglessness leads to a lack of motivation as well as an indifference to the consequences of their actions. These children are much more likely to become violent because they do not believe that their actions (violent or otherwise) have any meaning.
 7. Traumatized children have a tendency to seek out people with whom they can re-enact the same patterns of relating as they had with their abusive/neglectful caretakers. They have a fear of being alone, and have a constant need for external validation.
- C. **Scripts.** By observing the world around them, children learn and remember "stories" or "scripts" about how things happen in exchanges between individuals. The stories tell them the usual sequence of actions that occur between people in different circumstances. Children draw on these stories of violence when they themselves act, and have access to a repertoire of aggressive behaviors.
- D. **Cognitive Deficiencies.**
1. Abused and neglected children are likely to have cognitive and intellectual deficiencies and developmental problems. These deficits, in turn, impact their decision-making abilities in stressful situations. These deficits include:
 - a. an inability to assimilate and accommodate new information

- b. an inability to gain access to previously learned information
 - c. problems with memory/disassociation/confabulation
 - d. deficiency in words and consequently they are more prone to react to situations with action instead of talking
 - e. an inability to develop or apply problem-solving skills
 - f. a tendency to engage in concrete, "either/or", "black/white" thinking: life is "either/or," not "both/and"
 - g. impulsivity
 - h. inability to apply psychomotor skills to manipulate things in their environment
2. **Processing problems.** Social information processing problems mediate the effect of early physical harm on later externalizing outcomes. Children who experience abuse develop several specific chronic patterns of mentally representing and processing information that the child carries forward with him/her; these processing patterns become the proximal instigation to aggressive behavior toward peers and adults in new settings. (Dodge, pp. 278-81)
- a. Dodge identified four kinds of processing patterns in the abused children whom he examined:
 - (1) When faced with personally threatening stimuli, physically harmed children are distracted from relevant social cues and demonstrate errors in attending to irrelevant cues.
 - (2) Abused children's hypervigilance to hostile cues, which might be an adaptive and effective response to an abusive child-adult relationship, result in the chronic tendency to presume hostile intent in others even in circumstances where this interpretation is inappropriate. Dodge calls this pattern a "hostile attributional bias."
 - (3) The salience of abusive experiences observed by the child lead an abused child to acquire a large repertoire of highly accessible aggressive responses stored in memory.
 - (4) Abused children acquire a tendency to evaluate aggressive behaviors as often leading to successful instrumental and intrapersonal outcomes.
 - b. Dodge's study showed that harmed children had significantly more processing problems than non-harmed children: 60% of the non-harmed children had no problems, in contrast with just 32% of the harmed children. At the other extreme, only 11% of the nonharmed children had more than one processing problem, in contrast with 38% of the harmed children.
 - c. Specifically, the group of harmed children (as compared to the non-harmed group) demonstrated less attention to relevant cues, more hostile attributional biases, more aggressive response patterns, and more positive evaluations of the likely outcomes of aggressive behavior.
 - d. Dodge's study also showed that grade school students with 3 or 4 processing problems are at a significant risk of becoming violent. For a child with no processing problems in early elementary school, the relative risk of later clinically

significant externalizing problems is only 5%. On the other hand, the relative risk for a child with 3 or 4 processing problems is over 35%. This is a 7-fold increase in risk that accrues from processing problems.

- E. **Cognitive Problems Resulting from Chronic State of High Arousal.** Children who have been traumatized by abuse stay in chronic states of fear and anxiety. In these states of high arousal, children similarly experience difficulties in assimilating new information, employing problem solving skills, and other cognitive deficiencies that make it more likely that children will misread situations and react inappropriately.
- F. **Mental Health Problems.** Abused and neglected children also experience various mental health consequences including antisocial personality disorder, post-traumatic stress disorder, and higher rates of suicide attempts. They become emotionally and cognitively overwhelmed by their traumatic experience. These cognitive deficiencies and mental health problems help to skew their perception of situations.
- G. **Frustration-Aggression** suggests the importance of intentional and malicious frustrations as leading to anger and retaliatory aggression. Frequent “goal-blocking” and highly frustrating events, including experiencing physical harm, leads to the socialization of chronic aggressive behavior patterns. The child links the intentions of his abuser to the intentions of peers in current interactions, which leads to aggressive behavior. These are the children who are “quick to anger” – their early abusive experiences have created scripts of aggression that are now stored in their memories. (Dodge, p. 265-66, 276-77, with cite to Berkowitz 1989)
- H. **Genetics.** Environmentally altered genes – not inherited genes – may play a role in shaping violent behavior. Poor prenatal care (including stress, malnutrition, alcohol abuse) or other complications during pregnancy can leave a child more vulnerable to other risk factors in his/her environment, including maltreatment. For example, during the critical period of maturation of the brain, prolonged periods of intense stress may actually alter DNA, the building material of the genes. (Karr-Morse 10) (But remember: research has demonstrated that there is no crime gene.)
- I. **Temperamental Infants.** Infants who are temperamentally difficult – because of such factors as colic or other physical ailments – frustrate their parents, who sometimes become abusive as an outlet for their frustration. The parent’s abuse can play an important role in transforming the child’s difficult temperament into chronically aggressive behavior.

***Interactive Exercise:** Ask participants to recall young people they've worked with in the juvenile justice system who were abused by family members. What types of behaviors do these children exhibit; is there any pattern of behavior? How do these children relate to authority figures? To peers? Did you identify other factors within their lives that exacerbated the effects of being abused (e.g. poverty, violence in their home or community, gang activity, psychological problems)? What strategies, if any, have you successfully employed to work with these children? What types of programming and treatment, if any, is available in your jurisdiction to treat the effects of maltreatment (abuse and neglect) once these children come into the juvenile justice system?*

IV. Guiding Principles for Structuring Interventions for Maltreated Children

What Do We Know? What Do We Do About It?

1. Child maltreatment leads to survival strategies that are often anti-social and/or self destructive. Many violent youth were victims of child maltreatment. When maltreatment occurs as part of a more general accumulation of social and personal risk factors, it can lead to major developmental difficulties.

2. The experience of early trauma leads to hypersensitivity to arousal in the face of threat, with responses taking the form of dissociation and/or aggressive reactivity.

1. To assess and treat a youth who has committed violent acts, the professional must recognize the value of the young person's personal narrative or story in helping the young person make sense of his/her experience. The professional should focus on trying to make sense of the horrible act that was committed against the young person. No matter how dark that experience may have been, the young person must come to understand the experience so that the trauma will not overwhelm their emotions and cognition when faced with future stressful events. Deal with child maltreatment issues as part of the therapeutic program (e.g., include reading material and videos about child maltreatment and promote efforts to identify child maltreatment in counseling sessions). In this as in all efforts, identify the "zone of proximal development" in which learning and personal change are possible (i.e., neither simply validating the youth's understanding nor pushing too fast and too far too soon).

2. Interventions must be focused on reducing the perception of provocation and undermining the legitimacy of aggression as a response to perceived provocation and threat. Avoid power assertion whenever possible to reduce the experience of threat and thus maintain the youth in a non-dissociative and non-aggressive state. Understand that dissociative responses can make youth appear emotionless when they are actually filled with intense emotions and that aggressive reactivity can be triggered by what appears to be trivial incidents to an outsider but may loom large to the youth.

3. Traumatized kids require a calming and soothing environment to increase the level at which they are functioning.

What Do We Know?

What Do We Do About It?

3. Provide an environment that encourages calmness and reflection (including soothing classical music, videos that promote reflection, participation in creative arts, and meditation practices).
 4. Provide activities that promote future orientation through caring for plants, animals, and other human beings.
 5. Promote trust in adult authority by creating a highly controlled environment in which youth conclude rationally that they are safe and thus can afford to relinquish their defensive posture.
 6. Promote spiritual values that transcend the materialistic culture through staff modeling, directed reading and discussion, and spiritual practice (including uniforms, meditation, participation in the creative arts, and spiritually oriented instruction such as Tai Chi and yoga to increase self-discipline).
 7. Create the basis for new life narratives by exposing youth to the reading and writing of novels and biographies, and to relationships with staff that provide working models of meaningfulness in the face of loss and abandonment (e.g., sharing experiences of hope in the face of adversity).
 8. Communicate respect in every facet of institutional life (e.g., language used by staff to communicate with youth).
4. Traumatized youth are likely to evidence terminal thinking (i.e., an absence of future orientation).
 5. Youth exposed to violence at home and in the community are likely to develop juvenile vigilantism, in which youth do not trust adult capacity and motivation to ensure safety and therefore believe they must take matters into their own hands.
 6. Youth who have participated in the violent drug economy are likely to have distorted materialistic values.
 7. Traumatized youth who have experienced abandonment are likely to feel life is meaningless.
 8. Issues of shame are paramount among violent youth because of their personal and collective experiences (e.g. victimization, poverty, and racism).

What Do We Know?

9. Youth violence is an attempt to achieve justice as perceived by the youth. There is a sense to “senseless” youth violence. !

10. Promote the development of empathy as a principle for day to day interaction in the facility, among staff and youth (e.g., focus on effective and respectful communication of feelings among staff and youth.) !

What Do We Do About It?

9. Acknowledge the youth’s perception of the justice of their violent actions as a starting point. Then engage youth in dialogue to reinterpret their perceptions of justice. Focus on issues of violence, conflict, and justice designed to model higher stages of moral reasoning (e.g., readings and videos that present moral dilemmas).

10. Empathy is the enemy of aggression. Combining traditionally masculine and feminine traits is related to resilience.

- I.
- II.
- III.
- IV.

V. **Maltreatment Interacts With Other Risk Factors to Promote Violent Behavior**

- A. Research demonstrates that the combination of factors in a child's life context can either help prevent delinquent behavior, or increase the likelihood of a youth becoming violent. Most juvenile violence results from the accumulation of a variety of risk factors, not just one factor. Several studies have found that while the presence of one or two risk factors was generally manageable for children, the presence of three or more risk factors was associated with significant developmental impairment. See Appendix A for studies on the relationship between the accumulation of risk factors and violence.
- B. Interventions that address the multiple risk factors that a young person faces will have a much greater chance of success.

C. **Other Risk Factors for Violent Behavior**

1. **Poverty**

- a. The Children's Defense Fund's CHARACTERISTICS OF POOR CHILDREN IN AMERICA reports that the United States is the worst of all industrialized nations in the percentage of children living below the poverty level. In 1998, 18.9% of children ages 18 and under lived in poverty; 21.3% of children ages 3-5 lived in poverty; and 17.8% of children ages 6-17 lived in poverty.
- b. Poor neighborhoods, especially "inner-city war zones," generally have relatively high crime rates, unsatisfactory schools, and unhealthy living conditions. They provide a child with few resources, negatively affect development, and increase the chances a child will become violent.
- c. The residents of predominantly poor neighborhoods feel isolated from society. This increases a sense of resentment and hostility towards society. Because such persons do not feel like they are a part of the greater society, they are more likely to disregard laws and act out against societal norms and rules of social behavior.

Visual Aid:

*Trainer will need four tennis balls. Trainer should ask for a volunteer from the audience to come forward. First, the trainer should toss the volunteer one tennis ball, and ask him/her to toss it back and forth between his/her hands. Point out to the group that the volunteer is able to manage this easily. Give the volunteer a second ball, and observe that s/he is still able to toss them easily from one hand to the other. Add a third, and the trainer should point out that it takes special skill to juggle all three -- some people have that skill and others don't. Give the volunteer four balls, and s/he will drop them all. So it is with risk factors in a young person's life. Now suppose that the person got an electric shock any time s/he dropped the ball. This would make it difficult for him/her to handle the balls at all. **The lesson of the tennis ball metaphor is that once the capacity for absorbing risk factors is exceeded there is a collapse of the system -- namely the child's ability to cope with stress factors.***

- d. Impoverishment in and outside the family increases the risk that a child will experience traumas. Such children often experience impoverishment of human connectedness, trust, support, and emotional nurturing. Many of these families have felt angry and alienated for several generations. There is a sense of separateness; a chronic irritability; an absence of optimism, joy, and knowing how to laugh; and a need to numb against hopelessness. When children are born into such settings, child abuse and neglect are palpable potentials. (Karr-Morse, p. 271)
2. **Poor early childhood care.** Only 8.4% of infant and toddler care in U.S. child care centers are considered to provide developmentally appropriate care; 51.1% have been judged to provide mediocre quality of care; and 40.4% provide poor quality care. (Karr-Morse, pp. 13-14)
3. **Family conflict and/or lack of stable family structure.** This can include:
 - a. Observing marital violence and/or severe discord. (A Policymaker's Guide, pp. 12-14, with cites to Minty (1988), Krruttschmitt (1986), Grych and Fincham (1990), and Jaffe (1986)).
 - (1) Exposure to marital discord is a risk factor that causes adjustment problems similar to those experienced by abused children. Studies have concluded that the influence of marital discord on delinquent behavior ranges from moderate to strong.
 - (2) Serious or excessive marital discord (violence, alcoholism, drug abuse) predicts delinquency better than divorce or single parenthood. The type of familial interactions and familial environment affect child development, not merely family structure. Research shows that marital disharmony is the operative factor leading to developmental problems, not divorce or life in a single-parent home.
 - b. Lack of cognitive stimulation in the home. (Dodge)
 - c. Parents who move often, thus impacting the stability of their children's peer relationships. (Garbarino, p. 40)
4. **Living in a Socially Toxic Environment.** Children do not grow up in a vacuum, but, rather, in a social context. The characteristics of the community in which the child lives exert potent influences on the child's development. While the first important influence on the child is the family, children and families are interacting members of a larger social system including schools and neighborhoods. The child's wider social environment has a significant impact upon his/her development, his/her perceptions of the world, and the outcomes of his/her actions. Aggressive behavior is learned; children imitate the behavior of those around them as acceptable means of achieving goals. Environmental risk factors, therefore, put a child at greater risk to have developmental problems, including maladaptive thinking and behavior. By contrast, a healthy community environment provides satisfactory living conditions, safety, security, and helpful resources/institutions, all of which positively affect child

development and socialization. A healthy community enables most children to form a bond with society and subsequently a sense of purpose within and towards the community.

Interactive Exercise: Living in a Socially Toxic Environment

The purpose of this exercise is to explore the popular misconception that the youth of today are intrinsically different -- specifically, that they are naturally more violent -- than youth of earlier generations.

The following movie clips -- which depict juveniles in the 1940s, the 1960s, and the 1990s, respectively-- show how the environments in which youngsters grow up have become increasingly "toxic" over the years. We first see teenagers in 1940s East Side New York; they engage in petty larceny. We then see teenagers in the 1960s in New York City. The 1960s teenagers primarily engage in petty crime, including beating each other up. However, the social environment has been complicated by the tension caused by waves of immigration and the formation of gangs. Although at least one teenager attempts to find a peaceful resolution to a dispute, the activity of the 1960s group of teens eventually turns deadly. In the final clip, we see how a group of teens in modern-day Los Angeles live amidst a culture of poverty, guns and drug dealing.

The common theme we see in each of the three clips is a young person taking action to avenge a wrong committed against a friend -- under very different circumstances and with different outcomes. The teens in the different clips were all motivated to act by loyalty. However, the outcomes of their actions differed, in part, because their social environments were different.

It is important for the trainer to show the clips in the following order. The times given indicate the placement of the scene(s) in the respective movies.

#1 *Knock on Any Door* (1949) d. Nicholas Ray

21:00-21:50, 22:45-28:30, 30:00-31:00

Lawyer Andy Morton (played by Humphrey Bogart) is defending an adult, Nick Romano, who is accused of murder. In a series of flashbacks, Morton describes how Nick became a juvenile delinquent. We first see Nick Romano as he learns that his father, who was wrongly imprisoned, has died of heart attack. We then see Nick and his family move into a rough-and-tumble neighborhood, where Nick is immediately assaulted by local boys. Nick becomes involved in delinquent activity with two friends, engaging mostly in petty theft. Eventually, Nick and his friend, Jimmy, are caught stealing a car and are sent to reform school. In the last scene, Nick and Jimmy are toiling away at the reform school. Nick confronts the guards when they make Jimmy, who is ill, continue to work.

#2 **West Side Story** (1960) d. Robert Wise and Jerome Robbins

1:10:55-1:15:25, 1:36:30-1:43:45

In the first scene, rival gangs the "Jets" and the "Sharks" hold a "war council" at Pop's Drug Store. A final showdown between the two gangs -- who have been harassing and beating each other's members -- is planned for the following evening. Tony, a former Jet, convinces the gang members not to use any weapons at the showdown. In the second scene, the Jets and the Sharks meet under the highway to fight. Tony attempts to stop the fight, believing that fighting will only have negative consequences for all. But Tony ends up killing Bernardo, the leader of the Sharks, after Bernardo kills Riff, Tony's lifelong friend.

#3 **Boyz in the Hood** (1991) d. John Singleton

1:31:00-1:41:30

In the scene immediately preceding this one, Trey's close friend, Ricky, is murdered by a 27-year-old gang member who Ricky had insulted the previous night. Angered by the murder of his friend, Trey sets out with Ricky's brother, Doughboy, in pursuit of the killer. Trey decides at the last minute to get out of the car. Doughboy, however, avenges his brother's death.

Discussion questions:

- ! How, if at all, does Nick Romano in *Knock on Any Door* differ from Tony in *West Side Story*? From Doughboy or Trey in *Boyz in the Hood*?
- ! What influences shaped the identity development of the main characters in each of the movies? Has the source of these influences changed or stayed the same over time?
- ! Do any of these adolescents operate by a morality system? If yes, what is it?
- ! Has the environment in which young people grow up changed over the years? If yes, how?

a. **"War Zone Neighborhoods"**

- (1) Social scientist James Garbarino describes "war zone neighborhoods" as places where almost every fourteen-year-old has been to the funeral of a playmate who was killed, where two-thirds of the kids have witnessed a shooting and where young children play a game called "funeral" with the toy blocks in their preschool classroom. Such war zones have been the primary sites for children who kill. The number of such war zone neighborhoods have increased steadily since the 1960s, when they were primarily located in large urban centers. However, in the past two decades, such neighborhoods have developed in a number of medium-sized cities, such as Denver, Minneapolis-St. Paul and Salt Lake City (Garbarino, pp. 17-18).

- (2) Children who grow up surrounded by violence often exhibit developmental problems, including symptoms of post-traumatic stress disorder (PTSD). Violence within a neighborhood threatens a child -- the child feels unsafe. As a result the child does not believe adults and/or society can protect the child. Moreover, these children learn to distrust adults and society because they are let down by the false promises of adults and/or society concerning their feeling of safety and security. They learn to use violence to protect themselves because they feel a very real threat to their own safety.
- (3) Neighborhood violence affects children at a very young age -- first leading to aggressive behavior (i.e., fighting) and then to more severe acts of violence. (Becker & Rickel at p. 238 with cite to Bell & Jenkins 1994)

b. Association with Delinquent Youth and Prevalence of Gangs.

- (1) Research has shown that involvement with friends who engage in delinquent behavior is a major cause of chronic offending behavior. (Elliott, D.S., et al., GOOD KIDS FROM BAD NEIGHBORHOODS (Forthcoming)) (*Note to trainer: trainer should show overhead graphic entitled "Mean Gains in Self-Reported Delinquency Frequency Scores by Levels of Family and School Bonding and Delinquent or Prosocial Friends," attached at Appendix E.*)
 - (a) Question arises about the cause and effect pattern: do youth go from non-delinquent to delinquent behavior once they acquire delinquent friends, or do children who already engaged in delinquent behavior acquire delinquent friends? Elliott study: 90% of the cases tracked showed the former. (Elliott, D.S., and Menard, S., *Delinquent Friends and Delinquent Behavior: Temporal and Developmental Patterns* in D.J. Hawkins, ed., DELINQUENCY AND CRIME. New York: Cambridge University Press (1996))
 - (b) Research has also shown that if you are in a predominantly delinquent peer group, it makes little difference whether you are in a strong, stable family or positive school environment. (See overhead graphic entitled "Mean Gains in Self-Reported Delinquency Frequency Scores by Levels of Family and School Bonding and Delinquent or Prosocial Friends," attached at Appendix E.)
 - i) The highest risk for delinquent/violent behavior are for those children in a peer group that is made up of predominantly delinquent youth. For such youth, getting them out of the predominantly delinquent peer group is a critical intervention.
 - a) This has important implications for programming for adjudicated youth, i.e., placing a child in a residential facility with other delinquent youth increases the chances that the child will continue to engage in delinquent behavior.
 - ii) When a child is in a mixed group of peers (i.e., some delinquent, some non-delinquent), the strength of the family and school situations

become critical. If there is strong family bonding, for example, the child is more likely to be influenced by his prosocial peers than his delinquent peers.

- (2) According to the federal government, more and more children report that gangs are active in their schools and communities -- gang activity is up 50% between 1989 and 1995, according to these reports. Also, the average age of gangs is increasing, and thus children become involved in more serious offending. (Garbarino, p. 13)

c. **Substance Abuse.**

- (1) In 1997, the Centers for Disease Control and Prevention reported that 9% of high-school age males had used cocaine, and 50% of adolescent boys reported having used marijuana. The overall rate of drug use among teenagers is on the increase again (after declining from 1976-1994) and now stands at 36% of the teenage population. Heavy alcohol use among teenage boys is also common: 37% of boys surveyed reported that they drank five or more drinks on one occasion at least once in the previous month. (CDC Annual Youth Risk Behavior Surveillance)

- (2) However, studies show that illegal drug use typically follows (not precedes) the onset of violent behavior. (Elliott, D.S., *Serious Violent Offenders: Onset, Developmental Course and Termination* in 32 CRIMINOLOGY 1 (1994)). Drug use has more of an impact on the continuity of chronic violence. Drug use by youth who have already begun to engage in violent behavior will:

- (a) lengthen the duration of the youth's violent career into young adulthood;
and
- (b) increase the rate at which violence occurs.

- d. **Widespread Availability of Weapons.** A 1997 CDC survey revealed that 28% of adolescent boys carried a weapon – a gun, a knife, or a club – in the previous month, with 13% stating that they carried the weapon to school. Adolescents carry weapons primarily because they feel threatened and that they can't count on adults to protect them.

5. **Neurological and Biological Problems**

- a. Surveys point to a significant increase among children with conditions such as Attention Deficit Disorder (ADD) that result in behavioral difficulties. Such conditions may be caused by neurological problems. Moreover, improved medical care means that more premature infants are surviving today; the rate of learning difficulties in children who are born prematurely is about 25% higher than for those who are full term. (Garbarino, pp. 14-15)
- b. Children with neurological problems, such as ADD or Attention Deficit Hyperactivity Disorder (ADHD), often have difficulty concentrating and engaging in tasks and instead act out. Rather than being treated for their neurological

problems such children are often maltreated because they are more difficult to control, and because their neurological problem has not been identified. (Karr-Morse, pp. 106-08). As Karr-Morse states: "What we know is that children with early discernible impulse-control problems, such as attention deficit/hyperactivity disorder (ADHD), are at a considerably higher risk of later violent behavior when the problem is left untreated, or is treated only by stimulant medication. Negative outcomes for these children are greatly increased when ADHD is exacerbated by familial or environmental factors such as maternal rejection, child abuse, or the modeling of violent solutions to everyday problems." (Karr-Morse, p. 36)

- c. Poor prenatal care (drug/alcohol/tobacco use, malnutrition, and lack of access to medical care) increases the likelihood that a child will develop neurological problems and/or learning disabilities that may lead to problem behavior. (Karr-Morse, pp. 62-78)
6. **Learning Disabilities and Difficulties at School.** *The following material is excerpted from Module Five: Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise their Ability to Comprehend, Learn, and Behave.*
- a. **Estimates of the incidence of learning disabilities among the juvenile offender population vary based upon the definitional criteria used and the type of assessment instrument employed.**
 - (1) Studies that adhere strictly to federal standards for learning disabilities tend to find lower rates of learning disabled children among juvenile offenders as compared to studies that base disability qualification simply on observed academic lags (sharp discrepancy between intelligence (normal) and standardized test performance (sub-normal/radically inconsistent)).
 - (2) Direct assessment reveals substantially higher rates of learning disabilities than survey research and file reviews.
 - (3) Estimates from professional associations exceed the findings of research studies.
 - b. **Statistics on the prevalence of children with disabilities in the juvenile justice system** (as compared to the population as a whole):
 - (1) **General Population:** a recent statistical compilation estimates that 2-5% of all public school students in the United States are Severely Emotionally Disturbed (SED), 5% are Learning Disabled (LD), 1-2% are Mentally Retarded (MR), and 3-5% have an Attention Deficit/Attention Deficit Hyperactivity Disorder (ADD/ADHD). Between 7-12% of the school age population is believed to have some sort of educational disability.
 - (2) **Juvenile Delinquents:** 28-46% of the juvenile offender population has an educational disability. Within that group, 9-42% are LD; 16-50% are SED;

and 3-30% are MR. There are no applicable statistics to show the incidence of ADD/ADHD among this population.

- (3) **Incarcerated Juvenile Delinquents:** 28-60% of the incarcerated juvenile offender population has an educational disability. Within that group, 11% are LD; 20% are SED; 18% have some kind of ADD/ADHD; and 3-10% are MR.
- (4) **Arrest Rates:** It is estimated that 18% of the mentally retarded, 31% of the learning disabled, and 57% of the emotionally disturbed will be arrested within five years of leaving high school.
- (5) **Victims of Crime:** the disabled are far more often the victims of crime than the perpetrators, particularly among the developmentally disabled population, of whom 75-90% are estimated to have been the victims of sexual or physical abuse at the hands of care givers and others.
- (6) One recent study found that 100% of children who had committed homicide had a history of serious school problems; 86% had failed at least one grade; and 76% with documented learning disabilities. (From Karr-Morse p. 182, originally from Meyers, et al.)

c. **The relationship between disabling conditions and delinquency²**

(1) **Susceptibility.**

- (a) There are certain variables inherent in learning and developmental disabilities that make an individual more susceptible to criminal involvement. Specifically, these disabilities predispose an individual to:
 - i) make poor decisions and social judgments that lead to involvement in crime;
 - ii) have weak or no avoidance techniques that lead to detection and eventual arrest (i.e., they are more likely to get caught);
 - iii) have social skill deficits that result in harsher treatment once in the justice system; and
 - iv) have learning difficulties that almost ensure increased recidivism (i.e., it is more difficult for them to "learn their lesson" and reform their ways).

²For more information on the relationship between disabling conditions and delinquency, the trainer is referred to the following scholarly articles: Katherine A. Larson, *A Research Review and Alternative Hypothesis Explaining the Link Between Learning Disability and Delinquency*, 21 JOURNAL OF LEARNING DISABILITIES 289 (June/July 1988); Norman Brier, *The Relationship Between Learning Disabilities and Delinquency: A Review and Reappraisal*, 22 JOURNAL OF LEARNING DISABILITIES 546 (1989).

(b) There are several susceptibility variables, and for each variable lists there exist typically observed difficulties that may account for increased juvenile justice involvement:

- i) Reduced Cognitive Ability
 - a) Lower average IQ
 - b) Poor decision-making skills
 - c) Increased probation violations and recidivism
- ii) Language Immaturity
 - a) Reduced self-talk (i.e., guiding one's own actions through inner language)
 - b) Deficient verbal mediation skills
 - c) Need for outside coaching or direction
- iii) Developmental and Academic Lags
 - a) Immature/missing cognitive strategies
 - b) Information-processing deficits
 - c) Illiteracy and other skill deficits
- iv) Social Perception and Problem-Solving Deficits
 - a) Misinterpreted social cues
 - b) Reduced empathy and role-taking skills
 - c) Poor planning skills
 - d) Inability to generate adaptive solutions
- v) Interpersonal Skills Deficits
 - a) Social abrasiveness
 - b) High suggestibility
 - c) Inattention, distractibility and impulsivity

(2) **School failure/school frustration.**

(a) A disabled child enters junior high or high school with poor skills that have not responded to educational intervention, which leads to poor grades and underachievement in school. The resulting embarrassment in front of peers and negative self-image causes the student to develop a high level of frustration with academic tasks, cut classes and seek out delinquent-prone peer groups to find acceptance, a social identity, and a sense of achievement lacking in the school setting. Finally, the student drops out of school altogether, joins a gang, commits delinquent acts, and enters the juvenile justice system.

(b) Although clinical observation, school records, and tests of basic academic skills tend to support the School Failure Hypothesis, the evidence derived from academic studies does not support a direct causal relationship between academic underachievement and delinquency in learning disabled youth. (Larson 1988). One well-known educator of LD youth explained

the significance of the School Failure Hypothesis as “tell[ing] the story of frustration that many disabled teens feel in the peer group. Some of these youngsters will do almost anything to make up for their shortcomings and earn the respect of their peers. Thus many disabled students assume mascot status, especially in youth gangs, where they are used as “go-fers” or scapegoats.” (Cowardin 1998)

(3) **Differential treatment.** Studies support the claim that, when the treatment of disabled children in the juvenile system is compared with the treatment of similarly situated non-disabled children, those with disabilities are subject to harsher treatment at arrest, adjudication and disposition as compared to that of their non-disabled peers. The statistics below are provided by the National Center for State Courts and Nancy Cowardin.

(a) At Arrest.

- i) The Statistics: Learning disabled youth are 200% more likely to be arrested than nondisabled youth for comparable delinquent activity.
- ii) Possible reasons:
 - a) Lack of avoidance/nondetection strategies
 - b) Used as scapegoats by peer groups
 - c) Act defiantly, uncooperatively or evasively
 - d) Less adept at knowing how, when, and with whom to talk
 - e) Failure of the system to perceive disabilities and respond to them

(b) At Adjudication.

- i) The Statistics: Adjudication has been found to be 220% more likely if the offender has a LD. Nonadjudicated youth averaged two years higher in school achievement than those adjudicated delinquent, despite similar backgrounds of offenses.
- ii) Possible reasons:
 - a) Negative school history and continuing failure
 - b) Reduced ability to comprehend legal proceedings
 - c) Reduced ability to self-advocate
 - d) Poor social presentation
 - e) Failure of the system to perceive disabilities and respond to them

(c) At Disposition.

- i) The Statistics: despite similar records of prior offenses, once adjudicated delinquent, the term of incarceration and/or probation averaged 2-3 years longer for those with disabilities as compared to their nondisabled peers.
- ii) Possible reasons:

- a) Reduced ability to comprehend terms of probation and/or release document
- b) Inability to comply with academic and other requirements named as terms for termination/release
- c) Behavior and interpersonal problems with staff and other students
- d) Failure of system to understand and make allowances for cognitive differences

7. Exposure to violence in the media.

- a. Media violence is not the single cause of youth violence, but is a contributing factor to children at extreme risk. Media violence reinforces and legitimizes violence as an acceptable way to deal with various situations for children living in negative family and/or community environments. Children also become desensitized to violence by witnessing it in the media.
 - b. An expert panel of the American Psychological Association did a comprehensive review of research studies on the relationship between violence in the media to real-life violent behavior. The panel concluded that the evidence linking televised violence to real-life violence is about as strong as the research evidence linking smoking to cancer. While television violence is not the only cause of youth violence, it does play a significant role, accounting for about 10-15% of the variation in violent behavior. And the most psychologically vulnerable children are the ones most likely to show the effects. (Garbarino, p. 108)
 - c. Statistics:
 - (1) Violent acts appear 8-12 times per hour on television.
 - (2) Cartoons (aimed at children) have 25-50 violent acts per hour.
 - (3) The average child witnesses 10,000-12,000 violent acts per year on television.
 - (4) By the time children finish grade school they have viewed 8,000 murders and 100,000 violent acts on television.
 - (5) Children and adolescents on average watch 4 hours of television per day.
 - (6) Overall children spend more time watching television than any activity other than sleeping. (Sege, pp. 129-142)
 - (7) One study found that "good" characters or heroes commit 40% of violent acts on television, more than a third of the bad characters aren't punished, and more than 70% of the aggressors show no remorse and experience no criticism or penalty for their violent actions. (Garbarino, p. 108, citing study by American Psychological Association)
- 8. Parental criminality.** Parental criminality is a significant risk factor which increases the chances a child will become violent. Parental criminal behavior is a model from which children learn. Also, parental criminality tends to disrupt social control (e.g., it is often accompanied by abuse and neglect, rejection and abandonment, and a lack of supervision). (Policymaker's Guide, p. 24, with cite Laub & Sampson 1988, p. 375).

- a. The most extensive investigation to date of the relationship between parental criminality and juvenile delinquency -- conducted by West and Farrington -- concluded that "the fact that delinquency is transmitted from one generation to the next is indisputable." This study showed that criminal fathers tend to produce criminal sons, and that the same is probably true of criminal mothers. (Policymaker's Guide, p. 23, with cite West & Farrington 1973, 1977, p. 109, 116).
- b. Another study found that children with two parents with criminal histories were at an extremely high risk of delinquency. (Policymaker's Guide, p.23)

9. Poor Interactions with Peers

- a. Peer interaction often reinforces both a child's insecurity and a child's belief in violence as an acceptable and effective form of protection from the environment in which they live. Children who feel rejected by their peers are also likely to feel a sense of rage and hostility stemming from the shame of rejection.
- b. Often the children who have the most difficulty with peer relations exhibit conduct disorder in school. They act out in class, skip school, and exhibit aggressive behavior. If these children are assessed and treated within the school setting there is a good chance their behavior will improve. However, children with conduct problems are often merely punished and further isolated by their adult supervisors rather than helped and supported.

VI. **Statistics on Violent Offending by Young People**

Source: Snyder, Howard N. and Sickmund, Melissa, *JUVENILE OFFENDERS AND VICTIMS: 1999 NATIONAL REPORT*. Washington, D.C.: National Center for Juvenile Justice (1999).

- A. The vast majority of children coming into juvenile justice system are NOT violent offenders.
 - 1. Clearance statistics show that between 1980 and 1997, adults (persons age 18 and older) were responsible for between 86%-91% of all violent crime in the U.S.
 - 2. In 1997, 5% of the 2.8 million juvenile arrests were for the violent crimes of aggravated assault, robbery, forcible rape or murder. The most serious charge in more than 40% of all juvenile arrests in 1997 was larceny-theft, simple assault, a drug abuse violation or disorderly conduct.
 - 3. Persons between the ages of 10-17 accounted for 19% of all arrests in 1997. Based on their representation in the population of arrested persons as a whole, juveniles were disproportionaltely involved in arrests for arson, vandalism, motor vehicle theft, burglary, larceny-theft, robbery, and weapons laws violations. In contrast, juveniles were underrepresented in arrests for murder, aggravated assault, forcible rape, driving under the influence, drunkenness, and drug abuse violations.
 - 4. The overall proportion of violent crimes committed by juveniles reported by victims to law enforcement officials has changed little in the last 20 years.
 - 5. From the early 1970s through 1988, the number of juvenile arrests for violent crimes (murder, rape, robbery and aggravated assault) varied with the size of the juvenile population; that is, the arrest rate remained constant. In 1989, the juvenile violent crimes arrest rate jumped up and continued to climb until it reached a peak in 1994; there was a 62% increase in that arrest rate between 1988-1994. The rapid increase was followed by a rapid decline. By 1997, the juvenile violent crime arrest rate was at the lowest level in the 1990s: 7% above the 1989 rate but still 25% above the 1988 rate.
- B. Approximately 10% of males and 3% of females who come into contact with the juvenile justice system for a delinquent act will be charged with at least one violent offense by the time they reach age 18.

VII. The Developmental Dynamics of Violent Offending

A. Three Major Points of Onset of Aggressive Behavior in Youth. (Note to trainer: trainer should show overhead attached as Appendix F entitled "Lifestyle Violent Offender Types".)

1. **Ages 4-5:** when children start school a group is identified as being "out of control." These children are diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), Conduct Disorder or Oppositional Defiant Disorder.
 - a. half of this group will become serious chronic offenders if there are no interventions.
 - b. BUT the other half will grow out of these problem behaviors by the age of ten.
 - (1) this suggests that there are protective factors (i.e., good parenting or mentoring by nonfamily members) that intervene to "re-route" these children's developmental pathway.
2. **Late 20s, early 30s:** a small percentage of people in this age range will begin to exhibit aggressive behavior as they transition into adulthood. Research shows that the main factors contributing to this late onset are a failure to form intimate relationships and to obtain a steady job.
3. *****Ages 12-18:** huge surge of onset of aggressive behavior in these adolescent years.
 - a. Onset of serious violence mostly takes place between ages 12-18. (Note to trainer: trainer should show line graph attached as Appendix G, entitled "Onset of Serious Violent DLQ.")
 - b. 80% of those who are violent in their adolescent years will NOT continue their violent behavior in their adults years. (Elliott, D.S., *Serious Violent Offenders: Onset, Developmental Course and Termination* in 32 *CRIMINOLOGY* 1 (1994)) Again, this suggests that there are certain protective factors at work that interrupt the developmental pathway to chronic violent offending.
 - c. It is not too late to intervene and "re-route" these children's developmental pathways when we see them as teenagers in the juvenile court!!! We must identify the protective factors that are critical at each stage of development, and then create programming that enhance these factors.

B. Protective Factors that Intervene in Pathways to Chronic Violence

1. Self-reported prevalence rates of violent behavior decline for white males as they go through their 20s. By contrast, the self-reported prevalence rates of violence among African-American men begins to pick up again in their 20s and wans again in their 30s. (Note to trainer: trainer should show bar graph attached as Appendix H, entitled "Prevalence of Serious Violence.")

2. Twice as many African-American males as compared to white males will continue their violent behavior (which began when they were teenagers) into their adult years.
3. This indicates that some factors are intervening in the lives of white males that takes them off a developmental pathway or trajectory of chronic offending, while these factors are absent in the lives of African-American males.
4. Researchers controlled for two variables or "protective factors" to understand the source of the differential between white and African-American males in the rate of continuity of violent offending into young adulthood. (Elliott, D.S., *Serious Violent Offenders: Onset, Developmental Course and Termination* in 32 CRIMINOLOGY 1 (1994)). When they controlled for these two variables, the differential disappeared. The two variables that were controlled were:
 - a. whether the men had a stable job. White and African-American men who had steady jobs had similarly low continuity rates of violent offending.
 - b. whether the men were in a stable, intimate relationship. When young people enter into intimate relationships, their adolescent peer group -- with whom they were involved in offending behavior -- breaks up. But when they fail to form these intimate relationships, males remain linked to their youthful peer groups well into their 30s and, thus, continue their involvement in offending behavior. We see the phenomenon today of gangs with members well into their 30s and 40s.
5. This research demonstrates at least two critical markers for a successful transition from adolescence to adulthood: steady, productive employment and stable, intimate relationships.

C. Structuring Developmentally Appropriate Interventions

1. We can use the research on protective factors to structure interventions for youth that will "re-route" their developmental pathways away from chronic violent offending.
2. These interventions must be developmentally appropriate. Programs must be structured to address the particular causes of onset and continuity of violent behavior for the particular age group you are targeting.

VIII. **Protective Factors**

Protective factors are those personal, familial and community attributes which help prevent children exposed to these risk factors from becoming chronic violent offenders, either directly or by virtue of buffering the child from the negative effects of risk factors. The Search Institute, a nonprofit research and technical support organization that works on issues affecting the quality of life for children and adolescents, has identified 40 external and internal "developmental assets" that all youth need to grow up healthy, competent, and caring. This asset list was compiled through extensive examination of youth development literature, field research, and consultation with experts. The following chart is reprinted with permission from Search Institute (Minneapolis, MN). Copyright © 1997 by Search Institute 1-800-888-7828. All rights reserved by Search Institute

(Note to trainer: trainer should show overheads attached as Appendix I, which replicate the chart below.)

EXTERNAL ASSETS

Support

Family support

Family life provides high levels of love and support.

Positive family communication

Young person and his/her parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).

Other adult relationships

Young person receives support from three or more non-parent adults.

Caring neighborhood

Young person experiences caring neighbors.

Caring school climate

School provides a caring, encouraging environment.

Parent involvement in schooling

Parent(s) are actively involved in helping young person succeed in school.

Empowerment

Community values youth

Young person perceives that adults in the community value youth.

Youth as resources

Young people are given useful roles in the community.

Service to others

Young person serves in the community one hour or more per week.

Safety

Young person feels safe at home, at school, and in the neighborhood.

EXTERNAL ASSETS

Boundaries and Expectations

Family boundaries

Family has clear rules and consequences, and monitors the young person's whereabouts.

School boundaries

School provides clear rules and consequences.

Neighborhood boundaries

Neighbors take responsibility for monitoring young people's behavior.

Adult role models

Parent(s) and other adults model positive, responsible behavior.

Positive peer influence

Young person's best friends model responsible behavior.

High expectations

Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time

Creative activities

Young person spends three or more hours per week in lessons or practice in music, theater or other arts.

Youth programs

Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.

Religious community

Young person spends one hour or more per week in activities in a religious institution.

Time at home

Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

Commitment to Learning

Achievement motivation

Young person is motivated to do well in school.

School engagement

Young person is actively engaged in learning.

Homework

Young person reports doing at least one hour of homework every school day.

Bonding to school

Young person cares about his/her school.

Reading for pleasure

Young person reads for pleasure three or more hours per week.

Positive Values

Caring

Young person places high value on helping other people.

Equality and justice

Young person places high value on promoting equality and reducing hunger and poverty.

Integrity

Young person acts on convictions and stands up for his/her beliefs.

Honesty

Young person tells the truth even when it is not easy.

Responsibility

Young person accepts and takes personal responsibility.

Restraint

Young person believes it is important not to be sexually active or to use alcohol or other drugs.

INTERNAL ASSETS

Social Competencies

Planning and decision-making

Young person knows how to plan ahead and make choices.

Interpersonal competence

Young person has empathy, sensitivity, and friendship skills.

Cultural competence

Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.

Resistance skills

Young person can resist negative peer pressure and dangerous situations.

Peaceful conflict resolution

Young person seeks to resolve conflict non-violently.

Positive Identity

Personal power

Young person feels s/he has control over things that happen to him/her.

Self-esteem

Young person reports having a high self-esteem.

Sense of purpose

Young person reports that "my life has a purpose."

Positive view of personal future

Young person is optimistic about his/her personal future.

IX. **Interventions for Violent Juvenile Offenders**

- A. The relationship between maltreatment and other risk factors, and committing violence is not inevitable. Appropriate intervention that is structured to reduce or eliminate risk factors and facilitate protective factors can promote long-range violence prevention.
- B. Truly integrated, developmentally-appropriate interventions which address the many "contexts" in which children live have the best chance of success.
 - 1. From infancy to late childhood, there is one dominant context for the child: the family. Early interventions are quite successful because they can be highly focused on the child's one, dominant context.
 - 2. By contrast, once a child enters adolescence, the social context of interactions with peers emerges and becomes dominant, as well as the school context. Therefore, interventions targetted at adolescents must address these multiple contexts.
 - 3. For a successful transition to adulthood, peer groups must cease to be the young person's dominant context, as work and intimate relationships become the dominant contexts.
- C. **The "Blueprint Programs."** In 1996, the Center for the Study and Prevention of Violence (CSPV), with DOJ funding, initiated a project to identify violence prevention programs that met a very high scientific standard of program effectiveness. The objective was to identify truly outstanding programs, and to describe these interventions in a series of "blueprints" that communities could use to replicate the model programs. The "blueprints" describe the theoretical rationale, the core components of the program as implemented, the evaluation designs and results, and the practical experiences that professionals encountered while implementing the program at multiple sites. More than 450 programs were evaluated, and the project identified 10 programs that met the criteria for effectiveness. The "blueprints" were designed to be very practical descriptions of effective programs which would allow states, communities, and individual agencies to:
 - 1. Determine the appropriateness of this intervention for their state or community.
 - 2. Provide a realistic cost estimate for this intervention.
 - 3. Provide an assessment of the organizational capacity needed to ensure its successful start-up and operation over time.
 - 4. Give some indication of the potential barriers and obstacles that might be encountered when attempting to implement this type of intervention.
- D. **Selection Criteria.** *(Note to trainer: for a full description of the selection criteria for the Blueprint Programs, see Appendix B.)*
 - 1. **Strong research design that allows for empirical measurement of outcomes.**

2. **Evidence of significant prevention or deterrent effects.** This is an obvious minimal criterion for claiming program effectiveness. Relatively few programs have demonstrated effectiveness in reducing the onset, prevalence or individual offending rates of violent behavior.
3. **Multiple site replication.** Replication is an important element in establishing program effectiveness. It establishes the robustness of the program and its prevention effects and its exportability to new sites.
4. **Sustained Effects.** A number of programs have demonstrated initial success in deterring delinquency, drug use, and violence during the course of treatment or over the period during which the intervention was being delivered and reinforcements controlled. This selection criterion requires that these short-term effects be sustained beyond treatment or participation in the designed intervention.

E. Blueprint Programs for juvenile offenders.

1. Multisystemic Therapy (MST).

a. Program Overview.

- (1) MST is an intensive, time-limited, family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. Because different combinations of these factors are relevant for different adolescents, MST interventions are individualized and highly flexible.

Audiovisual Aid

A videotape on the programs that are discussed below is available for purchase from the Center for the Study of Violence Prevention. An order form is attached at Appendix D. The three programs described below -- Multisystemic Therapy, Multidimensional Treatment Foster Care, and Functional Family Therapy -- are featured in minutes 14:30-20:05 of the videotape.

- (2) MST is an alternative to out-of-home care that was developed precisely because traditional treatment efforts in institutional settings have been largely ineffective in reducing chronic offending. There is overwhelming evidence that serious antisocial behavior is determined by the interplay of individual, family, peer, school, and neighborhood settings. Restrictive out-of-home placements fail to address these known determinants and fail to change the environment to which the young person will eventually return.

- b. **Program Targets:** MST targets chronic, violent, or substance abusing male or female juvenile offenders, ages 12 to 17, at high risk of out-of-home placement, and the offenders' families.

- c. **Program Content.**
 - (1) MST addresses the multiple factors known to be related to delinquency across the key settings, or systems, within which youth are embedded. MST strives to promote behavior change in the youth's natural environment, using the strengths of each system (e.g., family, peers, school, neighborhood, indigenous support network) to facilitate change.

 - (2) The major goal of MST is to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. Within a context of support and skill building, the therapist places developmentally appropriate demands on the adolescent and family for responsible behavior. Specifically, MST interventions aim to:
 - (a) improve caregiver discipline;
 - (b) enhance family relations;
 - (c) decrease youth association with deviant peers;
 - (d) increase youth association with prosocial peers;
 - (e) improve youth school or vocational performance;
 - (f) engage youth in prosocial recreational outlets; and
 - (g) develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes.

 - (3) Intervention strategies are integrated into the existing social ecological context and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

 - (4) MST is provided using a home-based model of services delivery. Services are provided by master's level counselors with low caseloads and 24 hours/day, seven days/week availability. The individualized treatment plan is designed with family members and is, therefore, family driven, not therapist driven. This model helps to overcome barriers to service access, increases family retention in treatment, allows for the provision of intensive services, and enhances the maintenance of treatment gains. The usual duration of MST treatment is approximately 60 hours of contact over four months, but frequency and duration of sessions are determined by family need.

 - (5) Recognizing that there are crisis situations when residential care is necessary, the developers of the MST model are incorporating residential beds and therapeutic foster care families in the continuum of services that are available through the MST program. In that way, the child's MST treatment plan will not be interrupted if an emergency out-of-home placement is required.

(6) The people who developed MST credit its success to four key elements:

- (a) Factors determined through empirical research to be related to dysfunctional behavior are addressed comprehensively;
- (b) services are delivered to youth and families in their natural settings;
- (c) therapists are well-trained, well-supported, and monitored for adherence to the treatment approach; and
- (d) considerable effort is invested to develop, nurture, and maintain positive relationships among the various agencies involved.

d. **Program Outcomes.** MST has received the most empirical support as an effective treatment of violent criminal behavior in adolescents. (Borduin and Schaffer, p. 163) Numerous studies have established the efficacy of MST in serious and violent adolescents in both the short- and long-term. Moreover, MST has also been found effective across cultural, regional, and treatment setting variables. (Henggeler, S.W., Mihalic, S.F., et al., 1998) Evaluations of MST have demonstrated for serious juvenile offenders:

- (1) reductions of 25-70% in long-term rates of rearrest;
- (2) reductions of 47-64% in out-of-home placements;
- (3) extensive improvements in family functioning; and
- (4) decreased mental health problems for serious juvenile offenders.

e. **Program Costs.** MST has achieved favorable outcomes at cost saving in comparison with usual mental health and juvenile justice services, such as incarceration and residential treatment. At a cost of \$4,500 per youth, a recent policy report concluded that MST was the most cost-effective of a wide range of intervention programs aimed at serious juvenile offenders. This compares to the estimated cost of \$16,300 for the average course of institutional treatment. (Henggeler et al., 1992)

f. **Where has it been tried?** Sites where MST has been or currently is being implemented include Charleston, S.C., Columbia, MO, Memphis, TN, Philadelphia, PA, and Boston (Roxbury), MA.

2. **Multidimensional Treatment Foster Care (MTFC).**

a. **Program Overview.**

- (1) MTFC is an effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with

chronic antisocial behavior, emotional disturbance, and delinquency. The program was developed to decrease reliance on congregate care interventions that place juvenile delinquents together (such as RTCs, training schools), because empirical research has shown that association with deviant peers is a strong predictor of involvement in and escalation of aggressive and delinquent behavior.

- (2) Social learning theory -- the way in which individuals learn to behave in social contexts -- is the underpinning of the program. Daily interactions between family members shape and influence both prosocial and antisocial patterns of behavior that children develop and carry with them into their interactions with the outside world. MTFC aims to strengthen these familial interactions to promote prosocial behavior while at the same time reducing interactions with delinquent youth.
 - (3) Adolescents are placed in a family setting for a period of six to nine months. Community families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with:
 - (a) treatment and intensive supervision at home, in school, and in the community;
 - (b) clear and consistent limits with follow-through on consequences;
 - (c) positive reinforcement for appropriate behavior;
 - (d) a relationship with a mentoring adult; and
 - (e) separation from delinquent peers.
- b. **Program Targets:** Teenagers with histories of chronic and severe criminal behavior who are at risk of incarceration. The MTFC model has also been shown to be effective for children and teenagers leaving state mental hospital settings.
- c. **Program Content.**
- (1) **MTFC Training for Community Families.** Emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a pre-service training and placement of the youth, MTFC parents attend a weekly group meeting run by a program case manager where ongoing supervision is provided. Supervision and support is also given to MTFC parents during daily telephone calls to check on youth progress and problems. Crisis intervention is available 24 hours/day, seven days/week.
 - (2) **Services to the Youth's Family.** The youth's parents participate in treatment throughout the course of the MTFC placement, so that by the time

the child goes home the parent is practiced in setting limits and keeping their child from associating with negative peers. Family therapy is provided for the youth's biological (or adoptive) family, with the ultimate goal of returning the youth back to the home. The parents are taught to use the structured system that is being used in the MTFC home. Closely supervised home visits are conducted throughout the youth's placement in MTFC. Parents have frequent contact with the MTFC case manager to get information about their child's progress in the program.

- (3) **Services to the Youth.** Youth participate in a structured daily behavior management program implemented in the MTFC home. Youth are not permitted to have unsupervised free time in the community, and their peer relationships are closely monitored. Individual, skill-focused therapy is also provided weekly for program youth. School attendance, behavior, and homework completion are closely monitored, and interventions are conducted as need for the youth in school.
 - (4) **Coordination and Community Liaison.** Frequent contact is maintained between the MTFC case manager and the youth's parole/probation officer, teachers, work supervisors, and other involved adults.
- d. **Program Outcomes.** Evaluations of MTFC have demonstrated that program youth compared to control group youth:
- (1) Spent 60% fewer days incarcerated at 12 month follow-up;
 - (2) Had significantly fewer subsequent arrests;
 - (3) Ran away from their programs, on average, three time less often;
 - (4) Had significantly less hard drug use in the follow-up period; and
 - (5) Had quicker community placement from more restrictive settings (e.g., hospital, detention).
- e. **Program Costs.** The cost per youth is \$2,691 per month; the average length of stay is seven months. MTFC is less expensive than placement in group, residential care, or institutional settings.
- f. **Where has it been tried?** Eugene, OR; Flagstaff, AZ; Lynchburg, VA; Allentown, PA; Waupaca, WI; and various sites in Kentucky and Tennessee.

3. **Functional Family Therapy (FFT).**

- a. **Program Overview.** FFT is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out

behaviors and related syndromes. FFT integrates treatment strategies from both systems theory and behavioral therapy.

- (1) Family therapy approaches attempt to change aspects of family relations that correlate with aggression and violence (e.g. lax parental discipline, conflict, low affection). To be effective, treatments of serious antisocial behavior should include family therapy.
 - (2) Behavioral parent training for aggression is the best researched family-based treatment for aggression, and this approach has shown considerable success with young children. Behavioral parent training, however, has had limited success when used with serious adolescent offenders. Hence, behavioral parent training has limited effectiveness with violent offenders and is best accompanied by other modes of intervention.
 - (3) FFT combines the best of both family therapy and behavioral training, and is regarded as one of the most promising treatments of antisocial behavior in adolescents
- b. **Program Targets:** Youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder.
- c. **Program Content.** FFT requires as few as 8-12 hours of direct service time for commonly referred youth and their families, and generally no more than 26 hours of direct service time for the most severe problem situations.
- (1) **Delivery modes:** Flexible delivery of service by one- and two-person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement.
 - (2) **Implementation:** Wide range of interventionists, including para-professionals under supervision, trained probation officers, mental health technicians, and degreed mental health professionals (e.g., M.S.W., Ph.D, M.D., R.N., M.F.T.).
 - (3) **Phases of program.** FFT effectiveness derives from emphasizing factors which enhance protective factors and reduce risk, including the risk of treatment termination. In order to accomplish these changes in the most effective manner, FFT is a phasic program with steps which build upon each other. These phases consist of:
 - (a) *Engagement*, designed to emphasize within youth and family factors that protect youth and families from early program dropout;
 - (b) *Motivation*, designed to change maladaptive emotional reactions and beliefs, and increase alliance, trust, hope, and motivation for lasting change;

- (c) *Assessment*, designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they related to change techniques;
- (d) *Behavior Change*, which consists of communication training, specific tasks and technical aids, basic parenting skills, contracting and response-cost techniques; and
- (e) *Generalization*, during which family case management is guided by individualized family functional needs, their interface with environmental constraints and resources, and the alliance with the FFT therapist/Family Case Manager.

d. **Program Outcomes.** Clinical trials have demonstrated that FFT is capable of:

- (1) Effectively treating adolescents with Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, alcohol and other drug abuse disorders, and who are delinquent and/or violent.
- (2) Interrupting the matriculation of these adolescents into more restrictive, higher cost services.
- (3) Reducing the access and penetration of other social services by these adolescents.
- (4) Generating positive outcomes with the entire spectrum of intervention personnel.
- (5) Preventing further incidence of the presenting problem.
- (6) Preventing younger children in the family from penetrating the system of care.
- (7) Preventing adolescents from penetrating the adult criminal system.
- (8) Effectively transferring treatment effects across treatment systems.

e. **Program Costs.** The 90-day costs in two ongoing programs range between \$1,350 to \$3,750 for an average of 12 home visits per family.

f. **Where has it been tried?** Kentucky, Illinois, Indiana, Montana, Washington, Kansas, Utah, Arizona, North Carolina, Florida, Delaware, Pennsylvania and Nevada.

F. **Promising Programs for Juvenile Offenders.** Programs that did not fit all of the criteria for a Model Program were designated Promising programs. Promising programs have a demonstrated quantitative effect on one or more of the following outcome variables: delinquency/crime, violence, drug use, and predelinquent aggression (e.g.,

Conduct Disorder). Promising programs must have good experimental or quasi-experimental (with control group) design. Programs which have *failed* to produce a sustained effect do not qualify as Promising, although programs which have not yet demonstrated their long-term effects may remain in the Promising category. Promising programs can be single site, unreplicated projects or have a small effect on outcome measures.

1. Intensive Protective Supervision (IPS).

- a. **Program Overview.** Intensive Protective Supervision (IPS) removes juvenile offenders from criminal justice institutions and provides them with more proactive and extensive community supervision than they would otherwise receive. Its primary goals are to reduce undisciplined acts, decrease the likelihood of future, serious delinquency, and increase socially acceptable behaviors.
- b. **Program Targets:** IPS can be used for any youth under age 16 who is adjudicated as a status offender and who receives a protective supervision disposition. These juveniles tend to be non-serious offenders with little prior history of delinquency (they were primarily female in the research study).
- c. **Program Content.** Offenders assigned to IPS are closely monitored by project counselors who have fewer cases and interact more extensively with the youth and his/her family than traditional parole officers. The counselors make frequent home visitations to assess family and youth needs, provide support for parents, and role model appropriate behavior. The IPS treatment provides youth with external expert evaluation to identify areas of need and service providers, individualized service plans to target desired behavioral changes, and identification and delivery of professional and/or therapeutic services. Youth assessments, needs, and goals are viewed as ongoing and changing.
- d. **Program Outcomes.** When compared to regular protective supervision, IPS has demonstrated both short- and long-term reductions in juvenile offending, including the following:
 - (1) 7.1% of IPS youth compared to 25.9% of the control group were referred to juvenile court for delinquency during the period of supervision.
 - (2) 65% of IPS youth compared to 45.3% of control group youth were judged to have successfully completed treatment.
 - (3) One year after case closing, 14.3% of IPS youth compared to 35.2% of the control group were referred to juvenile court for delinquency.
 - (4) **Where has it been tried?** Raleigh, NC.

G. Limitations of traditional approaches to reducing juvenile delinquency

1. Cognitive-Behavioral Interventions. Cognitive-behavioral skills training approaches assume that juvenile offenders lack cognitive and interpersonal skills for managing challenges in family, peer, and school situations. These intervention programs tend

to focus on skill building, social skill training, anger management, and problem solving. (Borduin & Schaffer, p. 160; Stanton & Meyer, p. 212)

- a. Relative to youths in control conditions, those who received cognitive and behavioral skills training showed (a) greater improvements on instrumental outcomes (e.g., social problem-solving measures), (b) modest changes in behavioral problems, and (c) no difference in aggressive behavior outside the institution at a 24-month follow-up. (Broduin & Schaeffer, p. 160)
- b. Based on research findings, reviewers have noted that the effectiveness of cognitive-behavior skills training and moral reasoning have not been demonstrated with samples of serious adolescent offenders, such as violent offenders. (Borduin & Schaeffer, p.160)
- c. Although cognitive-behavioral treatment programs have been moderately effective, treatment gains appear to be more promising in those programs that combine a strong environmental (ecological) approach with cognitive-behavioral training, individualized contacts, and family therapy. (Stanton & Meyer, p. 213)

2. Social System Treatment Interventions

a. Peer Group Interventions.

- (1) Guided-group interaction (GGI) and its derivatives (e.g., positive peer culture, peer group counseling, and peer culture development) have been widely used in school and residential settings to prevent or decrease delinquent behavior. (Stanton & Meyer, p. 214) Unfortunately, GGI approaches have proliferated in spite of little support for their effectiveness. (Borduin & Schaffer, p. 161) In fact, group association with other delinquents may exacerbate their problems.
- (2) These programs have been ineffective probably because they work primarily with artificially-created peer groups rather than the offenders' actual friendship network. (Henggeler, 1989)
- (3) Broad-based interventions that emphasize change in adolescents' natural environment, including peer relations in community, have been shown to be more effective -- namely, the context of each child's life-experiences must be a part of treatment. (Stanton & Meyer, p. 214)

b. Restitution and Meditation

- (1) Restitution is a community-based treatment approach that requires the juvenile offender to pay the victim directly to compensate his/her loss, perform a useful service to the victim, and/or perform a comparable amount of public service. In addition, mediation between the offender and the victim can be a component of the restitution program.

- (2) Research shows that restitution may have a small but important impact on recidivism. In two of four studies, the juveniles in restitution programs had fewer recontacts with the court during a 2-3 year follow-up. The study concluded that the mechanism of the positive effect might be attributed to processes such as reduced stigmatization, greater understanding of the effects of the crime on the victim, deterrence, and more intense supervision.
- (3) However, restitution alone has not proven to be an effective treatment -- it must be coupled with other modes of treatment to be successful. (Stanton & Meyer, pp. 214-215) Example: The New Mexico Center for Dispute Resolution has developed a service continuum of mediation and conflict resolution programs for children, youth, and family. This program has demonstrated that mediation and resolution interventions can be effective in responding to *some* needs of at-risk juveniles and their families. The underlying goal of the program is to equip youth and their families with basic communication and conflict resolution skills; model alternatives to violence; and improve youth functioning in the environments of home, school, and community. (Stanton & Meyer, p. 215)

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APPENDIX A
Research on the Relationship
Between the Accumulation of Risk Factors and Violence

1. A 1991 study, conducted by psychologist Paul Zagar et al., found that a boy's chances of committing murder are twice as high if he has the four following risk factors:
 - a. He comes from a family with a history of criminal violence.
 - b. He has a history of being abused.
 - c. He belongs to a gang.
 - d. He abuses alcohol or drugs.

The same study by Zagar showed that the odds a boy commits murder triple when, in addition to the aforementioned risk factors, the following also apply:

- e. He uses a weapon.
 - f. He has been arrested.
 - g. He has a neurological problem that impairs thinking and feeling (i.e., the development of cognitive and emotional processing).
 - h. He has difficulties at school and has a poor attendance record.
- (Garbarino, p. 10)

2. There is a link between risk accumulation, intellectual development, and resilience (the ability to bounce back from highly stressful or traumatic situations). Sameroff has investigated the impact of risk accumulation – including poverty, abusive parent, mental illness, substance abuse problem, absent parent, neglect, low educational attainment, and large family size -- on intellectual development.
 - a. His research showed the following on the relationship of risk factors and IQ:
 - i. Average IQ of an adolescent with no risk factors: 119
 - ii. Average IQ of an adolescent with 1 risk factor: 116
 - iii. Average IQ of an adolescent with 2 risk factors: 113
 - iv. Average IQ of an adolescent with 4 or more: 93.
 - b. The same study also found that having at least average level of intellectual functioning is a predictor of resilience.
3. Research shows that the presence of three (3) or more risk factors increases the chances a child's emotional and cognitive defense mechanisms will be overwhelmed. As "threats accumulate without a parallel accumulation of compensatory 'opportunity' factors a child becomes emotionally and cognitively overwhelmed." (Garbarino, p. 75-6)

APPENDIX B

Selection Criteria for Blueprint Programs

This set of selection criteria establishes a very high standard—one that proved difficult to meet. But this standard reflects the level of confidence needed to build a violence prevention initiative, for the objective is to allow communities to implement these programs with confidence that they will be effective in deterring violence if they are implemented with integrity. Not all of the ten programs selected meet all of the four individual standards, but as a group they come the closest to meeting these standards that the Blueprints project could find. With one exception, they have all demonstrated deterrent effects with experimental evaluation designs using random assignment to experimental and control groups (the Bullying Prevention Program involved a quasi-experimental design). All involve multiple sites and thus have information on replications and implementation integrity, but not all replication sites have been evaluated as independent sites, i.e., the Big Brothers Big Sisters program was implemented at eight sites, but the evaluation was a single aggregated evaluation involving all eight sites. With one exception, all selected programs have demonstrated sustained effects for at least one year post-treatment.

1. **Strong Research Design.** Experimental designs with random assignment provide the greatest level of confidence in evaluation findings, and this is the type of design required to fully meet this standard. Two other design elements are also considered essential for the judgment that the evaluation employed a strong research design: low rates of participant attrition and adequate measurement. Attrition may be indicative of problems in program implementation; it can compromise the integrity of the randomization process and the claim of experimental-control group equivalence. Measurement issues include the reliability and validity of study measures, including the outcome measure, and the quality, consistency, and timing of their administration to program participants.
2. **Evidence of Significant Prevention or Deterrent Effects.** This is an obvious minimal criterion for claiming program effectiveness. Relatively few programs have demonstrated effectiveness in reducing the onset, prevalence or individual offending rates of violent behavior. We have accepted evidence of deterrent effects for delinquency, drug use, and/or violence as evidence of program effectiveness. We also accepted program evaluations using arrests as the outcome measure. Evidence for a deterrent effect on violent behavior is certainly preferable, and programs demonstrating this effect will be given preference in selection, all other criteria being equal. However, this has not proved to be a determining factor in the selection of the first ten model Blueprint Programs. Both primary and secondary prevention effects, i.e., reductions in the *onset* of violence, delinquency or drug use compared to control groups and pre-post reductions in these *offending rates* compared to control groups meet this criteria. Demonstrated changes in the targeted risk and protective factors, in the absence of any evidence of changes in delinquency, drug use or violence was not considered adequate to meet this criterion.
3. **Multiple Site Replication.** Replication is an important element in establishing program effectiveness. It establishes the robustness of the program and its prevention effects and its exportability to new sites. This criterion is particularly relevant for selecting model programs for a national prevention initiative where it is no longer possible for a single

program designer to maintain personal control over the implementation of his or her program. Adequate procedures for monitoring the integrity of implementation must be in place, and this can be established only through actual experience with replications.

4. **Sustained Effects.** A number of programs have demonstrated initial success in deterring delinquency, drug use, and violence during the course of treatment or over the period during which the intervention was being delivered and reinforcements controlled. This selection criterion requires that these short-term effects be sustained beyond treatment or participation in the designed intervention. For example, if a preschool program designed to offset the effects of poverty on school performance (which in turn effects school bonding, present and future opportunities, and later peer group choice/selection, which in turn predicts delinquency, drug use and violence) demonstrates its effectiveness when children start school, but these effects are quickly lost during the first two to three years of school, there is little reason to expect this program will prevent the onset of violence during the junior or senior high school years when the risk of onset is at its peak. Unfortunately, there is clear evidence that the deterrent effects of most programs deteriorate quickly once youth leave the program and return to their original neighborhoods, families, and peer groups (e.g., gangs).

APPENDIX C

Contact information for Blueprint and Promising Programs

FUNCTIONAL FAMILY THERAPY

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Department of Psychology
University of Utah
390 S 1530 E, Room 502
Salt Lake City, UT 84112
(801) 581-6538 Office

Kathleen Shafer, Project Coordinator
(801) 585-1807

MULTISYSTEMIC THERAPY

For information on research related questions: Scott W. Henggeler, Ph.D.
Family Services Research Center
Department of Psychiatry & Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue, Annex III
Charleston, SC 29425-0742
(843) 876-1800

For information on training related questions: Keller Strother
MST Inc.
268 West Coleman Blvd, Suite 2E
Mount Pleasant, SC 29464
(803) 856-8226 x11

URL: www.mstservices.org
E-mail: mst@sprintmail.com

MULTIDIMENSIONAL TREATMENT FOSTER CARE

Patricia Chamberlain, Ph. D., Clinic Director
Oregon Social Learning Center
160 E 4th Street
Eugene, OR 97401
(541) 485-2711

URL: www.oslc.org/tfc/tfcosl.html

INTENSIVE PROTECTIVE SUPERVISION PROJECT

Kathy Dudley, Juvenile Services Division
Administrative Offices of the Courts
P.O. Box 2448
Raleigh, NC 27602
(919) 662-4738

You may also contact the Blueprint website at <http://www.colorado.edu/cspv/blueprints>

APPENDIX D

Order form for Blueprints for Violence Prevention Video

APPENDIX E

Overhead

Mean Gains in Self-Reported Delinquency Frequency Scores by Levels of Family and School Bonding and Delinquent or Prosocial Friends

APPENDIX F
Overhead

Lifestyle Violent Offender Types

APPENDIX G
Overhead

Onset of Serious Violent DLQ

APPENDIX H
Overhead

Prevalence of Serious Violence

APPENDIX I

Asset List from Search Institute

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EXTERNAL ASSETS

Support

Family support

Family life provides high levels of love and support.

Positive family communication

Young person and his/her parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s).

Other adult relationships

Young person receives support from three or more non-parent adults.

Caring neighborhood

Young person experiences caring neighbors.

Caring school climate

School provides a caring, encouraging environment.

Parent involvement in schooling

Parent(s) are actively involved in helping young person succeed in school.

Empowerment

Community values youth

Young person perceives that adults in the community value youth.

Youth as resources

Young people are given useful roles in the community.

Service to others

Young person serves in the community one hour or more per week.

Safety

Young person feels safe at home, at school, and in the neighborhood.

EXTERNAL ASSETS

Boundaries and Expectations

Family boundaries

Family has clear rules and consequences, and monitors the young person's whereabouts.

School boundaries

School provides clear rules and consequences.

Neighborhood boundaries

Neighbors take responsibility for monitoring young people's behavior.

Adult role models

Parent(s) and other adults model positive, responsible behavior.

Positive peer influence

Young person's best friends model responsible behavior.

High expectations

Both parent(s) and teachers encourage the young person to do well.

Constructive Use of Time

Creative activities

Young person spends three or more hours per week in lessons or practice in music, theater or other arts.

Youth programs

Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.

Religious community

Young person spends one hour or more per week in activities in a religious institution.

Time at home

Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

Commitment to Learning

Achievement motivation

Young person is motivated to do well in school.

School engagement

Young person is actively engaged in learning.

Homework

Young person reports doing at least one hour of homework every school day.

Bonding to school

Young person cares about his/her school.

Reading for pleasure

Young person reads for pleasure three or more hours per week.

Positive Values

Caring

Young person places high value on helping other people.

Equality and justice

Young person places high value on promoting equality and reducing hunger and poverty.

Integrity

Young person acts on convictions and stands up for his/her beliefs.

Honesty

Young person tells the truth even when it is not easy.

Responsibility

Young person accepts and takes personal responsibility.

Restraint

Young person believes it is important not to be sexually active or to use alcohol or other drugs.

INTERNAL ASSETS

Social Competencies

Planning and decision-making

Young person knows how to plan ahead and make choices.

Interpersonal competence

Young person has empathy, sensitivity, and friendship skills.

Cultural competence

Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.

Resistance skills

Young person can resist negative peer pressure and dangerous situations.

Peaceful conflict resolution

Young person seeks to resolve conflict non-violently.

Positive Identity

Personal power

Young person feels s/he has control over things that happen to him/her.

Self-esteem

Young person reports having a high self-esteem.

Sense of purpose

Young person reports that "my life has a purpose."

Positive view of personal future

Young person is optimistic about his/her personal future.

*SPECIAL ED KIDS
IN THE JUSTICE SYSTEM:*
How to Recognize and Treat
Young People with Disabilities
That Compromise Their Ability to
Comprehend, Learn, and Behave

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Lourdes M. Rosado, Editor

AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

ABA JUVENILE JUSTICE CENTER/NATIONAL JUVENILE DEFENDER CENTER
740 15th Street, NW, Washington, DC 20005
202-662-1515 - Fax: 202-662-1501

E-mail: juvjus@abanet.org - Website: www.abanet.org/crimjust/juvjus

JUVENILE LAW CENTER

Juvenile Law Center is a non-profit public interest law firm that advances the rights and well being of children in jeopardy. Founded in 1975, JLC is one of the oldest legal services firms for children in the United States. JLC uses a range of strategies -- including individual advocacy, reform of state and national law and policy, and training of public defenders and lawyers for children -- to improve the juvenile justice and child welfare systems. The children we serve include abused or neglected children placed in foster homes, delinquent youth sent to residential treatment facilities or adult prisons, and children in placement with specialized health and education needs. JLC works to ensure that children and youth are not harmed by -- but instead receive appropriate care from -- the systems that are supposed to help them.

JUVENILE LAW CENTER
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Website: www.jlc.org

YOUTH LAW CENTER

Youth Law Center is the leading national legal advocacy program working on juvenile justice issues. For the past 22 years, YLC staff have worked with defense attorneys, prosecutors, judges, and probation officials in virtually every state throughout the nation. In addition to authoring a major text, *Representing the Child Client*, and more than two dozen articles, book chapters, and other publications on the representation of minors, YLC staff have conducted literally hundreds of trainings and presentations throughout the country on delinquency-related matters, conditions of confinement, liability, alternatives to detention, and coordination of services.

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*SPECIAL ED KIDS
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How to Recognize and Treat
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This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM
June 2000

Preface

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*

Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

- Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*
- Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*
- Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*
- Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a “tool kit” containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can be assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer – is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

Executive Summary

The goal of Module Five is for participants to learn how to identify and help children in the juvenile justice system with disabilities that affect their ability to comprehend, learn, and behave appropriately. Children who are learning disabled, severely emotionally disturbed, suffer from Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, or are developmentally delayed may be at greater risk for delinquent behavior as a result of their disabling conditions. Studies, in fact, have shown that there is a high prevalence of such disabilities among the youth who come into contact with the juvenile courts. As a result, juvenile court professionals often make critical decisions regarding how the justice system will respond when a special education child offends. Moreover, juvenile court personnel regularly face the challenge of securing an appropriate education for children with special needs in the justice system.

In this Module, participants will learn:

- ! The learning/behavioral/emotional disabilities that are most prevalent among youth in the juvenile justice system.
- ! How to determine if a child has such a disability by using diagnostic tools and checklists introduced in the Module.
- ! The relationship between disabling conditions and delinquency, including the specific attributes of special education children that may predispose them to delinquent behavior.
- ! The federal legal entitlements of children to special education, including:
 - the nuts and bolts of the referral, evaluation, and Individualized Education Plan (IEP) development process under the Individuals with Disabilities Education Act (IDEA).
 - due process rights and proceedings mandated by IDEA.
 - disciplinary actions under the IDEA when special education children get into trouble at school, including the rules for disciplinary exclusions.
 - Children's right to education when they are involved in the juvenile and adult criminal justice systems.

In addition, participants will experience first hand what it is like to be a learning disabled child by engaging in a series of unique simulation exercises on visual perception, reading comprehension, visual-motor coordination, and oral expression. Participants will come to understand how children with learning disabilities often misinterpret both visual and audio cues, especially in stressful situations.

Table of Contents

I. Introduction	1
A. Goal of this module	1
B. Where in the juvenile justice system do we make decisions related to education and a child's disabilities?	1
II. Children in the Juvenile Justice System with Disabilities that Compromise Their Ability to Comprehend, Learn, and Behave in Socially-Acceptable Ways	2
A. Estimates of the incidence of learning disabilities among the juvenile offender population	2
B. Prevalence of children with disabilities in the juvenile justice system	2
C. Types of disabilities commonly found in children in the juvenile justice system	3
D. The Identification of Children with Disabilities	10
III. The Relationship Between Disabling Conditions and Delinquency	12
A. Susceptibility	12
B. School Failure/School Frustration	13
C. Differential Treatment	13
IV. Attributes of Special Ed Children that May Predispose Them to Delinquent Behavior	16
V. Overview of Law on the Right to Education Generally	19
A. Federal Law	19
B. State Law and State Constitution	19
VI. Overview of Federal Special Education Law: The Individuals with Disabilities Act	20
A. The Entitlement	20
B. What is a free and appropriate education (FAPE)?	21
C. Who is Disabled under IDEA?	22
VII. The Referral, Evaluation and IEP Development Process under IDEA	23
A. Referral Process	23
B. Evaluation Process	23
C. Developing an Individualized Education Program (IEP)	24
VIII. Legal Rights and Proceedings Under IDEA	26
A. Parental Rights	26
B. The Advocate's Role at a Due Process Hearing	29
IX. Disciplinary Actions under IDEA	32
A. Legal Obligations of the School	32
B. Suspensions (Short-Term Removal) Requirements	32
C. Expulsion Requirements	32
D. Exceptions to the General Expulsion Rules	33
E. Due Process Rights in School Disciplinary Exclusions	35

X. Right to Education in the Juvenile and Criminal Justice Systems	39
A. Ensuring an appropriate education	39
B. Parental participation	40
C. Aftercare	41
D. Children in Adult Facilities	41
E. The Relevance of a Child's Special Education Status in Key Juvenile Court Decisions	42
 Bibliography	 45
 APPENDIX A	 A1
APPENDIX B	B1
APPENDIX C	C1
APPENDIX D	D1
APPENDIX E	E1
APPENDIX F	F1
APPENDIX G	G1
APPENDIX H	H1
APPENDIX I	I1
APPENDIX J	J1
APPENDIX K	K1
APPENDIX L	L1
APPENDIX M	M1
APPENDIX N	N1

I. Introduction

- A. **Goal of this module.** The goal of this module is for participants to learn:
1. How to identify children with disabilities that affect their ability to comprehend, learn, and behave in an appropriate manner;
 2. What it is like to be a child with such a disability;
 3. The possible relationship between these disabling conditions and delinquent behavior;
 4. The legal entitlements of children to special education, including when they get into trouble at school and when they are in state custody pursuant to a delinquency adjudication or criminal conviction; and
 5. How a better understanding of these disabilities can lead to better-informed decision-making in court.
- B. **Where in the juvenile justice system do we make decisions related to education and a child's disabilities?**
1. Whether the juvenile justice system should proceed with cases referred from a school, especially in instances where the child has some type of disability that may be related to his/her misbehavior.
 2. Whether to adjudicate delinquent a child who has diminished capacity due to a disability. Is a child with a disability "responsible" for his/her misbehavior, or is the misbehavior a manifestation of the disability?
 3. In disposition planning, how to teach accountability and community responsibility to a child with a disability that affects his/her ability to learn, comprehend and/or behave.
 4. At disposition review hearings, how to evaluate the quality of education being delivered to adjudicated children in out-of-home placements, i.e., residential treatment facilities, state training schools.
 5. In discharge planning, how to place children back in schools in the community after they are discharged from court-ordered placements, when the schools themselves put up improper barriers to their enrollment.
 6. At a disposition review or probation revocation hearing, how to evaluate whether a child has committed a probation violation by not going to school, when there is a question of whether the child is appropriately placed and the school does not meet the child's needs.
 7. Whether judges and prosecutors should take into account what type of education would be available to a given child in an adult jail and/or prison in deciding whether to transfer/direct file a child to adult court.

II. **Children in the Juvenile Justice System with Disabilities that Compromise Their Ability to Comprehend, Learn, and Behave in Socially-Acceptable Ways**

A. **Estimates of the incidence of learning disabilities among the juvenile offender population** vary based upon the definitional criteria used and the type of assessment instrument employed.

1. Studies that adhere strictly to federal standards for learning disabilities tend to find lower rates of learning disabled children among juvenile offenders as compared to studies that base disability qualification simply on observed academic lags (sharp discrepancy between intelligence (normal) and standardized test performance (sub-normal/radically inconsistent)).
2. Direct assessment reveals substantially higher rates of learning disabilities than survey research and file reviews.
3. Estimates from professional associations exceed the findings of research studies.

B. **Statistics on the prevalence of children with disabilities in the juvenile justice system** (as compared to the population as a whole) *(Note to trainer: trainer should show as overhead chart attached as Appendix L):*

1. **General Population:** a recent statistical compilation estimates that 2-5% of all public school students in the United States are Severely Emotionally Disturbed (SED), 5% are Learning Disabled (LD), 1-2% are Mentally Retarded (MR), and 3-5% have an Attention Deficit/Attention Deficit Hyperactivity Disorder (ADD/ADHD). Between 7-12% of the school age population is believed to have some sort of educational disability.
2. **Juvenile Delinquents:** 28-46% of the juvenile offender population has an educational disability. Within that group, 9-42% are LD; 16-50% are SED; and 3-30% are MR. There are no applicable statistics to show the incidence of ADD/ADHD among this population.
3. **Incarcerated Juvenile Delinquents:** 28-60% of the incarcerated juvenile offender population has an educational disability. Within that group, 11% are LD; 20% are SED; 18% have some kind of ADD/ADHD; and 3-10% are MR.
4. **Arrest Rates:** It is estimated that 18% of the mentally retarded, 31% of the learning disabled, and 57% of the emotionally disturbed will be arrested within five years of leaving high school.
5. **Victims of Crime:** the disabled are far more often the victims of crime than the perpetrators, particularly among the developmentally disabled

population, of whom 75-90% are estimated to have been the victims of sexual or physical abuse at the hands of care givers and others.

- C. **Overview of the types of disabilities commonly found in children in the juvenile justice system.** Note to trainer: citations to the relevant sections of the Individuals with Disabilities Education Act, 20 U.S.C. § 1401 et seq, and/or accompanying regulations, 34 C.F.R. Part 300, are provided below.

1. **Learning Disabled (LD).** See 20 U.S.C. § 1401(26); 34 C.F.R. § 300.7(c)(10).
 - a. LD is a disorder in children of average or above average intelligence that affects one or more of the basic psychological processes involved in understanding or using language and manifests itself as difficulties in listening, thinking, speaking, reading, writing, spelling, and the ability to do math.
 - b. Learning disorders are diagnosed when the individual's achievement on standardized tests in reading, math, or written expression fall substantially below that expected for that child's age, schooling level, and normal intelligence.
 - c. Types of LD disorders:
 - (1) Perceptual disabilities
 - (2) Brain injury
 - (3) Minimal brain dysfunction
 - (4) Dyslexia
 - (5) Developmental asphasia (an inability to acquire language normally that cannot be attributed to a specific factor, i.e., mental retardation, sensory disorder, neurological damage, emotional problems, or environmental deprivation)
2. **Seriously Emotionally Disturbed (SED).** See 34 C.F.R. § 300.7(c)(4). SED is a condition exhibited by one or more of the following characteristics over a long period of time and to a marked degree that adversely affects the child's educational performance:
 - a. An inability to learn that is not attributable to intellectual, sensory or health factors;
 - b. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
 - c. Inappropriate types of behavior or feelings under normal circumstances;
 - d. Pervasive, chronic unhappiness or depression;

- e. Tendency to develop physical symptoms or fears associated with personal or school problems.

Note: SED does not include children who are simply socially maladjusted, although distinguishing such children from those with severe emotional disturbance is difficult in practice. The term includes children with schizophrenia.

3. **Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).** See 34 C.F.R. § 300.7(c)(9).

- a. ADD/ADHD is an educational handicap caused by substantial inability to pay attention, impulsivity (making a series of unpremeditated decisions with poor outcomes), distractibility, and/or hyperactivity that interferes with developmentally appropriate social or academic functioning.

- b. Diagnostic criteria.

(1) Child exhibits either (a) or (b) below:

- (a) six or more of the following symptoms of inattention have persisted for at least six months to a degree that is maladaptive and inconsistent with the normal developmental level of children that age:

- i) often fails to give close attention to details or makes careless mistakes in schoolwork or activities;
- ii) often has difficulty sustaining attention in tasks or play activities;
- iii) often does not seem to listen when spoken to directly;
- iv) often does not follow through on instructions and fails to finish chores, schoolwork (and this failure is not due to oppositional behavior or failure to understand instructions);
- v) often has difficulty organizing tasks and activities;
- vi) often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
- vii) often loses things necessary for tasks or activities (e.g., pencils, books, assignment sheets);
- viii) is often easily distracted by extraneous stimuli;

- ix) is often forgetful in daily activities.

AND/OR

- (b) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with the normal developmental level of children that age:
 - i) often fidgets with hands or feet or squirms in seat;
 - ii) often leaves seat in classroom or in other situations in which remaining seated is expected;
 - iii) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness);
 - iv) often has difficulty in playing or engaging in leisure activities quietly;
 - v) is often "on the go" or often acts as if "driven by a motor";
 - vi) often talks excessively;
 - vii) often blurts out answers before questions have been completed;
 - viii) often has difficulty awaiting turn;
 - ix) often interrupts or intrudes on others (e.g., butts into conversations or games).

AND

- (2) Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age seven; **AND**
 - (3) Some impairment from the symptoms is present in two or more settings (e.g., school, home); **AND**
 - (4) Clear evidence of clinically significant impairment in social or academic functioning; **AND**
 - (5) The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).
- c. ADD/ADHD are not separate disability categories under either federal or state law. Instead they are covered under the IDEA

“Other Health Impairments” provision in cases where the condition is a chronic or acute health problem that results in heightened alertness to environmental stimuli that, in turn, causes the child to have limited alertness with respect to the educational environment. See II.C.6 *infra*.

4. **Mental Retardation/Developmental Delay.** See 20 U.S.C. § 1401(3)(B), 34 C.F.R. §§ 300.7(b) and (c)(6), 300.313.
 - a. Mental retardation is a disability as a result of the interaction between the limitations in capability (intelligence and adaptive skills) and the demands of the environment.
 - b. Mental retardation/development delays are diagnosed when significantly sub-average general intellectual functioning (IQ of 75 or below) exists concurrently with deficits in two or more of the following adaptive skill areas:
 - (1) communication
 - (2) home living
 - (3) use of community resources
 - (4) health and safety
 - (5) leisure
 - (6) self-care
 - (7) social skills
 - (8) self-direction
 - (9) functional academics
 - (10) work
5. **Language and Speech Disorders.** See 34 C.F.R. § 300.7(c)(11). Language and speech disorders are defined by a difficulty in understanding or using spoken language resulting from one or more of the following:
 - a. articulation disorders
 - b. abnormal voice characterized by persistent, defective voice quality, pitch or loudness
 - c. fluency difficulties
 - d. inappropriate or inadequate acquisition, comprehension, or expression of spoken language
 - e. hearing loss.
6. **Other Health Impairments.** See 34 C.F.R. § 300.7(c)(9).
 - a. This is a catch-all category that covers children who have limited strength, vitality, or alertness due to chronic or acute health

problems, such as heart condition, tuberculosis, rheumatic fever, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, nephritis, or diabetes, that adversely affects the child's educational performance.

- b. In addition, children diagnosed with ADD/ADHD are classified, for the purposes of statutory entitlements to special education, as having "other health impairments."

Interactive Exercises: What is it like to be a Learning Disabled child?

*The following exercises are reproduced from the video "The F.A.T. (Frustration, Anxiety and Tension) City Workshop," Produced by Peter Rosen Productions Inc. for the Eagle Hill School Outreach Program, Greenwich, Connecticut
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Note: To be effective, these exercises must be conducted in an atmosphere of stress and tension. The trainer must be willing to intimidate the participants to a degree. Also, trainers are advised to conduct a number of these exercises at one sitting, to create a fatigue factor that will enhance the impact of the exercises. Trainers are greatly encouraged to view "The F.A.T. City Workshop" video prior to running the exercises themselves. To obtain a copy of "The F.A.T. City Workshop" video, please see the information attached as Appendix M.

Exercise #1 -- Experiencing the anxiety of being a LD child

The key to this exercise is for the trainer to give directions and ask questions very quickly, and respond with sarcasm, impatience, blame, etc., when people give incorrect answers or fail to respond.

The trainer should provide participants with the packet of materials that is attached at Appendix F. This packet contains pages of various colors with drawings of various animals, and minimal text. Trainer should then ask rapid-fire questions and give rapid-fire directions to the participants (i.e., turn to page three, what color is page three, what is the animal on page five, name me three stories that have that kind of animal in it, what does it say on the top of page seven, etc.). Trainer should engage in this rapid-fire questioning for at least five minutes, going around the room to engage as many participants as possible.

Exercise #2 -- Visual Perception

The purpose of this exercise is to clarify the distinction between vision and perception. In this exercise, the participants will be able to see the photo, but won't be able to give meaning to the photo until the trainer gives them cues to help them understand what they are seeing.

Trainer should give out copies of one of the photos attached as Appendix G. Trainer should give the participants approximately a minute to look at the photo, and then guess what is depicted in the photo. Trainer should then reveal what is in the photo.

Exercise #3 -- Reading Comprehension

Reading is traditionally taught through vocabulary comprehension. In other words, we teach children the words we think they don't know in a given piece of text, and then assume that if they know all the words they will understand the text. The purpose of this exercise is to demonstrate that reading comprehension is a much more complex process.

Trainer should first give out and/or put on an overhead projector the Table of Words attached at Appendix H. The trainer should ask participants if they've seen the words on the table, and if they know the meaning of the words. Next the trainer should give out and/or put on an overhead of Text #1, also attached at Appendix H. Ask if anyone in the room can explain the meaning of the text.

Then the trainer should give out and/or put on an overhead of Text #2, also attached at Appendix H. Trainer should then ask the following about Text #2: When did story take place? Who was Fligledobe with? Where were they? What were they "treppering"? What were they cleaning? What kind of "strezle" came along? What did the "strezle" do? Where did the "strezle" "boof"?

Although participants will recognize and know the meaning of all the words in Text #1, they will not be able to explain Text #1. Participants will be able to answer all of the trainer's questions regarding Text #2, but they will have no idea what the story is about.

Exercise #4 – Effect of Perception on Behavior

The purpose of this exercise is to demonstrate how children with Learning Disabilities can misperceive stimuli and, as a result, engage in unacceptable behavior, without even knowing that what they did was wrong.

Trainer should show drawing attached at Appendix I, entitled "Vanity." (The drawing appears to be that of a skull, but is in reality, upon a closer examination, of a woman looking at herself in the mirror.) Trainer should then ask participants to write down a title for the drawing, and then call on an individual to read out loud his/her answer. When the participant provides a title (which will be appropriate for a drawing of a skull), the trainer should berate the participant (i.e., what, do you think that's funny? Are you trying to be a smart aleck?) Trainer should then give participants a closer look at the drawing to demonstrate that it is, in fact, a drawing of a woman.

Exercise #5 – Visual-Motor Coordination

(Note to trainers: A mirror approximately the size of an 8 ½ x 11 sheet of paper, and tracing paper is needed for this exercise.)

The purpose of this exercise is to demonstrate how difficult the writing process is for many Learning Disabled children.

Trainer should ask for volunteer(s) from the audience, and provide the volunteer(s) with a copy of the fictional letter, "tedra," attached as Appendix J. The volunteer should place the sheet on top of a desk or table, with a piece of tracing paper on top of it. The volunteer should then place a mirror on the table so that it is perpendicular to the sheet of paper and thus reflects the fictional letter. Volunteer should then attempt to trace the letter by *only* looking at its reflection in the mirror.

Exercise #6 – Oral Expression

This exercise illustrates a problem – dysnomia – that many Learning Disabled children experience. Dysnomia is when you have the problem of finding the right word to express yourself. This happens to the average person a few times a day; this happens to a child with a learning disability hundreds of times a day.

Trainer should start off a round-robin story-telling exercise. Specifically, the trainer should pose the opening line of a story (i.e., the two boys decided that they wanted to go on a picnic). The trainer should then go around the room and have participants supply the next line of the story. The trainer should then conduct the same exercise, but this time instruct participants that they can not use any words containing the letter "n." The trainer should switch the prohibited letter every so often, so that participants will not be able to prepare their answers prior to their turn.

Exercise # 7 – Reading and Decoding

This exercise demonstrates the difficulty LD children often have in reading because of problems with spatial identification.

Trainer should show the figure attached at Appendix K (which could be a "d," "b," "q" or "p" depending on its orientation). Trainer should rotate the figure, and ask participants to identify the figure at each new spatial orientation. Trainer then should take off his/her watch and rotate it, similarly asking participants to identify the object at each orientation.

Up until the time we go to school, we learn that spatial orientation has nothing to do with object identification: a watch is a watch no matter which way you turn it. Then children are taught to read, and they learn that spatial orientation does, indeed, have a relationship to object identification. Many children with learning disabilities have problems with spatial orientation.

D. The Identification of Children with Disabilities**1. Development of the science of learning disabilities.**

- a. Pre-1900: the standard response to disabled people was to segregate them in institutions that provided few, if any, services.
- b. 1900-1950: scientific research on brain functioning, chromosomes, and human behavior/psychology promoted greater understanding of disabilities and spurred the development of specialized teaching methodologies.
- c. 1950-1970: specialized teaching methodologies proliferate; special education classes established in many public schools; efforts made to develop culturally unbiased tests to eliminate minority over-representation in special education classes; more disabled children included in regular classrooms.
- d. 1970-present: the era of "mainstreaming," in which children with special needs educated without segregation and stigmatization. The goal of mainstreaming is to identify children with educational disabilities, design and implement individualized education programs to compensate for those disabilities, and implement those programs, to the maximum extent possible, in the regular classroom.

2. Importance of identifying disabilities early on. Early detection of learning disabilities appears to be the determining factor in the degree of success to which learning disabled children are able to compensate for deficiencies in their ability to learn and develop intellectually. The earlier the disability is addressed, the faster the child receives the educational training and services appropriate to her special needs, the more likely the child will be to compensate successfully for his/her disability.

3. Legal obligation to identify disabilities in children. School districts and other agencies have an affirmative obligation under state and federal law (the so-called "Child Find" Requirement) to identify all children suspected of having a disability and refer them for an evaluation to determine eligibility for special education services, so that the child can obtain an Individual Education Program (IEP). See 20 U.S.C. § 1412(a)(3); 34 C.F.R. §§ 300.125, 300.300. We will be reviewing federal and state education special education law in more depth later in the module.

4. Diagnostic Tools for Identifying Disabilities: Learning Handicap Checklist. (Trainer should hand out checklist attached as Appendix A and explain how the checklist can be used as a diagnostic tool). Because a child's disabilities may not be readily apparent or documented, it is important that everyone in the juvenile court system who is involved in

handling the child's case be alert to the existence of possible educational disabilities. Probation officers interviewing the child at intake, attorneys appointed at the time of the initial court hearing, judges observing the child in court, and medical/psychiatric experts should incorporate questions about educational disabilities into their routine investigative work. To that end, those who work in the juvenile court should be familiar with the legal definitions of educational disabilities and the tests/checklists designed to ferret them out.

III. The Relationship Between Disabling Conditions and Delinquency²

- A. **Susceptibility.** (Note to trainer: trainer should show as overhead and/or distribute chart attached as Appendix C to illustrate susceptibility.)
1. There are certain variables inherent in learning and developmental disabilities that make an individual more susceptible to criminal involvement. Specifically, these disabilities predispose an individual to:
 - a. make poor decisions and social judgments that lead to involvement in crime;
 - b. have weak or no avoidance techniques that lead to detection and eventual arrest (i.e., they are more likely to get caught);
 - c. have social skill deficits that result in harsher treatment once in the justice system; and
 - d. have learning difficulties that almost ensure increased recidivism (i.e., it is more difficult for them to "learn their lesson" and reform their ways).
 2. The chart attached as Appendix C outlines several susceptibility variables, and, under each variable, lists typically observed difficulties that may account for increased juvenile justice involvement:
 - a. Reduced Cognitive Ability
 - (1) Lower average IQ
 - (2) Poor decision-making skills
 - (3) Increased probation violations and recidivism
 - b. Language Immaturity
 - (1) Reduced self-talk (i.e., guiding one's own actions through inner language)
 - (2) Deficient verbal mediation skills
 - (3) Need for outside coaching or direction
 - c. Developmental and Academic Lags

²For more information on the relationship between disabling conditions and delinquency, the trainer is referred to the following scholarly articles: Katherine A. Larson, *A Research Review and Alternative Hypothesis Explaining the Link Between Learning Disability and Delinquency*, 21 JOURNAL OF LEARNING DISABILITIES 289 (June/July 1988); Norman Brier, *The Relationship Between Learning Disabilities and Delinquency: A Review and Reappraisal*, 22 JOURNAL OF LEARNING DISABILITIES 546 (1989).

- (1) Immature/missing cognitive strategies
- (2) Information-processing deficits
- (3) Illiteracy and other skill deficits

d. Social Perception and Problem-Solving Deficits

- (1) Misinterpreted social cues
- (2) Reduced empathy and role-taking skills
- (3) Poor planning skills
- (4) Inability to generate adaptive solutions

e. Interpersonal Skills Deficits

- (1) Social abrasiveness
- (2) High suggestibility
- (3) Inattention, distractibility and impulsivity

B. **School failure/school frustration.** *(Note to trainer: trainer should show overhead attached as Appendix D to illustrate the relationship between school failure and delinquency.)*

1. A disabled child enters junior high or high school with poor skills that have not responded to educational intervention, which leads to poor grades and underachievement in school. The resulting embarrassment in front of peers and negative self-image causes the student to develop a high level of frustration with academic tasks, cut classes and seek out delinquent-prone peer groups to find acceptance, a social identity, and a sense of achievement lacking in the school setting. Finally, the student drops out of school altogether, joins a gang, commits delinquent acts, and enters the juvenile justice system.
2. Although clinical observation, school records, and tests of basic academic skills tend to support the School Failure Hypothesis, the evidence derived from academic studies does not support a direct causal relationship between academic underachievement and delinquency in learning disabled youth. (Larson 1988). One well-known educator of LD youth explained the significance of the School Failure Hypothesis as "tell[ing] the story of frustration that many disabled teens feel in the peer group. Some of these youngsters will do almost anything to make up for their shortcomings and earn the respect of their peers. Thus many disabled students assume mascot status, especially in youth gangs, where they are used as "go-fers" or scapegoats." (Cowardin 1998).

C. **Differential treatment.** Studies support the claim that, when the treatment of disabled children in the juvenile system is compared with the treatment of similarly situated non-disabled children, those with disabilities are subject to harsher treatment at arrest, adjudication and disposition as compared to that of their non-disabled peers. The statistics below are provided by the National Center for State Courts and Nancy Cowardin.

1. At Arrest.
 - a. The Statistics: Learning disabled youth are 200% more likely to be arrested than nondisabled youth for comparable delinquent activity.
 - b. Possible reasons:
 - (1) Lack of avoidance/nondetection strategies
 - (2) Used as scapegoats by peer groups
 - (3) Act defiantly, uncooperatively or evasively
 - (4) Less adept at knowing how, when, and with whom to talk
 - (5) Failure of the system to perceive disabilities and respond to them

2. At Adjudication.
 - a. The Statistics: Adjudication has been found to be 220% more likely if the offender has a LD. Nonadjudicated youth averaged two years higher in school achievement than those adjudicated delinquent, despite similar backgrounds of offenses.
 - b. Possible reasons:
 - (1) Negative school history and continuing failure
 - (2) Reduced ability to comprehend legal proceedings
 - (3) Reduced ability to self-advocate
 - (4) Poor social presentation
 - (5) Failure of the system to perceive disabilities and respond to them

3. At Disposition.
 - a. The Statistics: despite similar records of prior offenses, once adjudicated delinquent, the term of incarceration and/or probation averaged 2-3 years longer for those with disabilities as compared to their nondisabled peers.
 - b. Possible reasons:
 - (1) Reduced ability to comprehend terms of probation and/or release document (*Note to trainers: attached at Appendix E is alternate wording for juvenile probation conditions that probation officers can use with LD children.*)
 - (2) Inability to comply with academic and other requirements named as terms for termination/release
 - (3) Behavior and interpersonal problems with staff and other students

- (4) Failure of system to understand and make allowances for cognitive differences

IV. **Summary of Attributes of Special Education Children that May Predispose Them to Delinquent Behavior**

*Reproduced from the CRIMINAL JUSTICE TRAINING WORKBOOK FOR IDENTIFYING AND ACCOMMODATING LEARNING AND DEVELOPMENTAL DISABILITIES, by Nancy Cowardin, Ph.D.
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- A. **External Locus of Control.** Many learning disabled individuals have a limited inner guidance system, depending instead on outside direction or relying on "luck". Without self-direction, they are easily lead by others into criminal activity.
- B. **Impulsivity.** This quality may result in making a series of quick, bad decisions. The individual does not take the time to think through and weigh the possible consequences of a proposed action, but simply "jumps in" using a "seat of the pants" mentality.
- C. **Poor Social Cognition/Perception.** The learning disabled individual may be unable to intuit people or actions which can lead him in to trouble. He is likely to trust the wrong people for the wrong reasons, and they in turn may use him as an accomplice, then leave him as a decoy when the police arrive.
- D. **Poor Planning Ability.** In contrast to impulsivity, this quality is evident even when a Learning Disabled individual has sufficient time to plan and think through a proposed action. However, even under these circumstances, he does not seem able to envision various logical consequences or outcomes, hold them in mind simultaneously, and plan steps to attain the best one. These individuals will often operate using a "half-plan" to obtain a nebulous goal. They do not take into account the various pitfalls which may arise, and have no alternative responses ready when things begin to go wrong.
- E. **Hyperactivity.** Hyperactivity is not only defined by high activity level, but also includes random and purposeless actions which seem beyond physical control. Imagine how a hyperactive youth or adult might act if handed a gun to hold in a tense situation. Without intending to, he could suddenly find himself arrested - very confused - for murder.
- F. **Poor Social Cognition.** Often the Learning Disabled individual does not intuit or grasp the precariousness of his actions or the magnitude of the predicament once apprehended. At the outset, he thinks he is invincible. Once caught, he shows no "presupposition", that is, he naively believes that any story he offers will be believed despite evidence to the contrary.
- G. **Poor Avoidance Techniques.** Some Learning Disabled individuals cannot avoid detection because social "tip-off" cues are not being received. The are often left literally "holding the bag" by peers who, sensing danger, have left the crime scene. Here, the disabled individual remains behind, confused and without an escape plan of his own.

- H. **Inability to Conceal Thoughts.** Many individuals with language-based disabilities need to speak aloud to organize themselves mentally. Since this practice would appear odd to others, they often become followers, relying on outside direction from a group leader. We might also encounter this sort of individual, before a planned crime, discussing his group's plans within earshot of school authorities.
- I. **Social Abrasiveness.** Many persons with Learning Disabilities resort to unacceptable verbal behavior when cornered. They do not have other strategies available to extricate themselves from unpleasant social situations, and instead offer sullen, defiant, or confrontive responses. Needless to say, this sort of behavior can result in police detention for minor as well as major offenses.
- J. **Deficient Language Processing Skills.** The police interview can pose additional problems for language disordered individuals which can result in formal charges. We have seen disabled suspects agree with facts and events which did not occur, provide misinformation to fill in memory gaps, and allow interviewers to manipulate, cajole and coerce confessions, leaving them upset and confused.
- K. **Illiteracy.** At arrest, poor and nonreaders are occasionally presented with written versions of the *Miranda* warnings and their own transcribed verbal statements and asked to sign them. We have found that, almost without exception, they will do so in an attempt to mask their deficiencies.

Interactive Exercise: Assessing the Culpability of Learning Disabled Youth Who Commit Offenses

Step One: Hand out the case profile of Bobby Carlisle attached at Appendix N and ask participants to read it to themselves.

Step Two: Pose the following questions for discussion:

- ! How would you assess Bobby's culpability (his intent) in the charged offense? What other information would you need to know before making this assessment?
- ! How would you compare Bobby's culpability to that of a child without Bobby's disabilities who committed a similar offense?
- ! How would an assessment of Bobby's cognitive abilities – i.e., his ability to make decisions and foresee the long-term consequences of his actions – impact your assessment of his culpability?
- ! How do you assess Bobby's dangerousness or level of risk to his family and community? Do you see Bobby's level of risk as a permanent condition, or do you think his level of risk could be reduced by interventions? What type of interventions might decrease his risk of re-offending?

- ! How, if at all, do you think Bobby's disability affects his ability to process and apply a value system (i.e., knowing what's right versus wrong) to his decisions?

V. **Overview of Law on the Right to Education Generally**

A. **Federal Law**

1. U.S. Supreme Court has held that the U.S. Constitution does not explicitly establish a right to education. *See, e.g., San Antonio Ind. Sch. Dist. V. Rodriguez*, 411 U.S. 1 (1973). Therefore the Court has never held that a state has an obligation to provide education.
2. Absence of an explicit constitutional right to education does not bar federal legislation creating such an entitlement. However, the U.S. Congress to date has not established such a right through legislation. Congress has passed statutes establishing equal access to education, such as the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq, which we will be discussing at length in this module.

B. **State Law and State Constitution**

1. Absent a federal constitutional or statutory right to education, the creation of the right to education depends on state constitutions and statutes.

(Note to trainer: at this point in the module, trainer should give a brief overview of the right to education as defined by his/her state constitution and/or statutes.)

VI. **Overview of Federal Special Education Law: The Individuals with Disabilities Act, 20 U.S.C. § 1400 et seq³**

(Note to trainer: trainer should weave into this part relevant state law and local practice.)

- A. **The Entitlement.** The Individuals with Disabilities Act (IDEA) entitles disabled children ages 3-21 to a free, appropriate public education (FAPE), which includes

³ This module focuses on the IDEA. However, the trainer should briefly mention two related anti-discrimination statutes which provide further protections to disabled students: Section 504 of the Rehabilitation Act of 1974 (29 U.S.C. § 794) (implementing regulations at 34 C.F.R. § 104 *et seq*), and the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-12134 (implementing regulations at 28 C.F.R. Part 35).

Section 504 is a general anti-discrimination law that states “no otherwise qualified individual with a disability shall . . . solely by reason of [that] disability, be excluded from any program or activity receiving Federal financial assistance.” Although most disabled students are covered under the IDEA, there are exceptions. For example, some ADD-diagnosed children do not fall under the IDEA’s “other health impairment provision” but can still receive special education and related services under Section 504. Sometimes a child is disabled under the IDEA, but does not need special education. For example, a child may have a purely physical disability that does not affect his/her ability to learn. In such cases, the child may still receive related services and accommodations (i.e., transportation, special seating in the classroom, etc.) under Section 504.

Section 504 and the ADA also provide rights to children in disciplinary exclusions. This is extremely important for disabled children who are not covered by IDEA because: (a) they do not have one of the specific disabilities listed in IDEA; (b) they are disabled but do not require special education; and/or (c) although they were IDEA-eligible, they were not identified, through no fault of the school district, prior to the disciplinary event in question. The protections afforded disabled students in disciplinary exclusions under Section 504 and the ADA, however, are significantly weaker than under the IDEA; most importantly, these statutes do not provide “stay put” protection or a right to education after suspension/expulsion for behavior that is not a manifestation of the child’s disability.

Section 504 and ADA also provide protection against disability discrimination in investigations of school misconduct. The manner in which school officials gather and use information when investigating allegations of disabled student misconduct may constitute impermissible disability discrimination under Section 504 and the ADA, which require school disciplinarians to take into account and accommodate the disabilities of accused students. For example, rapid-fire, repeated questioning may cause a child with cognitive disabilities to give confused and contradictory responses. If the student is subsequently deemed guilty of the charged offense on the basis of her “dishonesty” during questioning, then the student has been discriminated against on the basis of her disability.

For more information about the protections provided disabled students under Section 504 and the ADA, trainers should consult Joseph Tulman & Joyce A. McGee, *SPECIAL EDUCATION ADVOCACY UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) for Children in the Juvenile Delinquency System* (The University of the District of Columbia School of Law Juvenile Law Clinic, Washington, D.C., 1998.)

“special education,” “related services,” and “transition services” in the Least Restrictive Environment. See 20 U.S.C. § 1412.

- B. **What is a free and appropriate education (FAPE)?** A free and appropriate education includes the following components:
1. **Special education.** See 20 U.S.C. §§ 1401(8) and (25); 34 C.F.R. §§ 300.13, 300.26, 300.121 and 300.300. Specially designed academic programs tailored to meet the unique needs of disabled children that:
 - a. are provided at public expense;
 - b. meet state educational standards;
 - c. include an appropriate pre-school, elementary and secondary education; and
 - d. are provided in conformity with an Individualized Education Program (IEP).

 2. **Related Services.** See 20 U.S.C. § 1401(22); 34 C.F.R. § 300.24. In addition to special education services, federal law mandates that eligible children receive any other needed related services, defined as “transportation and such developmental, corrective, and other supportive services as may be required to assist a child with a disability to benefit from special education.” Related Services include but are not limited to the following:
 - a. speech-language pathology and audiology
 - b. psychological services
 - c. physical and occupational therapy
 - d. recreation and therapeutic activity
 - e. early identification and assessment of disabilities
 - f. counseling services, including rehabilitation counseling
 - g. orientation and mobility services
 - h. school health services
 - i. social work services in school
 - j. parent counseling and training
 - k. transportation
 - l. medical services for diagnostic and evaluation purposes.

 3. **Transition Services.** See 20 U.S.C. §§ 1401(30), 1414(d); 34 C.F.R. §§ 300.29, 300.47, and 300.348.
 - a. Transition Services are defined as a coordinated set of activities for a student that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult educational services, independent living and community participation.

- b. Pursuant to the 1997 IDEA Amendments, IEPs of a child aged 14 and older must include a statement of the transition services needs of the child that relate to that child's education.
 - c. IEPs of children 16 and older must integrate the full panoply of transition services, based upon the child's needs and taking into account the student's preferences and interests.
 - 4. **Least Restrictive Environment.** See 20 U.S.C. § 1412(a)(5); 34 C.F.R. §§ 300.130, 300.550-300.556. (Trainer should show overhead attached as Appendix B depicting the Cascade Model of Special Education Services.) LRE promotes the underlying goal of "mainstreaming" in selecting the optimal education placement for disabled children. The LRE requirement mandates that schools:
 - a. seek "to the maximum extent appropriate" to educate disabled children with children who are nondisabled; and
 - b. only remove children with disabilities from the regular classroom when the nature or severity of the disability is such that no other reasonable alternative exists.
- C. **Who is Disabled Under IDEA?** See 20 U.S.C. § 1401(3); 34 C.F.R. § 300.7. The following disabilities qualify a child for special education services under IDEA. (The asterisk * indicates disabilities that are most prevalent among children in the juvenile justice system):
 - 1. mental retardation/developmental delays*
 - 2. hearing impairments including deafness
 - 3. speech or language impairments
 - 4. visual impairments including blindness
 - 5. serious emotional disturbance*
 - 6. orthopedic impairments
 - 7. autism
 - 8. traumatic brain injury
 - 9. specific learning disabilities*
 - 10. multiple disabilities
 - 11. other health impairments, including ADD/ADHD* where the condition is a chronic or acute health problem that results in heightened alertness to environmental stimuli that, in turn, causes the child to have limited alertness with respect to the educational environment.

VII. **The Nuts and Bolts of the Referral, Evaluation and IEP Development Process under IDEA.**

(Note to trainer: in this part, trainers should alert participants to the relevant time lines in their jurisdiction if such time lines are not set by federal law.)

A. **Referral Process.** *(Note to trainer: trainer should discuss the referral process in his/her state as set out in state statute and/or regulation.)*

1. A child suspected of having a disability should be referred for an evaluation to determine if she is eligible for special education services.
2. Most jurisdictions require that the referral be in writing, and may be made by a teacher, parent, or other service provider.
3. The referral, delineating specific areas of concern, should be sent to the child's school principal or to the school district's special education office.
4. When the school district declines to conduct the requested evaluation, federal law requires that the school district send a notice to the child's parents informing them of their right to a due process hearing to challenge the decision. See 20 U.S.C. §§ 1415(b)(3); 34 C.F.R. § 300.503, 300.507.

B. **Evaluation Process.** See 20 U.S.C. §§ 1414(a)-(c); 34 C.F.R. § 300.126, 300.320-300.321, 300.530-300.543.

1. **The evaluation plan.** Within a set period of time (set by the state) of receiving the referral, the local education agency (trainer should name the LEA in their locality) must prepare a written evaluation plan explaining each type of assessment that the school plans to conduct. The parent then has a fixed period of time within which to send back a written consent to the assessments. For children who have already been assessed and determined eligible for special education services, a reassessment is required every three years.
2. **Who conducts the assessments?** An evaluation must be conducted by a "qualified person." For example, a health assessment should be completed by a credentialed and appropriately trained school nurse or physician. Similarly, a psychological evaluation must be completed by a credentialed school psychologist with appropriate training.
3. **The final product.** An evaluation is intended to be a comprehensive assessment of the child's functioning in all areas of potential concern relating to the suspected disability. The final product must be a written report containing the following information:

- a. a statement of whether the child needs special education services;
 - b. the basis for this determination;
 - c. relevant behavior noted during observation of child;
 - d. relationship of observed behavior to child's academic and social functioning;
 - e. educationally relevant health and development information, including any medical findings;
 - f. for children with learning disabilities, a statement as to whether the discrepancy between achievement and ability is so extreme as to be unremediable without special education services;
 - g. assessment of the effects of cultural, environmental or economic factors.
4. **Reevaluations.** Reevaluations must be conducted at the request of the child's parent or teacher. If not requested by the parent or teacher, they must be conducted at least once every three years.
- C. **Developing an Individualized Education Program (IEP).** See 20 U.S.C. §§ 1412(a)(4), 1414(d), 1436(d); 34 C.F.R. §§ 300.128, 300.340-300.350.
- 1. After a parent has sent back his/her written consent to the school district's proposed assessments, the school has a set period of time within which to conduct the assessments.
 - 2. If, after conducting the assessments, the child is found eligible for special education, the school has 30 days within which to conduct an IEP meeting.
 - 3. Using the information provided in the assessment, a special IEP team analyzes the child's needs and determines what must be done to meet those needs.
 - 4. **The IEP Team:**
 - a. **MUST** include:
 - (1) a representative of the local education agency who is familiar with area resources;
 - (2) the child's special education teacher;
 - (3) the child's regular education teacher;
 - (4) the parent;
 - (5) an individual who participated in the assessment and determined the child eligible for special education services; and
 - (6) the child, if the purpose of the meeting is to plan for transition services.
 - b. **MAY** also include:

- (1) the child;
 - (2) any one else, with the consent of the parent or school officials, with relevant knowledge or expertise. Such persons may include attorneys, probation officers, social workers, or case managers.
5. **The IEP format.** The IEP must be a written statement that includes the following information:
 - a. the pupil's present levels of educational performance;
 - b. measurable annual goals and short-term instructional objectives;
 - c. the special education instruction and related services needed (amount, frequency and setting for services);
 - d. the extent to which the child will not participate in regular educational programs with nondisabled children;
 - e. the date for the commencement of services and anticipated frequency, location, and duration of such services;
 - f. objective criteria and evaluation procedures for determining, on at least a yearly basis, whether the child's instructional goals are being met; and
 - g. a statement of how the parents will be informed of their child's progress.
6. The IEP must be reviewed, and if necessary revised, on at least an annual basis.

VIII. Legal Rights and Proceedings Under IDEA

A. Parental Rights Regarding the Child's Identification, Evaluation, and Placement.

1. **Definition of parent for purposes of special education law.** See 20 U.S.C. §§ 1401(19), 1415(b)(2); 34 C.F.R. §§ 300.20, 300.515.
 - a. A "parent" is legally defined to include a natural or adoptive parent, a guardian (but not the state if the child is a ward of the state), a person acting in the place of a parent (such as a grandparent or step-parent with whom the child lives, or a person who is legally responsible for the child's welfare), or a "surrogate parent."
 - b. A "surrogate parent" is legally defined as a person assigned by the state to act as the child's parent for purposes of special education services, in cases where the parent cannot be located or the child is a ward of the state. A state or school employee may not act as the child's surrogate parent.
2. **Records.** See 20 U.S.C. § 1415(b)(1); 34 C.F.R. §§ 300.501, 300.517. Parents have the right to inspect and review all education records with respect to the identification, evaluation, and educational placement of their child.
 - a. Such records include: attendance records, progress reports, truancy notices, suspension/expulsion notices, report cards, standardized test results, class schedules, evaluation referrals, evaluations, IEP's, and notices of placement.
 - b. Some states may also give the child access to educational records depending on the student's age and the type or severity of the child's disability. Students aged 18 and older have a statutory right to access their records.
3. **Independent Evaluation.** See 20 U.S.C. § 1415(b)(1); 34 C.F.R. § 300.502. If a child is tested by the school and found ineligible for special education, or is found eligible but the parents disagree with the specific test results, then the parents have the right to seek an independent evaluation at public expense, the results of which must be considered by the school in any educational placement decision for that child. The independent evaluation must meet the same standards used by the school in its own evaluations.
4. **Notice.** See 20 U.S.C. §§ 1415(b)(3), (b)(4), (c) and (d); 34 C.F.R. §§ 300.345, 300.501, 300.503-504.
 - a. Before a school either proposes to initiate or change or refuses to initiate or change the identification, evaluation, or educational

placement of a disabled student, it must provide written notice -- in the native language of the parents, if feasible -- within a "reasonable" period of time. Such notice must include:

- (1) a description of the action proposed or refused by the school;
 - (2) the basis for the school's decision;
 - (3) a justification for the rejection of alternative options;
 - (4) a description of the assessment techniques/tests and records used in reaching the decision; and
 - (5) any other relevant factors.
- b. When the school informs the parents of a referral for evaluation, reevaluation, an IEP meeting, or upon the filing of a complaint, the school must provide to the parents a "procedural safeguards notice," which includes a full description of:
- (1) the parents' rights regarding independent evaluations;
 - (2) prior notice;
 - (3) parental consent;
 - (4) access to records;
 - (5) how to file complaints and request a due process hearing, mediation or appeal;
 - (6) educational placement alternatives;
 - (7) civil actions and attorney's fees.
5. **Consent.** See 20 U.S.C. § 1414(a)(C); 34 C.F.R. § 300.505.
- a. Informed parental consent is required before a school conducts an initial evaluation, before a school provides special education and related services for the first time, and before the school conducts a reevaluation of the child. The exceptions are cases of reevaluation; parental consent for reevaluation is not required if the school can demonstrate that it took reasonable steps to obtain parental consent and the parents failed to respond.
 - b. The school may not use parental consent to one or more services to deny the provision of other services to which the parents have consented.
 - c. If the parent refuses to consent to an evaluation or reevaluation, and the school remains committed to conducting one, the school may seek mediation or a due process hearing to resolve the dispute, unless state law provides otherwise.
6. **Participation.** See 20 U.S.C. § 1415(b)(1); 34 C.F.R. §§ 300.345, 300.501, 300.552. Parents have the right to participate in meetings with respect to the identification, evaluation, and educational placement of their child.

7. **The “Stay Put” Provision.** See 20 U.S.C. §§ 1415(j) and (k); 34 C.F.R. § 300.514.
- a. If the parents dispute a school’s proposed placement or program, they have a statutory right to have their child remain in her current placement unless the school can reach an alternative resolution with the parents. Legally, the IDEA provision operates as an “automatic injunction” to prevent a school from initiating a change in a child’s placement over parental objections.
 - b. Not every change in educational placement triggers the “stay put” provision; instead, it is only those changes that result in a fundamental reworking of the student’s basic educational program that allow its invocation. Compare *Concerned Parents v. New York City Bd of Ed.*, 629 F.2d 751 (2d Cir. 1980) (holding that transfer of special education classes at one school to substantially similar classes at other schools in same district did not trigger “stay put” rule) with *Lunceford v. District of Columbia*, 745 F.2d 1577, 1582 (D.C. Cir. 1984) (holding that “stay put” is triggered by “a fundamental change in, or elimination of a basic element of the educational program”).
 - c. **Two major exceptions to the automatic “stay put” provision.** See Part IX.D *infra* for discussion.
 - (1) There are two major exceptions to the *automatic* injunction which prevents a school changing a child’s placement over the parent’s objections:
 - (a) School personnel may change the placement of a child who brings a weapon or illegal drugs into school; and
 - (b) A hearing officer may change a child’s placement on a finding that keeping the child in his/her current placement is substantially likely to result in injury to the child or others.
 - (2) *However, a parent can still trigger the stay-put provision by requesting a hearing or appealing the decision.*
8. **Due Process Rights.** See 20 U.S.C. § 1415; 34 C.F.R. §§ 300.506-511.
- a. **Right to a Hearing.**
 - (1) Parents challenging the identification, evaluation, or educational placement of their child or the provision of a free, appropriate public education to their child, are

entitled to a due process hearing before an impartial hearing officer.

(2) Pursuant to the 1997 Amendments to the IDEA, school districts must make mediation available -- at the state's expense -- as an alternative dispute resolution to identification, evaluation or educational placement challenges. However, mediation cannot be used to deny parents a due process hearing and it must be voluntary on the part of the parties.

(3) The child has no standing to demand a hearing, since federal law confers the right to a due process hearing only upon the parent. Thus an advocate for the child may not seek a due process hearing without the parent's cooperation.

b. **Right to Counsel.** Parents have the right to be accompanied and advised by counsel and by experts in the disability field at the hearing.

c. **Right to Confront.** Parents have the right to present evidence and to confront, cross-examine, and compel the attendance of witnesses.

d. **Right to Exclude Evidence.** Parents have the right to prohibit the introduction of evidence that has not been disclosed at least five working days before the hearing.

e. **Right to a Written Record.** Parents have the right to choose either a written or electronic verbatim version of the record, which includes findings of fact and the decision of the hearing officer.

f. **Burden of Proof.** The allocation of the burden of proof at due process hearings varies among jurisdictions. Some jurisdictions allocate the burden of production to the parent and the burden of persuasion to the school. Some jurisdictions assign both the burden of production and persuasion to the school, while other jurisdictions assign both burdens to the parent. Similarly, rules regarding evidence and witnesses vary by state.

g. **Right to Appeal/Bring Civil Action.** If the hearing is conducted by a local educational agency, the parent has the right to appeal to the state educational agency. The parent also has the right to bring a civil action in state or federal court.

B. **The Advocate's Role at a Due Process Hearing.**

1. **Pre-hearing preparation**

- a. **Identify the legal issues.** For each issue identified (inappropriate/untimely identification, inappropriate IEP, inappropriate placement), the child's advocate should make a complete record so that s/he can rely on specific documents and testimony as well as cite the relevant legal authority. Each issue should be tied to a claim for specific relief.
 - b. **Filing the complaint/Requesting a hearing.** Federal law requires that the complaint must state the child's name, address, school, fact-based description of the underlying problem, and a proposed resolution. Filing the complaint triggers the hearing.
 - c. **Preparing documents.** The child's advocate must obtain and analyze all of the student's records kept by the school. The child's advocate should document each contact with the school system by contemporaneous correspondence, so that every violation of the child's or parent's rights by the school is noted in a letter to the school. This correspondence serves as evidence that the school has failed the child, knew it was failing the child, and did nothing about it.
 - d. **Submitting documents.** All documents used in the hearing, as well as all evaluations and evaluation-based recommendations must be submitted to opposing counsel at least five business days before the hearing.
 - e. **Preparing witnesses.** The general rules of witness preparation apply to due process hearings. The child's advocate must discuss with the witness his/her planned testimony and prepare that witness for cross-examination. Whether or not the child testifies depends upon the specifics of the case and the child's willingness to do so. The child's advocate can also compel the attendance of school system employees to testify on behalf of the parent.
2. **At the Hearing**
 - a. **Arguing the case.** Although due process hearings are less formal than non-jury judicial proceedings, the procedures are very similar. At the opening of the hearing, the presiding official will make formal remarks as required by statute, at which time the parents may also be read their rights. Each party may then make an opening statement (the advocate's opening should state the legal basis for the parent's claim and the relief sought), which is following by the admission of documents, direct and cross-examination of witnesses (including expert witnesses), and finally, closing arguments. At the close of the hearing, the hearing officer may choose to leave the record open for receipt of briefs.
 3. **After the Hearing**

- a. **If the decision is favorable.** The decision of the hearing officer, if favorable, is not self-executing. The advocate should ensure that the decision is actually implemented by notifying the appropriate parties with a copy of the decision. If the school still refuses to comply with the decision, counsel can file a § 1983 claim to seek its enforcement by the courts.

- b. **If the decision is unfavorable.** The advocate must determine the merits of an appeal to the state education agency and/or filing a civil action in state or federal court.

IX. **When Special Ed Children Get into Trouble at School: Disciplinary Actions under IDEA.** See generally 20 U.S.C. § 1415; 34 C.F.R. §§ 300.121, 300.300, 300.519-529.

A. **Legal Obligations of the School**

1. **Schools must address child's problem behavior.** The 1997 amendments to IDEA require school personnel to address a disabled child's problem behavior as an educational matter by developing pro-active, interventionist strategies to help the child control his own behavior, rather than responding by simply removing or excluding the child from regular classroom activities.
2. **IEP modification upon suspension or expulsion for disciplinary reasons.** When a school does suspend a disabled child from school or otherwise removes him for disciplinary reasons, school personnel must conduct a behavioral assessment and develop a behavioral intervention plan. If such a plan already exists in the child's IEP, then the IEP team must review the plan and modify it as necessary to address the behavior that prompted the child's removal.

B. **Suspensions (Short-Term Removal) Requirements.** See 20 U.S.C. § 1415(k); 34 C.F.R. §§ 300.523-524.

1. **First-time suspensions.** Services need not be provided to the child, even if s/he is disabled, during the first 10 school days in that school year during which the child is suspended.
2. **Subsequent suspensions once first 10 days are up.** Subsequent short-term removals (not more than 10 days) are permissible as long as:
 - a. It is not a change in placement; and
 - b. Services are provided to allow the child to appropriately advance toward achieving the goals in the child's IEP.

C. **Expulsion Requirements.** See 20 U.S.C. § 1415(k); 34 C.F.R. §§ 300.523-524.

1. **The General Rule.**
 - a. No child with a disability can be expelled for conduct related to or deemed to be a manifestation of that disability.
 - b. A child can be expelled for conduct deemed not to be a manifestation of her disability.
 - c. The right to FAPE includes children with disabilities who have been suspended or expelled from school.

2. **The Procedure.** If the school seeks to remove a child for misconduct, including behavior related to weapons or drugs, the school must first follow this procedure.
 - a. Within 10 days of the school's decision to take action, the IEP team is responsible for determining whether the misconduct was related to, or a manifestation of, the child's disability. The child's parent must be given notice of the meeting and an opportunity to participate. This "manifestation determination" may be reached only after consideration of all of the relevant information, including diagnostic tests, evaluations, the IEP program, and input from the parents and the child.
 - b. The IEP team must find that the cited misbehavior was a manifestation of the child's disability if at least one of the following apply:
 - (1) in relation to the misbehavior, the child's IEP or placement was inappropriate; OR
 - (2) in relation to the behavior, special education services, supplementary aids and services, and behavior intervention strategies were not implemented consistently with the child's IEP or placement; OR
 - (3) the child's disability impaired his/her ability to understand the impact or consequences of the behavior; OR
 - (4) the child's disability impaired his/her ability to control the behavior.
 - c. If the team determines that the misconduct is not a manifestation of the child's disability, the school must then follow the disciplinary procedures applicable to non-disabled students. See Part IX.E *infra*.
 - d. If expelled, services must still be provided to the child to allow him/her to progress appropriately toward the IEP goals.
- D. **Exceptions to the General Expulsion Rules.** See 20 U.S.C. §§ 1415(j) and (k); 34 C.F.R. §§ 300.520-521. The 1997 Amendments to IDEA call for a different approach for students accused of engaging in behavior in school (1) involving weapons or drugs or (2) that is "dangerous," irregardless of whether the misconduct is a manifestation of the child's disability. This approach provides students with fewer rights and gives the school greater flexibility. But even if the child is excluded on one of these two bases, the IEP team must still meet to conduct a manifestation determination and to modify the child's IEP and behavioral management plan to address the problem behavior.

1. **Weapons and drugs.**
 - a. A school may place a disabled child in an “appropriate interim alternative educational setting” for the same amount of time as a non-disabled child (but not exceeding 45 days) if the child:
 - (1) “carries” certain dangerous weapons to school or to a school function; OR
 - (2) knowingly possesses or uses illegal drugs at school or a school function; OR
 - (3) attempts to sell a controlled substance at school or a school function.
 - b. In order to place the child in an alternative interim education setting on these grounds, however, the school must show that:
 - (1) keeping the child in the current placement is substantially likely to result in injury to the child or other children; AND
 - (2) reasonable efforts were made to minimize the risk of harm in the current placement, including the use of supplemental aids and services and these measures were not effective; AND
 - (2) the interim alternative educational placement meets statutory requirements, i.e., it will provide the child with the services needed to appropriately progress toward the goals in his/her IEP.
2. **Dangerous Behavior.** If school personnel wish to change a disabled child’s placement because of dangerous behavior that is a manifestation of that disability, and the parents dispute the school’s decision, the school may seek permission from a hearing officer to place the child in an alternative interim educational setting for up to 45 days. To grant the school’s request, the officer must find that:
 - a. the school system has demonstrated by more than a preponderance of the evidence that keeping the child in the current placement is substantially likely to result in injury to that child or others; AND
 - b. the school system has made reasonable efforts to minimize the risk of harm in the child’s current placement, including the use of supplementary aids and services; AND
 - c. the alternative interim educational setting meets statutory requirements.

- E. **Due Process Rights in School Disciplinary Exclusions.** See 20 U.S.C. § 1415(k); 34 C.F.R. §§ 300.519-529.

1. **Procedural Rights in Disciplinary Exclusion of Any Student.**

- a. The Supreme Court has held that the amount of due process required varies with:
- (1) the interest at stake;
 - (2) the risk of erroneous deprivation of that interest through the procedures used;
 - (3) the probable value of additional safeguards; and
 - (4) the government's interests, including additional fiscal and administrative burdens. See *Matthews v. Eldridge*, 424 U.S. 319, 333-35 (1976).
- b. Any student suspended for any amount of time is entitled, at a minimum, to:
- (1) some form of notice of the charges;
 - (2) an explanation of the evidence supporting the charges;
 - (3) an opportunity to be heard;
 - (4) an impartial decision-maker; and
 - (5) if the student admits to the misconduct, s/he must be afforded a hearing on the issue of penalty. See *Goss v. Lopez*, 419 U.S. 565 (1975).
- c. If the suspension is for more than 10 days, the Supreme Court has said that more process is due. However, the Court has not further delineated the amount of process due and lower courts have varied widely in their holdings regarding due process requirements for longer-term suspensions. Note to trainer: trainer should discuss what due process protections in school suspensions/expulsions are created by statute, case law and/or regulation in his/her jurisdiction.

2. **Procedural Rights of Special Ed Students in Disciplinary Exclusions.**

Under *Honig v. Doe*, 484 U.S. 305 (1988), exclusion of a special education student from her regular placement for more than 10 days triggers all the rights and procedures ordinarily attendant to placement changes under the IDEA. The 1997 amendments to IDEA and the 1999 changes in the federal regulations incorporate the *Honig* ruling. Thus, a special education student and his/her parent have a number of due process rights, including:

- a. **The right to notice.** The school must provide same-day notice to parents of any decision to change a child's placement for more than 10 days or expel her. Such notice must inform the parents of their procedural rights under the IDEA.

- b. **The right to file a complaint.**
 - c. **The right to have a due process hearing.** Parents can contest the expulsion by requesting a due process hearing. (Or, if the decision was made by a local hearing officer, the parents can appeal that hearing officer's decision to the state education agency.) They are entitled to an expedited hearing if (a) they disagree that the child's behavior was not a manifestation of her disability; or (b) if they disagree with any decision made in the disciplinary context.
 - d. **The right to remain in the current educational placement pending the resolution of administrative/judicial proceedings (the "stay put" provision).** See 34 C.F.R. § 300.524. The "stay put" provision still applies when there are challenges regarding manifestation determinations and disciplinary removals!
 - (1) However, the "stay put" provision is not automatic in disciplinary exclusions. The parent must trigger the "stay put" provision by requesting a hearing or filing an appeal to challenge the disciplinary exclusion.
 - (2) Once the parent has triggered the "stay put" provision, the school must obtain a court order to remove a child from her current placement over parental objection. This requires a showing that maintaining the current placement is substantially likely to result in the injury of that child or other children, despite reasonable efforts to minimize the risk of harm through supplementary aids and services.
3. **Education After Expulsion.** See 20 U.S.C. §§ 1415(k)(1), (2) and (3); 34 C.F.R. §§ 300.519-522.
- a. **Alternative interim placement.**
 - (1) While school officials are entitled to expel a disabled student for reasons unrelated to her disability, the state remains obligated to provide that student with a free and appropriate public education. This generally requires the school to place the child in an "alternative interim educational setting." An "alternative interim educational setting" is defined under federal law as an education environment that enables the child to participate in the general curriculum while continuing to receive the services set out in the IEP as well as any additional services required to address the behavior that triggered the removal from the initial placement.

- (2) In a weapon or drug case, the interim alternative educational setting is determined by the IEP team, which, by definition, includes the child's parents.
- (3) In cases of "dangerous" behavior, the hearing officer, who often acts on the school's recommendation, makes the determination.

b. **What happens following the expiration of an alternative interim placement.** See 20 U.S.C. § 1415(k)(7)(c). Once the interim alternative educational setting has expired, the student is entitled to return to her initial placement. The school can request an expedited hearing to change the child's placement because the child continues to pose a danger. (In expedited hearings, a decision must be mailed to the parties within 45 days of the agency's receipt of hearing request.) The hearing officer can grant the school's request and bypass the stay put requirement only if:

- (1) the school system has demonstrated by more than a preponderance of the evidence that keeping the child in the current placement is substantially likely to result in injury to that child and/or other children; AND
- (2) the school system has made reasonable efforts to minimize the risk of harm in the child's current placement, including the use of supplementary aids and services; AND
- (3) determines that the placement sought meets statutory requirements.

Interactive Exercise:

Trainer should pose the following questions for discussion:

- ! Has the juvenile justice system become a dumping ground for problem kids in the school system, who are mostly the mentally and emotionally challenged kids?
- ! Are there legal hooks (i.e., the provisions of IDEA that we just reviewed) to prevent dumping?
- ! How can the actors in the juvenile justice system use the law to prevent dumping?

- ! Have participants encountered special ed children who engaged in behavior in school that led to the school referring the child to the juvenile justice system?
- ! Did the school make a determination that the unacceptable behavior was/was not a manifestation of the child's disability?
- ! Did the school attempt to deal with the problem by modifying the child's IEP and/or behavior management plan? If not, did any of the court actors suggest this as a possible route for dealing with the problem behavior, as opposed to proceeding in the juvenile justice system?

X. **Right to Education in the Juvenile and Criminal Justice Systems**

A. **Ensuring that a special ed child involved with the juvenile justice system receives an appropriate education.**

1. Courts have long held that the IDEA requires that eligible children receive special education and related services regardless of their legal status or location. The 1999 amendments to the IDEA regulations specifically state that IDEA provisions apply to children in state and local juvenile and adult correctional facilities. See 34 C.F.R. § 300.2(b)(1)(iv). However, IDEA does carve out an exception for children ages 18-21 who are in adult prisons. See Part X.D. *infra*.
2. **School districts' obligations to educate children in the juvenile court system, and the overlapping responsibility of the juvenile court.** Under federal law, the state department of education and local educational agencies bear the ultimate responsibility for meeting the special education needs of children. At the same time, the juvenile court has the overlapping responsibilities of providing care, treatment, and rehabilitation to the children appearing before it according to state juvenile codes. While the allocation of responsibility as between these institutions is still somewhat confusing, the laws make clear that juvenile court professionals must work with the schools to ensure that the child's educational needs are appropriately met.

Interactive exercise:

Trainer should pose the following discussion questions:

- ! Has the juvenile court in your jurisdiction developed systemic procedures to address the special education needs of adjudicated youth?
- ! Are there any relevant state laws that set forth procedures for the court to follow when dealing with special education children?

(Note to trainer: trainer should be prepared to provide this information if audience does not proffer it.)

Example: in California, when a juvenile court commits an educationally disabled child to the state Youth Authority, that child cannot be placed in physical custody until the Youth Authority is furnished with a copy of the child's IEP. The juvenile court is further required to assure that the probation officer communicates with appropriate staff at the juvenile court school, county office of education, or special education local planning agency to facilitate this process. When referring a disabled child to any licensed children's institution, the court must notify the special education administrator that the child is eligible for special education.

- ! How do the juvenile court, probation and the schools in your jurisdiction work together, if at all, on providing an appropriate education to special education children involved in the juvenile justice system?
- ! How do these three agencies cooperate/fail to cooperate to ensure that a child meets the terms of his probation?
- ! Are there any interagency agreements or protocols (i.e., some jurisdiction are experimenting with school-based probation officers)?
- ! Is there a lack of systematic cooperation? If so, in what specific areas and what are your suggestions for improving the situation?

B. Parental participation in education decisions when child in detention or in court-ordered placement. The IDEA does not limit parental rights when children are in detention or court-ordered placement as a result of a juvenile delinquency case. Therefore, the parents should be given the same opportunities to participate in the assessment and IEP process.

1. Probation officers and the child's attorney should inquire of the parent about that child's special education needs or if there are any problems the child displays that are indicative of a disability. (Individuals can use some of the checklists provided during this training to determine if a child may have an undiagnosed special education need.) Probation officers and the child's attorney should obtain from the parent a copy of the child's most recent IEP, and provide this IEP to the facility.
2. Parents have a right to be involved in the development of a new IEP -- including participation in the IEP meeting -- while the child is in state custody. Juvenile court professionals involved in the case should facilitate the parent's involvement by arranging for transportation to the facility, or by setting up conference calls if the facility is far away.
3. Parents have the right to ask for a reevaluation of their child if they feel it is warranted.
4. Parents have the right to access their child's education records at the correctional facility.
5. Whether a parent retains the right to consent/decline specific education services for his/her child when the child is in court-ordered placement depends, in part, on whether legal custody of the child has been transferred to the state as part of the child's disposition.
 - a. If legal custody of the child has been transferred to the state, federal law requires that a "surrogate parent" be appointed by the school district; the "surrogate parent" will then have the authority to make special education decisions on behalf of the child. 20

U.S.C. § 1415(b)(2); 34 C.F.R. § 300.515. Federal law prohibits the appointment of a government agency or government employee as a "surrogate parent." In theory, the school district can appoint the child's parent to act as a "surrogate parent." The more difficult question to answer is whether and to what extent the parent can continue to exercise control over the child's special education program once the child is in the legal custody of a state and another adult has been appointed as "surrogate parent."

- b. If legal custody of the child has NOT been transferred to the state and is still with the child's parent, the parent should be able to continue making special education decisions. State statutes and local regulations may have some influence. (*Note to trainer: trainer should flag any relevant state statutes and regulations.*)
6. Whether parents have the right to challenge their child's exclusion from a facility school for disciplinary reasons is a difficult question to answer. Theoretically, they do, within the limits described in Part X.B.5 *supra*. Advocates can challenge a facility's decision to exclude a child from school on the grounds that the exclusion violates the goals of rehabilitation and treatment in that jurisdiction's juvenile act. Moreover, a disciplinary exclusion for behavior that is related to the child's disability may violate the Americans with Disabilities Act. *See, e.g., Pa. Dep't of Corrections v. Yeskey*, 524 U.S. 206 (1998) (holding that Title II of the ADA, prohibiting "public entity" from discriminating against "qualified individual with a disability" on account of that individual's disability, applied to inmates in state prisons).
- C. **Aftercare: Placing Children in Community Schools upon Their Release from Court-ordered Placements.** (*Note to trainer: trainer should be prepared to identify the procedures by which probation officers and/or defense counsel can re-enroll children in community schools upon their release from court-ordered placement.*)
 - D. **Children in Adult Facilities.** See 20 U.S.C. §§ 1412(a)(B), 1414(d)(6), 1416; 34 C.F.R. § 300.311.
 1. The 1997 Amendments to the IDEA circumscribe the state's obligation to provide special education and related services for children incarcerated in adult facilities. While the state is not relieved of its responsibility altogether, it has far greater leeway regarding the services it seeks fit to provide.
 2. Specifically, the 1997 Amendments authorize the states to exclude entirely from FAPE eligibility children 18-21 who are incarcerated in adult facilities if: (1) in the educational placement preceding incarceration, the child was not identified as disabled; or (2) the child did not have an IEP.

3. For children aged 18-21 in adult facilities, the states have no affirmative obligation to identify new disability cases within this age-bracket as disabled in order to provide such children with special services. Nor does the fact that a child was diagnosed as disabled at some point in the past guarantee her special education if she was not eligible at the time of incarceration.
4. The state must provide special education to 18-21 year old children deemed eligible at the time of incarceration if they also have a pre-existing IEP. BUT SEE #5 BELOW.
5. **The Withholding Formula.** Under the 1997 Amendments, states are permitted to deny the provision of all special education services to children incarcerated in adult facilities while incurring only a small financial penalty. The governor is permitted to shift the responsibility for meeting IDEA requirements from the state educational agency to another agency, most likely the Department of Corrections. If the state then decides to discontinue all special education services, the federal government may withhold state money only in the amount to which those children would otherwise be entitled according to their pro rata share, determined by the percentage of the overall educationally disabled population. (*Note to trainer: trainer should advise participants of the situation in his/her jurisdiction.*)
6. **Other Modifications under the 1997 Amendments.** If states do decide to continue providing special education services to children incarcerated in adult facilities, the states
 - a. do not need to ensure that these children have access to standardized statewide educational testing.
 - b. do not have to provide "transition services" to incarcerated children who will be older than 22 at the time of release from prison.
 - c. can change a child's IEP upon a showing of "a bona fide security or compelling pedagogical interest that cannot otherwise be accommodated."

Interactive exercise:

Trainer should pose the following question for discussion:

Should the lack of special education services in adult facilities influence the transfer/direct file decision?

E. The Relevance of a Child's Special Education Status in Key Juvenile Court Decisions

1. **Detention.** A child's special education status and history may be relevant to detention decisions. For example, if the child is enrolled in a special education program, it may be appropriate to argue that the child should remain in the community to avoid disrupting her receipt of services. One way to accomplish this while taking into account competing concerns such as safety or rehabilitation is to place disabled children under restrictive home supervision pending the outcome of the delinquency proceedings.
2. **Adjudication.** A child's special education status may be relevant to competency decisions (i.e., competence to stand trial, competence to waive constitutional rights). An entire separate module is devoted to competency issues, so it is not discussed at length here.

Interactive Exercise:

Trainer should pose the following question for discussion :

What difficulty, if any, do juvenile court professionals have in bringing up the child's special education needs at different points in court proceedings?
3. **Disposition.** Education may be the single most important service that the juvenile court, in its rehabilitative capacity, can offer delinquent children. If the child is adjudicated, a variety of sanctions and rehabilitative services may be provided. The court's order should dovetail with the assessment needs articulated in the child's IEP and other relevant evaluations. All participants in the juvenile court system bear collective responsibility for ensuring that dispositional placements take into account the child's special education needs. There should be a clear allocation of responsibility of completing the following tasks to accomplish this goal: interviewing the child and the parents, using educational/mental health experts, investigating educational services at potential placements, and coordinating juvenile court proceedings with the child's IEP team.

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APPENDIX A

**Diagnostic Tools for Identifying Disabilities: Learning Handicap Checklist
for Determining if a Child is Learning Disabled, Mentally Retarded/Developmentally
Delayed and/or has Attention Deficit Disorder**

*Reproduced from the CRIMINAL JUSTICE TRAINING WORKBOOK FOR IDENTIFYING
AND ACCOMMODATING LEARNING AND DEVELOPMENTAL DISABILITIES,
by Nancy Cowardin, Ph.D
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Diagnostic Tools for Identifying Disabilities: Learning Handicap Checklist

Academic Deficits (poor or failing school grades):

Does the child:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Have a record of poor to failing grades despite adequate elementary school attendance?	/	/	/
Not read or write well?	/	/	/
Have a history of special education classes?	/	/	/
Have a school record of low yearly achievement scores?	/	/	/
Have a "flat," sub-average academic profile (shows no areas of strength)?	/	/	/
Have a "spiky" profile (showing both high and low levels of skill across academic subjects)?	/	/	/

Intellectual Abilities (appears unintelligent or slow):

Does the child:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Lack general, age-appropriate information?	/	/	/
Have a history of late development in walking/talking?	/	/	/
Exhibit low IQ scores?	/	/	/

Attention Deficits (doesn't pay attention to what is said or what is going on):

Does the child:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Get easily distracted from task at hand?	/	/	/
Have trouble focusing/paying attention?	/	/	/
Have a high level of physical activity?	/	/	/
Have a need for constant redirection or prompting to complete tasks?	/	/	/
Exhibit self-stimulating behaviors while working, such as tapping, rocking, noise-making?	/	/	/
Take (or took at one time) Ritalin or Cylert?	/	/	/

Language Deficits (it is difficult to understand and/or communicate with the child):

Does the child:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Need constant restatement or simplification of questions and directions?	/	/	/
Have a limited vocabulary to express thoughts?	/	/	/

Talk a lot while making little sense?

' ' '

Lack correct labels for nouns/verbs, or use incorrect ones?

' '

PAGE 1 TOTALS

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Diagnostic Tools for Identifying Disabilities: Learning Handicap Checklist (continued)

Physical Disabilities:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Does the child have speech/articulation problems?	'	'	
Does the child have brain damage/head injury?	'	'	'
Did the mother take drugs during pregnancy?	'	'	'
Is the child a twin?	'	'	'
Was the child born prematurely and/or have a low birth weight?		'	
Are there family members with similar disabilities?	'		'
Is there a history of birth trauma/injury?	'	'	
Do medical records show chromosomal disorder?		'	

Adaptive Skill Deficits:

Does the child need assistance from others to do the following:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Communicate information?	'	'	'
Accomplish self-care tasks, i.e., grooming, hygiene, dressing?			'
Behave appropriately for his/her for age level?	'	'	'
Housekeeping and cooking?		'	
Find out about and use community resources?		'	
Make appropriate choices for self?		'	'
Maintain responsible health and safety practices?		'	
Apply academic skills to daily living?	'	'	
Engage in work/leisure activities?		'	

Social/Behavioral Deficits:

Does the child exhibit any of the following behaviors:

	<u>LD</u>	<u>MR</u>	<u>ADD</u>
Misinterprets facial expressions, social gestures, environmental cues?	'		
Impulsivity (i.e., rapid, poorly thought out decisions/actions)?	'		'
Difficulty planning and/or completing and executing plans?	'		'
Emotional mood swings?	'		'
A need for outside direction in a crisis?	'	'	'
Is used by peers as a scape-goat or "go-for"?	'	'	
Is easily led by others to get into trouble?	'	'	
A lack of confidence in decision making abilities?		'	
Feels (or is) unpopular, friendless, rejected by peers?	'	'	

PAGE 2 TOTALS

Special Education

LD MR ADD

PAGE 2 TOTALS

— — —

+

PAGE 1 TOTALS

— — —

LD MR ADD

FINAL TOTALS

— — —

Key:

LD: Learning Disabled

MR: Mental Retardation

ADD: Attention Deficit Disorder

LD MR ADD

,

,

,

Note: Clients may exhibit characteristics of more than one disability.

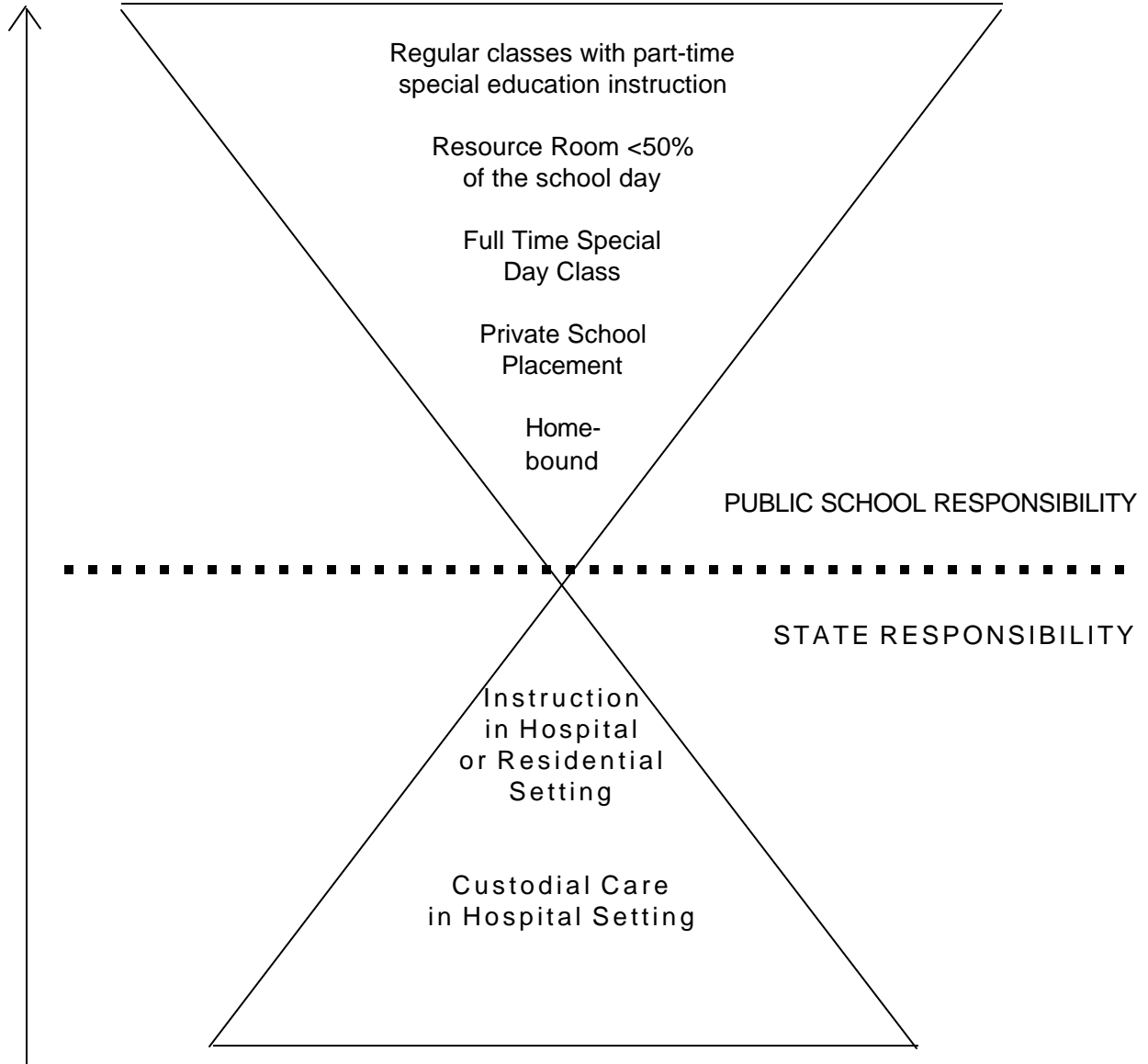
APPENDIX B

Overhead: Cascade Model of Special Education Services

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AND ACCOMMODATING LEARNING AND DEVELOPMENTAL DISABILITIES,
by Nancy Cowardin, Ph.D
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CASCADE MODEL OF SPECIAL EDUCATION SERVICES

L.R.E.



APPENDIX C

Overhead: Susceptibility Theory

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SUSCEPTIBILITY THEORY

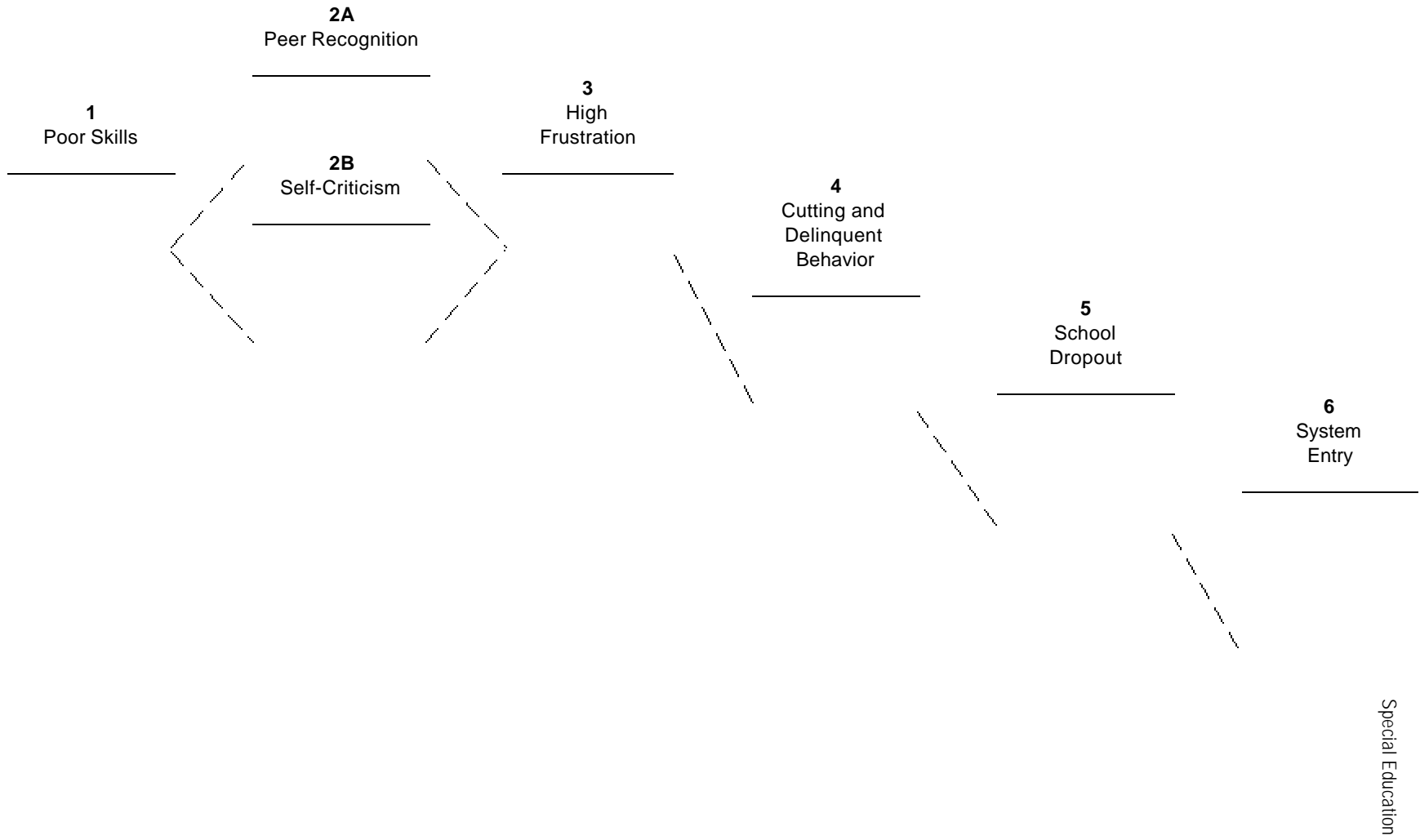
Reduced Cognitive Ability	Language Immaturity	Developmental and Academic Lags	Social Perception and Problem-Solving Deficits	Interpersonal Skill Deficits
Lower Average IQ	Reduced Self Talk	Immature/Missing Cognitive Strategies	Misinterpreted Social Cues	Social Abrasiveness
Poor Decision Making Skills	Deficient Verbal Mediation Skills	Information Processing Deficits	Reduced Empathy and Role-taking Skills	High Suggestibility
Increased Probation Violations and Recidivism	Need for Outside Coaching or Direction	Illiteracy and other Skill Deficits	Poor Planning Skills Inability to Generate Adaptive Solutions	Inattention, Distractibility, and Impulsivity

APPENDIX D

Overhead: School Failure/ School Frustration Theory

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SCHOOL FAILURE/SCHOOL FRUSTRATION THEORY



APPENDIX E

Alternate Wording for Standard Juvenile Probation Conditions

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ALTERNATE WORDING: Juvenile Conditions of Probation
 (Check Conditions Being Recommended)

1. ___ Obey the law. Do everything your Probation Officer (P.O.) says.
2. ___ Do what _____ says.
3. ___ Come to see your P.O. when she/he tells you to.
4. ___ Tell you P.O. if you move, change schools or jobs.
5. ___ Get a job.
6. ___ Don't _____.
7. ___ Don't leave home without permission.
8. ___ Work for _____ hours.
9. ___ Go to school and get good grades. Tell your P.O. when you are absent.
10. ___ Don't go near any school but your own.
11. ___ Don't leave your house between ___ and ___ unless your parents say it's OK.
12. ___ Don't leave home for more than one day unless your P.O. says it's OK.
13. ___ Don't hang around with _____.
14. ___ Don't be in a gang.
15. ___ Don't have a gun/weapon or be with anyone who does.
16. ___ Don't talk to or go near anyone who testified in your case.
17. ___ Don't be with little children under _____ years old.
18. ___ Don't drink any alcohol.
19. ___ Go to drug/alcohol counseling.
20. ___ Don't use drugs and stay away from places where people do.
21. ___ Don't use/have a beeper
22. ___ Don't be with people who sell drugs.
23. ___ Take drug tests at any time your P.O. says to.
24. ___ Take drug tests any anytime a policeman says to.
25. ___ Let the police or your P.O. search you or your house any time they ask to.
26. ___ Go to counseling.
27. ___ Pay \$_____ to the County.
28. ___ Pay for what you took/broke/_____.
29. ___ Pay back the \$_____ you owe.
30. ___ Don't drive without a license and insurance.
31. ___ Don't drive at all.
32. ___ You can only drive to school/work and back.
33. ___ Give your driver's license to the court clerk.
34. ___ Don't use a fake name.
35. ___ Don't write any checks or carry credit cards.
36. ___ Go to counseling with your parents.
37. ___ Your parents must take ten parent education classes before _____, and prove they graduated.
38. ___ If you don't follow these rules, you will go to juvenile hall for at least ___ days, up to ___ days.
39. ___ Go to the work services program for _____ days.
40. ___ Go to juvenile hall for a medical check up:
 _____ Location #1 _____ Location #2 _____ Location #3
41. ___ Other _____.

APPENDIX F

Packet of Materials for Simulation Exercise #1

*Reproduced from
"The F.A.T. (Frustration, Anxiety and Tension) City Workshop"
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(Note to trainer: trainer should photocopy the attached packet of materials on various colored paper so that each packet contains pages in an assortment of colors.)

APPENDIX G

Photo for Simulation Exercise #2

APPENDIX H

Materials for Simulation Exercise #3

Reproduced from
"The F.A.T. (Frustration, Anxiety and Tension) City Workshop"
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Contents:

1. Table of Words
2. Text #1
3. Text #2

TABLE OF WORDS

are
between
consists
continuously
corresponding
curve
draws
variation
graph
if
isolated
known

making
only
often
with
one
points
relation
set
tables
values
variables

TEXT #1

If the known relation between the variables consists of a table of corresponding variables, the graph consists only of the corresponding set of isolated points. If the variables are known to vary continuously, one often draws a curve to show the variation.

TEXT #2

Last Serny, Flingledobe and Pribin were in the Nerd-link treppering gloopy caples and cleaning burly greps. Suddenly, a ditty strezzle boofed into Flingledobe's tresk. Pribin glaped and glaped, "Oh, Flingledobe," he chafed, "that ditty strezzle is tunning in your grep."

Questions for participants:

When did the story take place?

Who was Flingledobe with?

Where were they?

What were they "treppering"?

What were they cleaning?

What kind of "strezzle" arrived?

What did the "strezzle" do?

Where did the "strezzle" "boof"?

APPENDIX I

Drawing for use with simulation exercise #4.

APPENDIX J

Fictional letter “tedra” for use in simulation exercise #5.



APPENDIX K

Figure for use with simulation exercise #7.

b

APPENDIX L

Overhead: Prevalence of Learning Handicaps in Juvenile Populations

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PREVALENCE OF LEARNING HANDICAPS IN JUVENILE POPULATIONS

	GENERAL POPULATION	OFFENDER POPULATION	ALMANSOR CAMP DATA	% ARRESTED 5 YRS. POST HIGH SCHOOL
EMOTIONALLY DISTURBED	2%	16.2%		57.6%
LEARNING DISABLED	3-6%	36% 30-50%	17.5%+ 38%++ 55.7%+++	31.0%
MENTALLY RETARDED `	2-3%	9.5%	3%	18.1%
VISUALLY HANDICAPPED	.1%	1.6%		3.7
HEARING IMPAIRED	.5%	1.4%		12.9
OTHER DISABILITIES	4.1%	2.8%		12.7%

* National Center for State Courts (1982)

** Statistics compiled from 55% of reviewed studies (Brier, 1989)

+ Students who qualify in all 3 academic areas

++ Students who qualify in 2-3 academic areas

+++ Students who qualify in 1-3 academic areas

APPENDIX M

*Information on how to obtain a video copy of
"The F.A.T. (Frustration, Anxiety and Tension) City Workshop,"
Produced by Peter Rosen Productions Inc.
for the Eagle Hill School Outreach Program, Greenwich, Connecticut
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APPENDIX N

Case profile of Bobby Carlisle

Bobby Carlisle is a 14 year old boy who lives in XYZ Suburb and attends the Carver Middle School. He is before the City Juvenile Court on a charge of indecent assault and battery, stemming from an allegation that he touched a girl inappropriately on a school bus. You know the following about Bobby from a psychologist who examined him:

Bobby's early speech was marked by stuttering, and Bobby now has significant language development problems. The most recent psychological testing found a full scale IQ of 65 (verbal 62, performance 73), consistent with overall mild mental retardation, especially in language related areas. He has shown consistent serious difficulty both with expressive and receptive language functions. His attention is adequate for simple stimuli, but when tasks become even moderately complex, he is not able to maintain attention and becomes more impulsive. His school functioning has been poor both in learning and in conduct.

He has demonstrated hyperactive and disruptive behavior in school and at home from preschool years, and problems with impulse control and aggressive conduct with resulting conflict with mother and sister (age 10). From about age four he had a preoccupation with matches which reportedly came close to causing serious fires. This abated at about age eight (along with his stuttering); at that time (by mother's report) his aggressive and impulsive behavior got worse.

In recent years his family has raised concerns about Bobby's safety and their own, because of his impulsiveness and aggression. He has had difficulty in the past maintaining himself in after school and summer programs because of his behavior. Over the years, Bobby has been treated with a variety of medications -- including Wellbutrin, Ritalin, and Dexedrine -- without any definitive benefit.

According to Bobby's mother, Bobby has no friends his own age. Instead, Bobby tends to hang out with the younger boys on his block.

Bobby's mother has a long history of drinking and, as a result, Bobby had significant fetal alcohol exposure. (Bobby's mother reports that she has been sober for the last 12 years.) A neurological evaluation last year found no basis for concern about organic brain pathology. CT scan of the head done this year was normal.

At the psychologist's first meeting with Bobby, Bobby related in a pleasant and cooperative but very passive manner. He frequently yawned and seemed tired, and maintained a general demeanor of dull, bland puzzlement through most of both interviews. He offered almost no spontaneous speech, and was responsive to questions only with one or two word answers, or with an occasional sentence. It was common that he did not respond to questions at all until he was prompted with multiple choice options. His responses to such questions were consistent over time, suggesting that they were valid indicators of his thoughts; but these responses may at times have reflected his perception of what was expected.

In general his affect was calm and showed little variation, and he appeared to be somewhat sedated. He did show indications of explicit anxiety when considering the possibility

of going to jail, and of embarrassment when discussing the specifics of the charges against him. He became somewhat less responsive and more oppositional in a subtle and passive way after about an hour of the second interview, when speaking of dispositional options; he replied "Yes" when asked if he was tired. He offered little enough spontaneous speech that it was not possible to determine the presence or absence of disorganized thought or bizarre thought content or perception from his speech; but he did not describe any such abnormalities, and he did not manifest any of the signs of agitation or emotional instability which commonly accompany disordered thought or perception.

*EVALUATING YOUTH
COMPETENCE IN THE
JUSTICE SYSTEM*

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Robert G. Schwartz and Lourdes M. Rosado, Editors

AMERICAN BAR ASSOCIATION JUVENILE JUSTICE CENTER

In 1999, responding to the crisis in juvenile indigent defense, the ABA, in partnership with Youth Law Center and Juvenile Law Center, created the National Juvenile Defender Center (NJDC). NJDC supports lawyers who represent children in delinquency and criminal proceedings throughout the country by improving access to counsel and the quality of representation. In order to develop the capacity of the juvenile defense bar, NJDC offers a variety of services including training, technical assistance, advocacy, networking, and resource and policy development. NJDC and its eight Regional Affiliates work together to provide quality representation for every child involved in the justice system. NJDC will ensure continuity in the development of each Regional Affiliate, coordinate efforts to provide a national voice on quality, access, and policy issues, and serve as a catalyst for change in the defense of children.

ABA JUVENILE JUSTICE CENTER/NATIONAL JUVENILE DEFENDER CENTER
740 15th Street, NW, Washington, DC 20005
202-662-1515 - Fax: 202-662-1501

E-mail: juvjus@abanet.org - Website: www.abanet.org/crimjust/juvjus

JUVENILE LAW CENTER

Juvenile Law Center is a non-profit public interest law firm that advances the rights and well being of children in jeopardy. Founded in 1975, JLC is one of the oldest legal services firms for children in the United States. JLC uses a range of strategies -- including individual advocacy, reform of state and national law and policy, and training of public defenders and lawyers for children -- to improve the juvenile justice and child welfare systems. The children we serve include abused or neglected children placed in foster homes, delinquent youth sent to residential treatment facilities or adult prisons, and children in placement with specialized health and education needs. JLC works to ensure that children and youth are not harmed by -- but instead receive appropriate care from -- the systems that are supposed to help them.

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The Philadelphia Building
1315 Walnut Street, 4th Floor
Philadelphia, PA 19107
215-625-0551 - Fax: 215-625-2808

Website: www.jlc.org

YOUTH LAW CENTER

Youth Law Center is the leading national legal advocacy program working on juvenile justice issues. For the past 22 years, YLC staff have worked with defense attorneys, prosecutors, judges, and probation officials in virtually every state throughout the nation. In addition to authoring a major text, *Representing the Child Client*, and more than two dozen articles, book chapters, and other publications on the representation of minors, YLC staff have conducted literally hundreds of trainings and presentations throughout the country on delinquency-related matters, conditions of confinement, liability, alternatives to detention, and coordination of services.

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417 Montgomery Street, Suite 900
San Francisco, CA 94104
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Website: www.youthlawcenter.com

*EVALUATING YOUTH
COMPETENCE IN THE
JUSTICE SYSTEM*

American Bar Association Juvenile Justice Center
Juvenile Law Center ! Youth Law Center

Robert G. Schwartz and Lourdes M. Rosado, Editors

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This curriculum does not necessarily represent
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This report has not been approved by the
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Governors of the ABA.

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ISBN *_*****_***_*

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This multidisciplinary curriculum is the result of much thinking, effort and collaboration by a truly multidisciplinary group of people from around the country. We owe our gratitude to a number of mental health professionals, developmental specialists, social scientists, psychologist and psychiatrists, social workers, special education experts, adult education consultants, juvenile court judges, prosecutors, defenders, and probation officers, all of whom contributed their talent and vast experience to this project.

First, this curriculum would not have been possible without the vision and generous support of the John D. and Catherine T. MacArthur Foundation. We in particular want to thank our program officer Laurie Garduque for her patience and confidence as we strived to create a unique training curriculum. We also are grateful to the MacArthur Foundation for its dedication to promoting so many other projects that will better the lives of those children involved in the juvenile justice system.

We extend many thanks to the experts who conducted our pilot training programs in West Palm Beach, Florida and Oakland, California. They are: Patricia Aguiar, James Bell, Marty Beyer, David Bjorklund, Harriet Brown, Elizabeth Cauffman, Nancy Cowardin, Deborah A. Davies, Delbert S. Elliott, Sheila Foster, James Garbarino, Kirk Heilbrun, Judith Larsen, Melinda Mills, Randy K. Otto, Paul Sayrs, John Shields, Joseph Smith, S. Alex Stalcup, Lee A. Underwood, and Michael Zatopa. We are also indebted to a number of individuals who contributed their research and expertise to the curriculum, including Shelli Avenevoli, James Backstrom, Richard Barnum, Donald Bruce, Pamela Bulloch, Thomas Grisso, Steven Harper, Thomas Hecker, Paul Holland, Amy Holmes Hehn, Randy Hertz, Antoinette Kavanuagh, Richard D. Lavoie, James Loving, Jr., Lee Norton, Lois Oberlander, William F. Russell, Robert E. Shepherd, Laurence Steinberg, and Joseph Tulman. These professionals brought a wealth of knowledge, scholarship and experience to the project that formed the foundation of the curriculum.

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This talented and diverse group of people created a curriculum that we hope will aid juvenile court practitioners in the many difficult decisions they have to make every day, and result in better outcomes for our children and our communities at large.

THE PROJECT TEAM
June 2000

Preface

Background

In 1996, the John D. and Catherine T. MacArthur Foundation funded the Youth Law Center, the Juvenile Law Center, and the American Bar Association Juvenile Justice Center to develop and provide training for juvenile justice professionals around the country. The goal of the project was to develop a training curriculum that applied the findings of adolescent development and related research to practice issues confronted by juvenile court practitioners at the various decision-making stages of the juvenile justice process.¹ The long range objective was to improve the quality of decisions made by juvenile court practitioners.

Two jurisdictions – West Palm Beach, Florida and Oakland, California – agreed to serve as pilot training sites. Project staff worked with juvenile court professionals at both sites and a national advisory committee of practitioners and trainers to identify the training topics. The topics chosen were relevant to adolescent development and related research, unique to juvenile court practice, and typically excluded from professional training curricula.

Over the course of two years, the project sponsored a series of trainings in the pilot sites. The trainings were developed and delivered by experts from all parts of the country. Project staff recruited trainers with specialized knowledge in the relevant subject matter whose expertise was broadly relevant to juvenile court practice. The trainings were cross-disciplinary -- delivering the information to judges, prosecutors, defenders and probation staff at the same time. In both sites, the presiding juvenile court judge set aside specific dates for the trainings, and either closed the courts or lengthened the lunch recess. Most of the trainings were three hours long.

Project staff then created training modules that corresponded to the training topics. The resulting modules incorporate the materials developed by the trainers; supplemental research, literature and training materials; and feedback from the pilot sites. The completed modules were reviewed by a group of professionals with broad expertise in each subject matter.

The Training Modules

The training curriculum consists of six separate modules:

Module One: *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*

Module Two: *Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*

¹The Foundation also launched the MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice in 1997. The mission of the Network is to develop new knowledge regarding the assumptions on which the juvenile justice system functions, and to improve legal practice and policy-making with accurate information about adolescent development. For more information about the Network, please consult its website: <http://www.mac-adoldev-juvjustice.org>.

Module Three: *Mental Health Assessments in the Justice System: How To Get High Quality Evaluations and What To Do With Them in Court*

Module Four: *The Pathways to Juvenile Violence: How Child Maltreatment and Other Risk Factors Lead Children to Chronically Aggressive Behavior*

Module Five: *Special Ed Kids in the Justice System: How to Recognize and Treat Young People with Disabilities That Compromise Their Ability to Comprehend, Learn, and Behave*

Module Six: *Evaluating Youth Competence in the Justice System*

The modules were designed for maximum flexibility and broad application. The modules stand alone, so that jurisdictions can use any individual module or any combination of modules. Each module contains extensive information on the topic, which can form the core of the training, as well as a "tool kit" containing interactive exercises, hypothetical cases, video clips and other training tools. The information in the modules is sufficiently general to apply in any jurisdiction. However, the tools can be adapted to make the subject matter relevant to the daily practice of participants in any particular training site. The curriculum also contains an extensive literature review listing materials relevant to the training topics and related subjects. Selected articles can be assigned for reading prior to the trainings, or the literature review can be made available as a general resource.

Project staff also incorporated the advice of adult learning specialists and professional trainers who served as consultants to the project. These consultants recommended that trainers emphasize a limited number of basic concepts in each subject area and actively engage participants in the learning process. Thus, each module contains a list of the major themes to be discussed, and the subsequent information refers back to those main themes. Similarly, the modules contain several interactive exercises to involve the audience in the training process and to draw upon their experiences to illustrate significant points.

How to Use the Curriculum in Your Jurisdiction

Effective use of this curriculum in a local jurisdiction requires an individual or group of people to organize trainings that are tailored to the specific needs of practitioners. It is important to engage practitioners in the planning process from the beginning. Organizers can work with representatives from the relevant professional groups to determine what areas they are interested in covering. This feedback will help organizers decide whether to present the entire curriculum or select individual modules.

Organizers can also ask the participants to recommend potential trainers. Trainers should have expertise and experience in the relevant subject matter. Familiarity with local juvenile court practice is also helpful. However, it is even more important that the trainer be skilled in engaging the audience in the learning process, drawing from their experience and utilizing tools to make the subject matter relevant to daily juvenile court practice. Straight lecture format – even by a learned and interesting trainer -- is not usually an effective method for presenting the material. Potential sources for trainers are local colleges and universities; law schools; local chapters of national organizations, such as the American Psychological Association; and local or state professional organizations and societies. Organizers may also contact the American Bar Association Juvenile Justice Center for suggestions for experts to conduct the trainings.

Organizers can work with trainers to adapt the curriculum to make it relevant to local practice and current issues. Again, consultation with the relevant professional groups is important. For example, a fact pattern in the curriculum may require some changes to accurately reflect state law, local practice and current trends. Similarly, a video clip in the tool kit may present a scenario that is not representative of the issues important to the audience.

Organizers can also decide whether to conduct cross-disciplinary trainings, or to train professional groups separately. There are advantages and disadvantages to each approach. Cross-disciplinary trainings ensure that all of the juvenile court practitioners benefit from the same information. Issues raised and insights gained from the trainings may lead to changes in practice, which will be more successful if there is shared understanding and consensus among juvenile court professionals. Training the professions together also presents the opportunity for lively discussions among practitioners who have different roles and perceptions of the juvenile court process. On the other hand, candid discussion may be less likely with traditional adversaries in the same room. Attorneys or probation officers might also be reluctant to openly discuss local problems in the presence of juvenile court judges. There is also some advantage to tailoring the presentation of information to the specific professional groups because they are likely to use the information differently. Organizers should consult with the professional groups and determine what means of delivering the training best meets their needs and concerns.

Executive Summary

The goal of Module Six is for participants to develop an understanding of the competencies that young people must have to perform different tasks in the juvenile and adult criminal court process, the skills needed by an expert conducting competency evaluations, and the elements of good competency evaluations. The issue of competence arises in many places in the juvenile court process -- *Miranda* and waiver of rights before making a statement, adjudicative competence in juvenile court, adjudicative competence in criminal court, and transfer between juvenile and criminal court, for example. Competence has become a more important issue than in the past because of changes in state laws increasing the severity of sanctions juveniles face, lengthening commitments in the juvenile justice system, increasing transfers to criminal court, and adding more long-term consequences for delinquency adjudications and criminal convictions. Consequently, juvenile court professionals routinely call on mental health professionals to conduct evaluations that will help answer the ultimate legal question: is this child competent?

Competence means having capacities that are directly connected to performing the task at hand. But the decision of whether a youth is legally competent can not be based on the level of ability alone, but on the degree of match or mismatch between the youth's abilities and the demands of the situation. Trial competence, for example, can not be treated as a single capacity for which the youth is either clearly able or significantly deficient. Sometimes juvenile respondents will be unimpaired in some areas but have significant problems in others. This requires a sophisticated analysis of the juvenile's abilities over the spectrum of tasks and decisions that the youth must perform during the court process.

In this Module, participants will learn:

- ! Qualifications and role of a professional conducting a competency evaluation.
- ! Elements of a good competence evaluation.
- ! Principles of forensic assessment relevant to competence to waive *Miranda* rights and for adjudicative competence.
- ! How to use competence evaluations to make key decisions at different stages in the juvenile and adult criminal court process.

Participants acquire this information and these skills by engaging in a number of interactive exercises, including analyzing evaluations and examining a mental health professional in court.

Table of Contents

I. Introduction	1
A. Goal of this module	1
B. What is “competence”?	1
C. Where does the issue of “competence” arise in the juvenile court process?	1
D. Why has competence become a more important issue?	1
E. Summary of major themes covered by this module	2
F. Source of principles guiding juvenile forensic assessments	2
II. Requirements for competence evaluations/evaluators	4
A. Is the examiner qualified to evaluate <i>children and adolescents</i> ?	4
B. Does the examiner understand the legal issue?	4
C. Were the psychological tests administered and their interpretation appropriate for children?	4
D. Has the examiner received a developmental and mental health history on the youth?	4
E. Does the examiner describe legally relevant functional abilities?	5
F. Does the examiner have appropriate methods for assessing the relevant capacities?	5
G. Does the examiner address more than the youth’s “mere understanding”?	5
III. The Role of the Evaluator	6
IV. Principles of Forensic Assessment Relevant to Competence to Waive <i>Miranda</i> Rights	8
A. Relevant U.S. Supreme Court decisions	8
B. Standard for competent waiver of <i>Miranda</i> rights	8
C. Focus on age	9
D. Retrospective versus present-time evaluation	9
E. Empirical studies	9
F. Analyzing legal competencies	10
G. Instruments for assessing whether a youth has the capacities to waive <i>Miranda</i> rights	10
H. Evaluating competence to waive <i>Miranda</i> rights: what the evaluator should do.	11
V. Principles of Forensic Assessment Relevant to Juvenile Evaluation for Adjudicative Competence	14
A. Introduction to adjudicative competence	14
B. Legal background of adjudicative competence	14
C. Purposes of adjudicative competence	15
D. Elements of adjudicative competence	15
E. Analyzing legal competencies	16
F. Evaluating adjudicative competence: what the evaluator should do	18
VI. Contents of a Well-Prepared Assessment	21
VII. Interpreting the Evaluation	23
VIII. Cases: Restoring the Youth to Competence– Rules Developed in the Adult System	24

Bibliography	26
APPENDIX A	A1
APPENDIX B	B1
APPENDIX C	C1

I. Introduction

A. **Goal of this module.** The goal of this module is for participants to:

1. Understand the competencies that young people must have to perform different tasks in the juvenile and adult criminal court process.
2. Appreciate the skills needed by an expert to conduct a competency evaluation.
3. Know the elements of a good competency evaluation.
4. Learn to use evaluation findings at different stages of the juvenile court process.

B. **What is “competence”?** “Competence” means having capacities that are directly connected to performing the task at hand, such as:

1. Having the capacities to make a meaningful decision about the particular issue to be decided, e.g., to waive *Miranda* rights.
2. Having the capacities to participate in a process, such as a juvenile or criminal court trial, with all that the process entails; the more complex the process, the greater the demand on the youth’s capacities.

C. **Where does the issue of “competence” arise in the juvenile court process?**

1. Capacity to have waived *Miranda* rights at the time of a statement.
2. Adjudicative competence in juvenile court.
3. Adjudicative competence in criminal court.
4. Transfer between juvenile and criminal court (e.g., in Virginia, judicial transfer decision must consider whether youth would be competent to stand trial as an adult, and Arkansas requires a finding of competence to stand trial as an adult when the state seeks to transfer 11-13 year olds to criminal court).

This module focuses on waiver of *Miranda* rights, and on adjudicative competence.²

D. **Why has competence become a more important issue?**

1. States have changed their juvenile and criminal codes to increase the severity of sanctions that juveniles face.
2. States have authorized longer periods of incarceration in the juvenile justice system.
3. Many states have lowered the age for transfer to criminal court.

²Current knowledge of adolescent development in general is covered in Module One, *Kids Are Different: How Knowledge of Adolescent Development Theory Can Aid Decision-Making in Court*.

4. More juveniles are transferred to criminal court.
5. There are more long-term, collateral consequences for delinquency adjudications and criminal convictions (ranging from juvenile adjudications being used to enhance adult sentencing, to loss of the right to vote).

E. Summary of major themes covered by this module

1. A forensic assessment usually involves a one-time evaluation for which there is no opportunity to make corrections over time. It is distinct from an assessment used for treatment purposes, which is revisited as new information is gathered over the course of treatment. Forensic evaluations – such as those to assess competency – thus require the best possible information “up front.”
2. Information for a forensic evaluation must include extensive background information, interviews with third parties, record reviews, etc. An evaluator cannot presume the “accuracy” of self-reported data, and must avoid relying on a single source of information.
3. The decision of whether a youth is legally competent should not be based on the level of capacity alone, but on the degree of match or mismatch between the youth’s capacities and the demands of the situation. Different cases present different demands.
4. “Trial competence” should not be treated as a single capacity for which the youth is either clearly able or significantly deficient. Sometimes juvenile respondents will be unimpaired in some areas but have significant problems in others. This will require court and counsel to explore whether there are remedies for the problem areas.

- F. Source of principles guiding juvenile forensic assessments.** Principles that underlie good juvenile forensic assessments – which are distinct from evaluations for treatment purposes – are the same principles discussed in Module Three on mental health assessments.³ Support for these principles – which are discussed in this module – are found in professional ethical standards, law, national standards, and standards of practice.

³ See Module Three: *Mental Health Assessments in the Justice System: How to Get High-Quality Evaluations and What to Do With Them in Court*

Interactive Exercise: Understanding the basic requirements for competence evaluations and evaluators

Step One: Trainer should hand out case profile of Mary Doe attached as Appendix A, and ask participants to read the profile to themselves.

Step Two: Trainer should pose the following discussion questions, designed to elicit from the participants their understanding of the: (a) qualifications and role of a competence evaluator; and (b) minimum criteria for a good competence evaluation. (This information is covered in Parts II and III of the curriculum which follow.)

- ! What qualifications and experience would you look for in a mental health professional to perform a competency evaluation of Mary Doe?
- ! Is the result of an IQ test sufficient to measure competence to stand trial? What else should the court want to know? What other information does the psychologist need to obtain about Mary in order to form an opinion on her competence? What other tests should be performed?
- ! What weight should the court give to the fact that Mary was well-oriented and able to carry on a conversation with the psychologist in determining whether she is competent to stand trial?

II. Requirements for competence evaluations/evaluators

A. Is the examiner qualified to evaluate *children and adolescents*?

1. Juvenile and criminal courts too often use forensic examiners who only have experience evaluating adult defendants. Whether the assessment is for use in juvenile or criminal court, or for transfer of youth between the courts, the evaluator must have specific training and experience in evaluating and diagnosing children and adolescents.
2. Diagnosing mental disorders in adolescents is a more difficult task than diagnosing adults. Many disorders experienced by adolescents are not the same as disorders of adults, and even those that have the same names – e.g., depression – do not look the same in adolescents as in adults. Many professionals highly experienced in forensic evaluations of adults will not be able to tell you, for example, the criteria for diagnosis of attention deficit disorders, will misinterpret the meaning of conduct disorder, or will lack basic knowledge of legally relevant developmental factors.

B. Does the examiner understand the legal issue? For example, in juvenile court an evaluator asked to assess a youth's competence to stand trial may not understand the issue because until recently the concept usually had not been raised in juvenile court.

C. Were the psychological tests administered and their interpretation appropriate for children?

1. Psychologists should use tests that have been designed for adolescents, not adults, to examine youths under 18. For example, when administering the Minnesota Multiphasic Personality Inventory (MMPI), evaluators should use the version designed for adolescents, not the one for adults.
2. Interpretations must also be appropriate for children. For example, many forensic clinicians are beginning to use the Hare Psychopathy Checklist, which was designed to identify individuals with certain traits – i.e., callousness or lack of remorse -- that are well ingrained and not likely to change. The test was developed for adults, though some clinicians use it for adolescents. The problem is that we don't know whether it means the same thing for adolescents, since some youth who score high *may* be developing psychopathic personalities, while others may be passing through a temporary phase. The results can be easily misinterpreted.

D. Has the examiner received a developmental and mental health history on the youth? A competence evaluation cannot be done merely with a clinical interview and a test or two. There must be a developmental history that includes information from parents about the youth's life-long development, and records regarding the youth's academic and mental health history.

For example, in *Miranda* cases courts have said that developmental disabilities and learning difficulties are important factors to consider when deciding whether youth could comprehend and make competent waivers of their *Miranda* rights. Intelligence testing alone will not pick up many kinds of developmental deficits. The picture will

be clearer when the case is set in the context of good information about the youth's pre-school development, academic performance across the school years, and his/her history of behavioral development at home.

- E. **Does the examiner describe legally relevant functional abilities?** It is not enough that examiners say that a youth is not mentally retarded or that the youth is mentally ill. Examiners must provide direct evidence about what the youth does or does not understand. Clinicians should be informing the court or counsel about how the youth functions when actually dealing with the information or situation that is at issue.

For example, every evaluation for capacity to waive *Miranda* rights should include, at a minimum, evidence about what the youth thinks that each component of the *Miranda* warning means. Every evaluation for competence to stand trial should include specific evidence about what the youth does or does not comprehend about the charges, the possible consequences of the trial, the trial process, the roles of people in the trial, etc. Thus, the evaluation should include more than just "yes" or "no" answers to inquiries. The youth should be able to explain the charges, consequences, etc.

- F. **Does the examiner have appropriate methods for assessing the relevant capacities?** A number of special methods – tests and interview schedules – are now available to experts for examining youths' capacities related to questions of legal competence. For example, there are commercially available instruments for assessing what youth do and do not comprehend regarding the *Miranda* warning and its significance. While examiners don't have to use special forensic clinical methods in every case, they should know them, have them available, and be able to explain why they did not use them.

- G. **Does the examiner address more than the youth's "mere understanding?"** Examiners should be required to explore how youths interpret what they understand, and whether their beliefs allow them to use their understanding meaningfully in making *Miranda* waiver decisions or participating in their defense. Examiners should also go beyond "understanding" and examine the youth's capacity for decisionmaking.

For example, in the *Miranda* context, youths may clearly know they can have someone called a "lawyer" but may not know what a lawyer does, or that lawyer-client communications are confidential, or that the lawyer is not just another agent of the court. The examiner who stops with "mere understanding" of the *Miranda* warning– "I can have a lawyer"– will not get to those other issues.

III. The Role of the Evaluator

- A. **A mental health professional should only accept referrals for evaluations within his/her area of expertise.** The evaluator should have:
1. knowledge, skill, experience and training in child and adolescent development.
 2. knowledge, skill, experience and training in juvenile or criminal justice issues, in particular with adolescents who are involved with the justice system.
 3. knowledge, skill, experience and training in evaluating competence of juveniles in the context of specific legal proceedings (such as a transfer hearing, or a juvenile court proceeding).
- B. **An evaluator should decline referral for an evaluation when s/he is unlikely to be impartial.** Are there any sources of potential bias, either internal (e.g., anger at offenders, belief that punishment is always wrong) or external (e.g., pre-existing extra-professional relationship with defense attorney, prosecutor, youth, or family) that would keep the mental health professional from considering the data fairly and reaching a balanced conclusion?
- C. **A mental health professional should decline an evaluation referral to avoid a dual relationship.** A psychologist cannot be the therapist to and evaluator of the same youth. Mental health professionals are strongly discouraged on ethical grounds from maintaining dual relationships with a client. Typically, such dual relationships would involve a professional role (e.g., therapy or assessment) combined with a personal or business relationship. Treating therapists could generally *not* play the role of evaluating forensic expert in juvenile proceedings.
- Problems arise when the evaluator seeks to obtain treatment records or consult with the therapist, since in most jurisdictions, only the patient/youth can waive the patient/therapist privilege or release confidential treatment records. The question then arises as to whether the youth is competent to waive the privilege. When reasonable efforts to obtain records fail, an evaluator may have to present the court with an informed judgment about the youth's capacities without reviewing treatment records or consulting with the therapist.
- D. **The evaluator should ensure that appropriate authorization to conduct an evaluation has been obtained,** i.e., the evaluator should obtain a court order or consultation request from defense counsel.
- E. **The evaluator must identify the relevant legal questions and forensic issues.**
1. The evaluator should be able to identify and recite the state's specific legal definition for the type of competence in question.
 2. The evaluator should identify the forensic issues that must be investigated in order to answer the legal question at hand. What are the abilities, capacities, and/or skills that a young person needs in order to be competent in this particular area?

3. The evaluator should then identify the specific legal question(s) which the court will ultimately decide, i.e., the youth's competence to waive *Miranda* rights, the youth's competence to stand trial.

IV. Principles of Forensic Assessment Relevant to Competence to Waive *Miranda* Rights

A. Relevant U.S. Supreme Court decisions

1. *Miranda v Arizona*, 384 U.S. 436 (1966): A suspect of crime has constitutional rights to avoid self incrimination and to advice of counsel prior to or during in-custody legal proceedings such as police questioning. Unless the suspect has made a “knowing and intelligent” waiver of these rights, his or her statements may not be used in subsequent delinquency or criminal proceedings.
2. *In re Gault*, 387 U.S. 1 (1967): Juveniles have a constitutional right to counsel and to avoid self-incrimination.
3. *Fare v. Michael C.*, 442 U.S. 707 (1979), in which the Court permitted into evidence a juvenile’s confession made to his probation officer:
 - a. While mere fact of being a juvenile does not invalidate waiver of rights, juveniles as a class are at greater risk than adults of having deficiencies in the intellectual or emotional characteristics required to satisfy the standard for valid waiver. Each case is to be decided on “totality of the circumstances” rather than any single factor such as age, intellectual functioning, or mental disorder. Legal descriptions of “totality of circumstances” focus on two broad types of factors: features of the situation in which youth confessed, and characteristics of the youth relevant to abilities to understand and apply the *Miranda* warnings.
 - b. Juveniles’ confessions require special scrutiny, *Haley v. Ohio*, 332 U.S. 596 (1948) and *Gallegos v. Colorado*, 370 U.S. 49 (1962).

B. Standard for competent waiver of *Miranda* rights

1. Waiver must be voluntary, knowing, and intelligent, based upon the totality of the circumstances.
2. Totality of circumstances involves an assessment of the interaction between:
 - a. The circumstances of the interrogation/confession, and
 - b. The characteristics of the youth.

Gallegos recognized that youth may fear police or give greater deference to authority than adults, that they are more susceptible to suggestions than adults, and that an assessment of “voluntariness” requires close scrutiny to ensure that youth are not coerced. However, in *Colorado v. Connelly*, 449 U.S. 157 (1986), the Supreme Court held that absent police coercion, a defendant’s mental state alone would not make a confession involuntary. The Court has never addressed the circumstances under which police conduct that would not be coercive for adults might be coercive with adolescents. Rather, it has left lower courts to determine “voluntariness” under the “totality of circumstances” test.

- C. **Focus on age.** Despite the “totality of circumstances” standard, judicial decisions on competence to waive *Miranda* rights tend to cluster around chronological age: courts, focusing on IQ, education and prior experience, tend to exclude confessions of children 12 or under, and admit confessions of youth who are 16 or older. Courts vary widely in cases involving 13-15 year olds. *Note to trainer: trainer should cite cases from local jurisdiction.*
- D. **Retrospective versus present-time evaluation.** Unlike adjudicative competence, competence to waive *Miranda* rights requires a *retrospective* evaluation. What did the youth understand *at the time* he or she was interrogated? Current capacities are more relevant if the youth has permanent deficits, such as mental retardation.
- E. **Empirical studies raise questions about the criteria that courts have used to determine competence.**

Empirical studies show that most juveniles who receive a *Miranda* warning do not understand it well enough to waive their constitutional rights in a “knowing and intelligent” manner. For example, Dr. Thomas Grisso conducted tests to determine whether juveniles could paraphrase the words in the *Miranda* warning, whether they could define six critical words in the *Miranda* warning such as “attorney,” “consult,” and “appoint,” and whether they could give correct true-false answers to twelve re-wordings of the *Miranda* warnings. **Most juveniles 14 and under, and many juveniles 15-17, did not understand the *Miranda* warning as well as the average adult offender.** Compared to adults, juveniles were far less able to understand the four components of a *Miranda* warning. Juveniles demonstrated significantly less comprehension of at least one of the four components of the warning. **Juveniles most frequently misunderstood the *Miranda* advisory that they had the right to consult with an attorney and to have one present during interrogation.** Other research has made similar findings.⁴

Younger juveniles exhibit even greater difficulties understanding their rights. Juveniles younger than 15 demonstrate significantly poorer comprehension of the nature and significance of *Miranda* rights. The level of comprehension exhibited by youths 16 and older, although more comparable to that of adults, left much to be desired.

⁴A replication of Grisso’s study in Canada reported that very few juveniles fully understood their warnings and that the youths who lacked comprehension waived their rights more readily. “[I]t seems likely that many if not most juveniles who are asked by the police to waive their rights do not have sufficient understanding to be competent to waive them.” Another study reported that youths interpreted the warning that “anything can and will be used against you in a court of law” to mean that “any disrespectful words directed toward police would be reported to the judge.” A study of urban, black high school students who participated in a year-long “Street Law” course reported that education about *Miranda* rights did not improve students’ understanding or comprehension in ways that would enable them to take meaningful advantage of their rights. Barry C. Feld, *Juveniles’ Waiver of Legal Rights: Confessions, Miranda, and the Right to Counsel* in T. Grisso & R. Schwartz, eds., *YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE*. Chicago, IL: University of Chicago Press (2000) (footnotes omitted).

- F. **Analyzing legal competencies.** Every evaluation of a youth's capacities – whether to waive *Miranda* rights or to participate in the trial process – must be done within a framework that evaluates the three basic components of legal competency. These components are functional, causal, and interactive.
1. **Functional abilities.** This includes the specific capacities, skills, and abilities relevant to each of the areas of the legal standard being evaluated; in the context of waiving *Miranda* rights, these are the:
 - a. Ability to **comprehend** *Miranda* warning (KNOWING what the words mean).
 - b. Ability to **grasp the significance** of rights in the context of the legal process (KNOWING that you don't have to speak to the police, that anything you say can be used against you in court).
 - c. Ability to **process information** in arriving at a decision about waiver (INTELLIGENTLY determining whether under the present circumstances it is in your best interest to talk to the police).
 2. **Causal factors.** Does the youth have cognitive or developmental deficits, or suffer from emotional disturbance, learning disabilities, mental retardation or other mental disorders, that interfere with his or her ability to understand the situation and decide whether to waive *Miranda* rights?
 3. **Interaction of abilities and situational demands.** Competency evaluations must consider the abilities of the youth in the context of the demands of the interrogation. What is the impact on the youth's abilities of factors such as the duration of the interrogation, whether a parent was present, the time of day, location, availability of food, bathroom breaks, etc.?
- G. **Instruments for assessing whether a youth has the capacities to waive *Miranda* rights.**
1. Comprehension of *Miranda* Rights (CMR). Examiner presents each of four main *Miranda* warning statements to youth, reading each while showing it to the youth in printed form. Youth is then asked to describe what each statement means "in your own words." Each response is scored "adequate," "questionable," or "inadequate" according to detailed scoring criteria provided for each warning, allowing a total CMR score (0-8) to be calculated. (NOTE: This test alone does not provide an evaluation. The examiner must still conduct an interview and gather other information. Note, too, that this instrument focuses on the knowing and intelligent part of *Miranda* criteria, not voluntariness.)
 2. Comprehension of *Miranda* Rights–Recognition (CMR-R). This instrument does not require youth to paraphrase, and thus may be helpful in identifying the youth who understands the warning but does not have the verbal ability to express this understanding. The youth is presented with three statements following each warning and is asked to say whether each of the three statements is the "same" or "different" from the warning. A total of 12 statements are presented, half of which

are the same and half of which are different. Total CMR-R score is the number of correctly identified statements.

3. Comprehension of *Miranda* Vocabulary (CMV). This is a vocabulary test that uses six key words in the *Miranda* warning and asks the youth to explain the meaning of each. Objective scoring criteria are used to score the youth's definitions and produce total CMV scores (ranging from 0-12.) The purpose of this instrument is to provide additional information with which to interpret the source of youths' poor understanding when manifested in the CMR and CMR-R instruments.
4. Function of *Miranda* Rights in Interrogation (FRI). This instrument assesses a youth's appreciation of the relevance of the *Miranda* warnings in the legal context, i.e., the reason that each of these rights is important. FRI poses four situations described in brief vignettes and drawings: youth about to be questioned by police officer after arrest; youth consulting with defense counsel; a youth being pressured by police officers to make a statement; and a youth in a hearing before a juvenile court judge. The youth is then asked a series of questions that focus on the youth's appreciation of the adversarial nature of the encounter with police officers, the advocacy nature of attorney-client relationship, the protective nature of the "right to silence" despite the authority of the police officers, and the role of an earlier confession or assertion of the right to silence at a later court hearing. The responses are again scored according to objective criteria.

**Interactive Exercise:
Competence to Waive *Miranda*
Rights**

Trainer should ask participants the following questions about a competence to waive *Miranda* rights evaluation:

- ! What are the key questions that such an evaluation should answer?
- ! Who must the evaluator interview?
- ! What records must the evaluator review?

H. Evaluating competence to waive *Miranda* rights: what the evaluator should do.

1. **Key questions that the evaluation seeks to answer:**
 - a. Did the youth understand and appreciate the significance of the *Miranda* warning?
 - b. Was the youth capable of exercising autonomous choice about waiver of the *Miranda* rights?
 - c. Was the youth's confession reliable? This last question is often asked by lawyers or judges who make the referral for an evaluation, but it is rare that an evaluation alone can answer this question.
2. **Use the instruments described in Part IV.G. *supra*.**
3. **Obtain records.** The evaluator should obtain various records, including:

- a. delinquency and dependency history and records, including those of previous parole/probation in community
 - b. arrest report
 - c. school performance
 - d. academic evaluations
 - e. mental health evaluations and records
 - f. medical evaluations and records
4. **Interview parents or custodians.**
- a. Parents or custodians should be interviewed for information about the interrogation. This should include a detailed chronology of events surrounding the arrest and questioning. The chronology should begin a few days before the arrest and continue to a few days after the arrest.
 - b. Parents or custodians should also be interviewed for information about the youth's life course development, including: birth/medical/injury history; social developmental milestones; educational history; history of emotional disturbances; and mental health issues (especially those resulting in mental health treatment).
5. **Interview other parties present at interrogation.** This would include police and attorneys.
6. **Interview youth.** This should include reviews of the statement, the *Miranda* waiver form, and the youth's prior legal experience, so his/her sophistication can be evaluated. Evaluator should, at minimum, ask youth what each of the *Miranda* questions means.
7. **Administer psychological testing to youth.** This would include tests to assess:
- a. intelligence
 - b. academic skills
 - c. personality and psychopathology
 - d. brain dysfunction (if indicated by history or observations)
8. **Analyze other data relevant to reasoning and processing information.**
- a. intellectual functioning
 - b. grossly impaired judgment

- c. brain damage
 - d. severe psychotic symptoms (delusions, hallucinations, confusion)
 - e. level of education
 - f. time of interrogation (capacity for attention and concentration)
 - g. experience with juvenile system and prior interrogation
9. **Analyze other data relevant to “voluntariness,”** such as whether there is evidence of mental retardation.
10. **Consider all relevant factors that may affect the youth’s abilities to use his or her capacities.** Such factors include psychosocial maturity, mental disorder, and emotional disturbance. In addition, research shows that adolescents’ decision-making is affected by stress, and by large fluctuations in mood and emotion.

V. Principles of Forensic Assessment Relevant to Juvenile Evaluation for Adjudicative Competence

A. **Introduction to adjudicative competence.** Adjudicative competence, or competence to stand trial (which includes the entering of a guilty plea), is one protection that has taken on new implications in the modern context of punitive approaches to youth who misbehave. Concerns about the capacities of immature youths to understand the nature of the adjudication process and to make critical decisions related to it are being raised in legislatures and courts across the nation. Historically, defendants could lack adjudicative competence because of their mental health status or mental retardation. For the first time, *immaturity* is being considered in adjudicative competence determinations, i.e., some defendants, by virtue of their age and developmental status, lack the capacities to be a competent defendant.

B. **Legal background of adjudicative competence.**

1. The "test" for adjudicative competence was enunciated by the U.S. Supreme Court in *Dusky v. United States*, 362 U.S. 402 (1960): "whether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding -- and whether he has rational as well as factual understanding of the proceedings against him."
2. In *Drope v. Missouri*, 420 U.S. 162 (1975), the Court held that the incompetence doctrine was "so fundamental to an adversary system of justice," that conviction of an incompetent defendant, or failure to adhere to procedures designed to assess a defendant's competence when doubt has been raised, violates the due process clause of the federal Constitution. "It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." Nor is such a defendant competent to enter a plea of guilty in lieu of a trial. *Godinez v. Moran*, 509 U.S. 389 (1993) holds that the legal tests for competence to stand trial and competence to plead guilty (and waive counsel) are the same. Incompetence bars adjudication, whether by plea or trial, and this includes any pretrial proceedings that could be adverse to the defendant's interests.

Interactive Exercise: Adjudicative Competence

Trainer should pose the following questions for discussion:

- ! What are the values underlying the principle that only competent people should be tried?
- ! What are the elements of adjudicative competence?
- ! What must a defendant/respondent be able to do and/or understand before a court will judge him/her competent to stand trial?
- ! What are the consequences if a defendant/respondent is competent in some areas but not others?
- ! What are the consequences if a defendant/respondent is not competent because of developmental immaturity?

C. **Purposes of adjudicative competence.** Adjudicative competence in juvenile and criminal proceedings serves three important purposes:

1. **Preserving the integrity of the criminal process.** The credibility of the criminal process is undermined if the defendant lacks a basic moral understanding of the nature and purpose of the proceedings against him or her.
2. **Reducing the risk of erroneous convictions.** The accuracy or reliability of the adjudication is threatened if the defendant is unable to assist in the development and presentation of a defense.
3. **Protecting the defendant's decision-making autonomy.** To the extent that decisions about the course of adjudication must be made personally by the defendant, he or she must have the abilities needed to make decisions.

D. **Elements of adjudicative competence.** Adjudicative competence has two components.

1. **Competence to assist counsel.** The minimum conditions legally required for participating in one's own defense generally include the capacity to:
 - a. understand the charges and the basic elements of the adversary system;
 - b. appreciate one's situation as a defendant in a delinquency or criminal prosecution; and
 - c. relate pertinent information to counsel concerning the facts of the case.

These abilities, taken together, fulfill *Dusky's* requirement that the defendant be able "to consult with counsel with a reasonable degree of rational understanding."

2. **Decisional competence.** A defendant who is competent to assist counsel may nevertheless not be competent to make specific decisions regarding the defense of his or her case that arise as the trial process unfolds.
 - a. Case law reflects four criteria that may be invoked in determining decisional competence:
 - 1) the capacity to understand information relevant to the specific decision at issue (understanding);
 - 2) the capacity to appreciate one's situation as a defendant confronted with a specific legal decision (appreciation);
 - 3) the capacity to think rationally about alternative courses of action (reasoning); and
 - 4) the capacity to express a choice among alternatives (choice).
 - b. The capacities required for trial in juvenile court are likely to be different than those in criminal court because the youth will have to understand different concepts and outcomes. The greater the severity of the consequences in a juvenile proceeding, the more that adjudicative competence in juvenile court should resemble the competence required for adult criminal court.

- 1) Thus, in states that use blended sentencing, the juvenile will need to understand the implications of a plea, or a right to a jury trial, or the implications of taking the witness stand, in ways that will differ from the competencies required for the traditional juvenile court. A youth in juvenile court who is charged with an offense that can lead to transfer to criminal court will need to know that his or her exposure to transfer in the future will be enhanced by a guilty plea (admission) today.
- 2) In some states, such as Virginia, transfer to criminal court is explicitly conditioned on a finding that the youth is competent to stand trial as an adult.

E. Analyzing legal competencies.

As with the analysis of competencies necessary for the waiver of *Miranda* rights, the evaluation for adjudicative competence will examine functional, causal and interactive factors.

1. **Functional abilities** can be analyzed by examining 13 capacities that arise during four aspects of the trial process.
 - a. **Understanding of charges and potential consequences**
 - 1) Ability to understand and appreciate the charges and their seriousness
 - 2) Ability to understand possible dispositional consequences of guilty, not guilty, and not guilty by reason of insanity
 - 3) Ability to realistically appraise the likely outcomes
 - b. **Understanding the trial process**
 - 1) Ability to understand the roles of participants in the trial process (e.g., judge, defense attorney, prosecutor, witnesses, and, where applicable, jury)
 - 2) Ability to understand the process and potential consequences of pleading and plea bargaining
 - 3) Ability to grasp the general sequence of pretrial and trial events
 - c. **Capacity to participate with attorney in a defense**
 - 1) Ability to adequately trust and work collaboratively with attorney
 - 2) Ability to disclose to attorney reasonably coherent description of facts pertaining to the charges
 - 3) Ability to reason about available options by weighing their consequences
 - 4) Ability to realistically challenge prosecution witnesses and monitor trial events
 - d. **Potential for courtroom participation**
 - 1) Ability to testify coherently
 - 2) Ability to control own behavior during trial proceedings
 - 3) Ability to manage the stress of trial

2. **Causal factors.** The assessment should include a description of the causal connection between the youth's clinical and developmental status and deficits in competence abilities. This is particularly important because of the later question of remediation, that is, whether the youth's functional deficits can be modified (i.e., whether and how competence can be developed or restored). Does the youth have cognitive or developmental deficits, or suffer from developmental immaturity, emotional disturbance, learning disabilities, mental retardation, or other mental disorders that interfere with his or her ability to participate in the trial process? The tendency should be resisted to treat trial competence as a single capacity, for which the youth is either clearly able or significantly deficient.
 - a. Can the deficits be fixed, or be made less problematic? For example, if the youth cannot understand written or technical language, will it help if the attorney explains proceedings and important decisions slowly and in very basic terms?
 - b. If the evaluator observes no significant deficits, then this should be noted clearly.
 - c. Sometimes defendants will be unimpaired in some areas but have significant problems in others.
 3. **Situational factors.** Because competence depends upon the degree of match or mismatch between the youth's abilities and the demands of the youth's situation, the evaluator must know the youth's legal situation and the trial circumstances that the youth might face. Court or counsel should inform the evaluator if any of the following situations are probable, since each in its own way may place a greater demand on the youth's capacities:
 - a. The trial is in criminal court rather than juvenile court;
 - b. The juvenile court hearing is for the purpose of deciding whether the youth should be transferred to criminal court;
 - c. Plea bargaining is likely to be involved;
 - d. The evidence against the youth is uncertain, so that the youth's ability to provide a coherent, personal account of events is likely to be relevant;
 - e. The trial process is likely to involve many witnesses;
 - f. The trial is likely to require a complex legal defense;
 - g. The defendant is likely to have to testify;
 - h. The trial is likely to be lengthy; or
 - i. The defendant has fewer sources of social support.
- F. **Evaluating adjudicative competence: what the evaluator should do**

1. **Use multiple sources of information for each area being assessed.** Avoid single sources of information, in particular self-reporting. Sources should include:
 - a. a clinical interview
 - b. collateral reports (e.g. family members, teachers, employers, therapists, case managers, parole/probation officers)
 - c. records
 - 1) delinquency and dependency history and records, including those of previous parole/probation in community
 - 2) arrest report
 - 3) school performance
 - 4) academic evaluations
 - 5) psycho-social history
 - 6) mental health evaluations and records
 - 7) medical evaluations and records

2. **Use structured interview guides for “competence to stand trial” abilities.** Most of these guides were not designed for adolescents but are flexible enough to be used with them. They include:
 - a. Competency Assessment Interview (CAI) examines the thirteen functional abilities described above as relevant for competence to stand trial.
 - b. Fitness Interview Test-Revised (FIT-R) provides greater structure for the interview than the CAI while focusing on three main areas: understanding of the proceedings, understanding of the possible consequences of the proceedings, and the ability to communicate with counsel.
 - c. MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA) is highly structured and uses an objective scoring system. Questions are grouped into four areas: understanding of charges and trials; appreciation of the relevance of information for a defense; reasoning with information during decision-making; and evidencing a choice. (The MacCAT-CA must be modified when assessing competence to stand trial in juvenile court.)

3. **Use competence screening instruments to assess defendants’ understanding of trial related concepts.**
 - a. Competency Screening Test (CST)
 - b. Georgia Court Competency Test-Mississippi State Hospital (GCCT-MSH)
 - c. Brief Symptom Inventory (BSI) (screens for mental and emotional disorders, though BSI results in research studies have raised questions about it)
 - a.-c. are brief paper and pencil tests that are best used as screening instruments to determine whether competence should be more thoroughly examined. They

have limited use for adolescents, especially regarding competence in juvenile court. For adolescents, a better instrument is:

- d. Competency Assessment to Stand Trial-Mental Retardation (CAST-MR), which was developed for adult defendants with mental retardation.
4. Administer psychological tests. These include tests that identify:
 - a. Mental/emotional disorders (e.g., Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A), Million Adolescent Clinical Inventory (MACI)). These are objective measures, though they all have limitations with youth in the justice system. The MMPI-A is so long that it is beyond the attention and reading capacities of most delinquent youth, and the MACI has not yet been normed for juvenile court samples.
 - b. Intellectual functioning (e.g., Wechsler Intelligence Scale for Children - III).
 - c. Academic achievement (e.g., Wide Range Achievement Test - 3).
 - d. Behavior (e.g., Child Behavior Checklist, but its focus on behavior problems is usually less relevant than clinical symptoms for explaining functional deficits related to trial competence).
 5. **Consider clinical characteristics:**
 - a. mental or emotional disorder, particularly
 - 1) depression
 - 2) schizophrenia
 - 3) brain dysfunction
 - 4) impulsivity
 - 5) anger control problems
 - b. intellectual functioning, particularly developmental disability/mental retardation
 - c. academic functioning deficits
 - d. attention-deficit/hyperactivity disorder
 - e. post-traumatic stress disorder
 - f. conduct disorder
 - g. substance abuse
 6. **Assessing developmental maturity. This is a significant way in which juvenile evaluations differ from those of adults. At age 14-15, juveniles in general begin to look like adults cognitively, but they may not catch up to adults on**

measures like risk-taking or future perspective until age 17 or 18. A developmental maturity assessment should consider:

- a. age
- b. interests
- c. peers, and role with them
- d. psycho social judgment
- e. cognitive maturity

VI. Contents of a Well-Prepared Assessment

- B. **The assessment should focus on forensic issues.** A good assessment should describe the youth's functioning in areas relevant to forensic issues (e.g., capacities for assisting counsel) rather than merely offering an opinion on the ultimate legal question (e.g., competence to stand trial).
- C. **The assessment should describe findings and their limits.**
1. Findings and opinions should be clearly described and well supported in report.
 2. Evaluator should be able to report that he or she considered other possibilities and rejected them for specific reasons. ("Yes, I took that into account, but my conclusion comes from other information, in particular X, Y, Z.")
- D. **The assessment should attribute information to sources.** All important factual information in a forensic evaluation should be attributed (e.g., "According to John, his school attendance has been fair although his grades have been poor; however, a review of his school records indicates that he has been late or absent for nearly two thirds of scheduled school days for the present year, and has passed only two subjects"). Thus, all parties should be able to determine where a particular piece of information was obtained.
- E. **The assessment should use plain language and avoid technical jargon.** When technical terms cannot be avoided, they should be explained clearly.
- E. **The assessment should include sections on:**
1. Identifying information, including:
 - a. who is being evaluated
 - b. age, school grade and status
 - c. current charges
 - d. reason for evaluation
 - e. who requested/ordered evaluation
 2. Procedures used by the evaluator, including:
 - a. records reviewed
 - b. persons interviewed other than the youth
 - c. procedures used with client
 - 1) interview

- 2) specific psychological tests
 - 3) other procedures
- d. where evaluation was conducted, with a description of the testing conditions
 - e. how long evaluation took
 - f. notification of purpose given and whether the child understood it
3. Relevant history
 4. Current clinical functioning
 5. Relevant forensic issue and capacities/functioning
 6. Conclusions
 7. Recommendations

Interactive Exercise: Analyzing Competence Evaluations

The purpose of this exercise is for participants to learn how to assess the strengths and weaknesses of competence evaluations.

Step One: Break the participants into small groups. (If at all possible, make sure that there is representation from each of the professions – judges, prosecutors, defense attorneys and probation officers – in each group.) Ask each group to select one individual to act as a recorder and reporter for the group. Hand out: (a) one of the competence evaluations attached at Appendix B; and (b) the work sheet attached as Appendix C. Ask participants to read over the selected evaluation, and complete Part A only of the worksheet.

Step Two: Reconvene as a large group to lead participants through a critique of the competence evaluation, using the worksheet to guide discussion.

VII. Interpreting the Evaluation

- A. The examiner must consider the ways in which the youth has manifested strengths and deficits in *legally relevant functional abilities*. The examiner must further offer explanations, if they are available from the data, for any deficits. The examiner must explain the significance of the deficits in light of the demands of the youth's trial. If the youth appears incompetent, the court will want to know about the youth's prospects for being restored to competence.
- B. A part of the interpretation should focus on the youth's deficits that might reduce the attorney's ability to represent the youth effectively. The deficits that make a difference here are those that cannot easily be remedied, e.g., a youth who has a psychotic delusion that everyone is against him, the traumatized youth who, because of childhood abuse, refuses to talk to adults, or the immature or fearful youth who can only shrug her shoulders. Other youth may lack the capacity to communicate with the attorney because of neuropsychological deficits, which prevent the telling of a coherent story. Still other youth with, for example, ADHD, may have difficulty keeping track of evidence in a prolonged trial, and thus may be unable to monitor or evaluate information that arises during the course of the trial.
- C. The evaluator's interpretation must address those important decisions that only the defendant can make, such as the right to a jury trial or the right to plead guilty. A youth may lack the ability to think abstractly, or may be able to think abstractly but may not have the judgment necessary to make choices. "Poor judgment" is not a bad decision, per se, but is one that is clearly influenced by psychopathology or by characteristics of the youth that are in developmental transition.
- D. The deficits must be interpreted in light of the complexity of the forthcoming proceedings. Some youths with monitoring and memory deficits due to an attentional disorder may have little difficulty in a brief juvenile court trial, but would be unable to deal with lengthier proceedings, especially those that may involve publicity and media attention.

VIII. **Disposition in Incompetence Cases: Restoring the Youth to Competence— Rules Developed in the Adult System**

- A. The examiner must provide information to the court on whether the conditions responsible for the defendant's incompetence can be changed. The examiner must form an opinion concerning:
1. Whether an intervention exists that could increase the defendant's relevant abilities.
 2. If so, the likelihood of change if that intervention were employed.
 3. The time that is likely to be required to bring about the necessary change.
- B. The likelihood of restoring a youth to competence will vary, depending upon whether incompetence is due to:
1. Mental disorder
 2. Mental retardation and specific cognitive disabilities
 3. Developmental immaturity
- C. Some experts suggest that if the youth is incompetent to stand trial as an adult, the case should remain in or be remanded to juvenile court.⁵
- D. Similarly, if the youth is incompetent to stand trial in juvenile court, the case should be treated as a dependency case (like those cases in which child accused of crime is younger than the lower age limit for delinquency jurisdiction).

Interactive Exercise: Pre-hearing Interview of Competence Evaluator

The purpose of this exercise is for participants to learn how to effectively question the professional who prepared a competence evaluation in anticipation of the professional being called as a witness at the competency hearing. The trainer should be prepared to act the role of the evaluator for this exercise. If possible, the trainer should arrange for additional forensic psychologists and psychiatrists to play-act the role of evaluator so that this exercise may be conducted in small groups.

Step One: Randomly assign participants to the role of either the defense attorney or prosecutor in the case.

Step Two: Direct participants to fill out Part B of the exercise worksheet attached at Appendix C in preparation for their interview with the

⁵Richard J. Bonnie & Thomas Grisso, *Adjudicative Competence and Youthful Offenders* in Thomas Grisso & Robert G. Schwartz, eds., *YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE*. Chicago, IL: University of Chicago Press (2000).

evaluator who conducted the evaluation which they read earlier in the class.

Step Three: Select one "defense attorney" and one "prosecutor" to conduct separate interviews of the expert in front of the large group. After these interviews are completed, allow other participants to ask additional questions that have not already been covered. Trainer will critique the questions during the course of the exercise, and make suggestions on how to fine tune them, and suggest additional questions.

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APPENDIX A

Case Profile for Interactive Exercise

Mary Doe is a 13-year-old eighth grader at Suburban Junior High School. Late one Friday night she calls 911 and tells the dispatcher, "I just stabbed my step-father." Police arrive, finding the step-father dead.

Police take Mary to the station house. Her mother, who was at a charity event, comes to the station and is in the waiting room while Mary is interrogated. After giving Mary her *Miranda* warning, police question Mary. She says that her step-father was cruel to her, and she "couldn't take it any more."

Under the law of Everystate, Mary is charged as an adult. Her defense attorney files a motion for a competency evaluation. The criminal court judge orders the court's chief psychologist to conduct an evaluation. The psychologist visits Mary at the juvenile detention center, where she is being held. Mary appears well-oriented and has no difficulty keeping up her end of the conversation. He learns from her that she is a B student in a regular education program at Suburban. She has never been arrested before, and has had no disciplinary problems at school other than infrequent truancy. Mary says that she saw a psychiatrist after sixth grade because she was unhappy. She stopped after six months, but reports that she saw him again once about a month ago because her mother insisted.

The psychologist reports to the court that he administered an IQ test and interviewed Mary. Mary's IQ was 90. The psychologist observes that Mary has no cognitive difficulties, no evidence of retardation or mental illness, and that he has "no doubt that she is competent."

APPENDIX B

Sample Competence Assessments for Use in Interactive Exercises

Includes:

9. Mark Haas evaluation on competence to waive *Miranda* rights.
10. Hillary Simpson evaluation on competence to waive *Miranda* rights.
11. Christopher Cowan evaluation on competence to waive *Miranda* rights.
12. Hope Wood evaluation on competence to stand trial.
13. Bobby Carlisle evaluation on competence to stand trial.
14. Diego Alvarez evaluation on competence to stand trial.

Psychological Evaluation Re: Comprehension of *Miranda* Rights

NAME: Mark Haas

DATE OF BIRTH: October 7, 1986.

CHRONOLOGICAL AGE: 9 years 8 months

DATE OF EVALUATION: June 10,11,12,13,1996

LOCATION OF EVALUATION: University Legal Clinic, University Law School

EXAMINER: Courtney Rosenberg, Ph.D., ABPP

DATE OF REPORT: June 27, 1996

IDENTIFYING DATA AND REASON FOR REFERRAL:

Mark Haas was referred for a psychological evaluation by Attorney Sarah Combs in order to assist in determining his competence to make a knowing, intelligent, and voluntary waiver of his *Miranda* rights. Mark was arrested on April 5, 1996, on the charge of First Degree Murder related to an incident alleged to have occurred on April 1, 1996.

STRUCTURE OF THE EVALUATION:

Prior to my evaluation, I informed all parties I interviewed that I am a psychologist, and that I was asked to evaluate Mark Haas concerning his comprehension of his *Miranda* rights. I informed them that the content of the interview, assessment results, and my observations would be shared with his attorney in the form of a psychological evaluation report, that the report potentially would be introduced into evidence in court, and that I might be asked to testify in court.

I was provided with a copy of the version of the *Miranda* warning used in the Metropolis Police Department jurisdiction; a copy of the statements given by Mark Haas to the Metropolis Police Department; Metropolis Police records concerning the alleged incident; a Juvenile Court Pre-trial Services Court Report, undated, by Ms. Jennifer D. Smith; and the Report of Postmortem Examination dated April 2, 1996, by Dr. Stuart J. Gittleman. In addition, I have had contact with Ms. Anne Haas (Mark's mother).

EVALUATION TECHNIQUES ADMINISTERED:

Clinical Interview (2 hours)

Mental Status Examination

Wechsler Intelligence Scale for Children, 3e, (WISC-III)

Wechsler Individual Achievement Test (WIAT)

Comprehension of *Miranda* Rights (CMR)

Comprehension of *Miranda* Rights, True/False (CMR-TF)

Comprehension of *Miranda* Vocabulary (CMV)

Function of Rights in Interrogation (FRI)

RELEVANT BACKGROUND INFORMATION:

Personal History. Ms. Haas said Mark is the third of three boys. She said Mark's biological father sees him about once a month. Mark enjoys spending time with him. He works as a cook at a Kentucky Fried Chicken. Ms. Haas said Mark's father treats him well. There is no history of abuse

or neglect. Ms. Haas said she formerly worked as a day care provider. She then became a Department Of Public Welfare (DPW) foster mother. Since the alleged incident, she has been unemployed. She is dating Mr. Andrew Johnson, who has a good relationship with Mark. He is employed as a truck driver. Ms. Haas described her relationship with Mark as "good." She said he listens well and does what he is supposed to do. She described him as "easy going." She said he gets along "fine" with his brothers. She said they argue over "petty simple little things," but from her perspective they do not argue more than most siblings. She said they do not engage in physical fights. Mark's older brothers are ages 14 and 16. Ms. Haas said there is no history of physical abuse, sexual abuse, neglect, mental illness, or substance abuse in the family. She said she lives in a safe neighborhood and does not worry when the children play outdoors.

When asked who is in his family, Mark said he has a mother and two brothers. He also named a father, four aunts, the children of his aunts, his grandfather, and two uncles. He said he gets along with his mother. When asked what he likes about her, he said, "She fix me dinner and she bought me clothes." He could think of nothing he wished was different about her. His brothers are ages 16 and 14. When asked to describe his 16 year-old brother, Mark said, "'He likes to play basketball and he likes to play the game, 'Playstation.'" He said his 14 year-old brother likes to play games, skate, and play basketball and football. Mark said his mother has a live-in companion named Andrew Johnson. When asked what he likes about Mr. Johnson, Mark said, "He take me to play basketball, he fix my bike for me one time." He could think of nothing he wished was different about Mr. Johnson. When asked how his mother disciplines him, Mark said, "Sometimes she whoop me." He said she "whoops" him "kinda soft," only once in awhile. Mark said that when he is in trouble with Mr. Johnson, "He tell my mamma to whoop me." Mark said he gets along "okay" with his brothers. He said he does not fight with them.

With respect to his educational background, Ms. Haas said Mark finished second grade. He is a third grade student. He earned good grades but had some difficulty in reading. She said his teacher told her he needed a little help in reading." She said Mark had no behavior problems in school. She said, "The teacher said he's nice." He had no history of visits to the principal's office, suspensions, or truancy. Mark was offered an alternative school placement after the arrest. Ms. Haas declined the offer because he would have been the youngest child in the class (she said the lowest class in alternative school is fifth grade). She also declined because she did not see a need for counseling for Mark.

Mark said he gets Bs in school "and sometimes I get As and Cs." He said he likes school. His favorite subject is math. He could think of nothing he disliked about school. He said he was never in trouble with the teacher or the principal in school. He has no history of truancy or suspensions.

Ms. Haas said she has lived in her current residence for four months. Mark has made five or six friends his age, who come over nearly every day. She said his friends seem like good children. She is not worried they might have a bad influence on him. She said he does not fight with his friends.

When asked about his friends, Mark said, "They're good." He plays with peers from his school and his neighborhood. They "play games" together such as "soccer, basketball." He said he never fought with his friends. He did not know whether any of his friends ever got into trouble. He shrugged and said, "I don't think so." Mark said he has never tried alcohol or drugs.

When asked what kinds of weapons he had, he looked surprised and said, "Nothing." He said he does not know anyone who has guns or knives.

Medical History. Ms. Haas said Mark has had no major illnesses or injuries. She said he began talking at age one, walking at 11 months, and he was toilet trained at age two. She was not worried he was delayed.

Psychiatric History. Mark has no psychiatric history. He has no history of trauma. Prior to the alleged incident, the only death he experienced was his grandmother's death. His grandmother died when he was about age five.

MARK'S ACCOUNT OF THE CIRCUMSTANCES OF THE ARREST, THE *MIRANDA* WARNING, AND THE CONFESSION:

Mark said he did not recall being read his rights or given a warning. When asked if the police read him something from a piece of paper, he shook his head no. When asked if the police asked him questions such as whether he understood what they were saying, he said, "No."

Mark said, "It was on a Sunday when I first talked to them. The police, they had come to pick up my mother. Then they took us to the police station. They said it was only gonna take an hour." He said he did not go to the police station with his mother. He said, "They took her." He said, "Then at nighttime she was still down there. Then they came to pick me and my two brothers up. Took us down there." He said he rode in the same car with his older brother David. They rode "in a detective car." He said it was not a police car with lights on it, but it had writing on it that indicated it was a police car.

Mark said the police told him, "Put on some clothes," He had been wearing a t-shirt and some shorts. He changed into "some blue jeans and another shirt." He said there were two police officers. When asked if the police officers told him why they were picking him up, he said, "No." They did not talk to him or David during the ride to the police station. He said, "Then they put us in a room and they put David in one room, they put me in a other room. They put Simon in another room." He said, "Then people was coming in and asking us questions. The police was asking us questions."

Mark said he could not recall how many officers questioned him. He knew it was more than one and less than five. He said, "It was like three." He said, "First they start asking me questions, then my mother came in." When asked what the police asked him before his mother came in to the room, he said, "I can't remember." Mark said when his mother came in the room, "They were asking her questions." He said he did not remember what they asked her. He did not recall that they read something to her. He did not recall whether they said something to her that sounded like the *Miranda* warning.

When asked if his mother gave the police permission to talk to him, Mark shook his head no. When asked if the police asked his mother if it was okay if they talked to him, Mark shrugged and said, "I don't know." He said the police officers did not give him and his mother a chance to talk to each other before they asked him questions. He said they did not ask him if he wanted to talk to his mother before he talked to them. When asked what his mother said about talking to the police, he said, "Nothing."

Mark said one police officer "had gave me a pop and a bag of potato chips." He said, "He asked me do I want it and I said yes." He did not describe any angry behavior in the police officers. He said one man was "nice, the one that bought me the pop." When asked if he felt afraid of the officers that night, he said, "No." When asked if he knew what the officers were up to that night, he said, "No."

When asked what kind of questions the police asked him, Mark said he did not remember. When asked what he thinks they asked him about that Sunday, he shrugged and said, "I don't know." When asked if the police questioned him on Sunday about the death of Robert Scoles, he said, "Yes, but I can't remember that." When asked if the police asked him about a fight with Robert Scoles, he said, "Yes." When asked what the police asked him, he said, "Did we have a fight?" He could think of no other questions the police might have asked him. Mark said he was in the interview room "for four hours, it was ten o'clock." He said he left the police station "at two." He said he knew it was four hours "because I had looked at the time, and then the Police came in the room and said, 'Y'all can get ready to go.'" He said he felt "happy" when the police told him he could go home. Mark said his mother did not say anything to him on the ride home. He did not remember talking with his mother later about what happened at the police station. He said his mother did not bring it up at all.

Mark did not recall what day it was the next time he talked with the police officers. He recalled, "It was in the morning time." He was "at my auntie's house." He said, "Then they came to pick us up from there. Me and David." He said the police officers did not say why they wanted to pick them up. He said, "They was gonna take us to the police station." He said two officers came to get them. He and his brother rode in the same car.

Mark said, "Then they took us in a room. Me and him was in a room together that time." He said he and David did not talk about anything. He said, "Only one officer came in. He asked us how old we were, what grade we in, when we got birthdays. That's the only thing he asked." He said, "Then we stayed in the room for a long time. Then my momma came down. Then she came to pick us up. Then we went home." He said the police asked him no other questions that day. When asked specifically if the police questioned him that day about the death of Robert Scoles, he shook his head no.

MS. HAAS ACCOUNT OF THE CIRCUMSTANCES OF THE ARREST, THE *MIRANDA* WARNING, AND THE CONFESSION:

Ms. Haas said on Sunday afternoon, at about 12:30 p.m., the police rang the bell. Her son David answered the door. Two detectives came in and informed her there is an investigation when a child dies. She invited him to her table, but they asked if she would accompany them to the police station. She expressed concern that there was no childcare for her children (she had her three sons and five foster children in her home). The police officers told her she would only be gone for one hour. They encouraged her to have her oldest old son mind the children.

Ms. Haas said she went to the police station in the police car. She said the police officers talked with her about how nice her house was. She said when they arrived at the station, an officer said he needed to call the coroner's office. She said two officers (Detective Pedro and Detective Hoddy) put her in a room and locked the door. They asked her to describe what happened on Saturday when the child died. They left and made a telephone call. They said they needed to leave and pick up the coroner's report. She inquired why they needed to do so

given that they had just told her they would get it by telephone. They assured her they would be gone only a short time. They were gone for two hours.

Ms. Haas said when the detectives returned, they "had a different attitude." She said, "They came back in and said I was wasting their time. They said I knew what happened to the boy. She exchanged expletives with them. They left the room. When they returned, the officers said they had her children in the other room. The officers told her that her children had admitted to a particular behavior. She said it was not possible. She explained why. The police informed her that Mark admitted to a particular behavior. Ms. Haas informed them that incident had occurred nine days before the alleged murder. The police officers told her Mark admitted to another particular behavior. She responded with an explanation. She said the police officers interpreted her child's behavior in a different way. She told the police they were not going to close the case with her children.

Ms. Haas said the officers left. She said they closed the door each time they left. They returned after another 30 or 40 minutes. She confronted the officers about telling her children they committed a particular act. She said the officers told her they had told the children something else. A female officer entered the room for a short time but asked no questions. It turned out she was a youth officer. About one hour before they left the station, the officer took her into a room with her other son. She explained what took place in the room with her other son. She was in the room for about the 20 minutes.

Ms. Haas said the officers took her out of the room. A youth officer explained the children were not going to jail, but the case had to be closed whether it was justifiable homicide or some other behavior. The officers took Ms. Haas to a room where Mark was sitting. One of the detectives, either Mr. Pedro or Mr. Hoddy, and a youth officer were in the room. A third individual (female) was in the room. Ms. Haas could not recall her name or position.

Ms. Haas said Mark started "saying what happened." She said from her perspective, they were putting words in his mouth. A detective yelled at Mark and used expletives. A detective informed her outside the room that Mark admitted to a particular behavior. Ms. Haas left the station at about 1:30 a.m. She called Mr. Johnson to pick them up and transport them home.

Ms. Haas said no officer read her the *Miranda* warning. She then said they might have read the *Miranda* warning but she did not pay attention. She said, "I was out of it." She said she was operating under the assumption that Robert Scoles died of illness--choking on vomit (she had been informed of this by the physician on Friday evening), so she did not see a reason to pay attention to the *Miranda* warning. She said she had not eaten since Friday evening and she was tired. She felt optimistic that her children would be exonerated. She did not recall reading or signing a card or piece of paper with the *Miranda* warning. She said they did not give her an opportunity to consult with her son before they questioned him. She said Mark was at the station for three hours before she was informed he was there. She said she knew it was three hours because the officers told her they picked him up at about 2:30 or 3:00 p.m.

Ms. Haas said on Wednesday she was visiting her sister. The police came to her sister's residence. DPW had taken the four foster children out of her home on Sunday. A DPW officer had been calling constantly threatening to take her children and asking her to sign a document. She refused to sign it. DPW asked her not leave her home so she would not talk to the press. The police officers advised her she might need an attorney. She began to trust the police

officers, thinking they were trying to help her. She called Detective Hoddy for advice about whether she was obliged to talk to DPW. When the police officers arrived at her sister's home on Wednesday, she was "happy to see them" because she thought they would help her keep her children rather than losing custody to DPW. The police officers asked her to come with them. She had her oldest son with her. She was confused concerning why they did not want to take her oldest son. The officer said her oldest son was safe there.

Ms. Haas said she was picked up by Detectives Pedro and Hoddy. They informed her that her two sons were in protective custody until the investigation was over. At the station, at around 4:00 p.m., Ms. Haas asked for the youth officer. Ms. Haas was ill and had not eaten well for five days. When she asked the youth officer for her children, the youth officer said, "The officers didn't tell you they arrested your children?" Ms. Haas "nearly fainted" and the youth officer began to pray for her. The youth officer called the detective and asked why Ms. Haas was not informed her children had been arrested. The detective cursed at her. She hung up and called the detective's supervisor. She asked the supervisor why the detective was being unprofessional and cursing at her, and why he had not informed the mother that her children had been arrested. The youth officer again told Ms. Haas her children were under arrest and she had to process them.

Ms. Haas said when the youth officer returned with their children, the boys were handcuffed together. Ms. Haas was informed her that 14 year-old son would be taken to juvenile detention. The nine year-old would be assessed to determine if he should be hospitalized or sent home. After they interviewed Mark, they decided to send him home. The youth officer informed Ms. Haas there would be a court hearing in the morning. The youth officer told her she did not need an attorney. Ms. Haas said she was not read her rights, nor were her children read their rights in front of her. She was not given an opportunity to consult with her children.

POLICE RECORDS CONCERNING THE ARREST, THE *MIRANDA* WARNING, AND THE CONFESSION:

Based on information from the Metropolis Police Department, Mark's statement is recorded in cursive writing on a small form. Because Mark does not have the ability to read cursive handwriting, it is unlikely he had an opportunity to review what was written. There is nothing in the police records that specifies when and whether the *Miranda* warning was read to Mark. There is no *Miranda* card or sheet of paper that bears Mark's or his mother's signature.

ASSESSMENT RESULTS:

Mental Status Examination. Mark presented with no evidence of problems with self care skills. He was dressed in casual play clothes. He separated easily from his mother, but he was anxious to return home at the end of each assessment session. He was cooperative and compliant during the assessment. He had no difficulty paying attention. He sometimes was mute. He sometimes showed animation in his face (e.g., a puzzled look) during his elective mutism. When queried during periods of muteness, he typically said he did not know the answer to the question. He made few spontaneous statements. His spontaneous speech was limited to the expression of manners (e.g., saying Bless you, or Thank you). He gave brief responses to questions during small talk. He did not ask for clarification when he misunderstood questions or instructions.

Mark showed no behavioral abnormalities. He showed an unusually low level of kinetic behavior for a boy his age. He did not show any attention seeking behavior. He did not emit any behavior that required setting limits. He sometimes sucked on his pinky fingers. His mood was calm with little affective expressiveness or variation. His speech was simple but coherent. He had limited vocabulary and expressive language abilities. To the extent that he was able to describe information in a narrative sequential manner, his speech was organized. He responded to questions in a concrete manner. He showed no evidence of distorted perceptions in his speech or behavior.

Mark was oriented to person, place, and approximate time of day. He had difficulty describing his situation or describing the reason for the evaluation. His appetite was variable as observed over lunch breaks. He described no difficulty with sleep or energy. His energy level was adequate throughout the assessment, but he showed passive behavior. He showed fatigue on the final day of the assessment. When the interview contained distressing questions, he showed passivity and withdrawal.

Cognitive Functioning. On the WISC-III, Mark obtained a Full Scale IQ of 78, placing him in the "Borderline" range of intellectual functioning. His Full Scale IQ falls at the 7th percentile relative to children his age. His Verbal IQ was 76 and his Performance IQ was 83 (a nonsignificant discrepancy). Relative to his other subscale scores, he demonstrated strength on the Arithmetic subscale (associated with calculation abilities and concentration skills) and weakness on the Similarities subscale (associated with abstract conceptual reasoning skills) and the Coding subscale (associated with decoding skills, rote memorization skills and rapid learning skills).

On the Wechsler Individual Achievement Test (WIAT), Mark obtained a total composite score of 84, which is at the 14th percentile relative to children his age. Results suggest he is functioning at an age level of seven years and six months. He obtained a Reading Composite Score of 78 (the 7th percentile relative to children his age, age equivalent of 7:9), a Mathematics Composite Score of 92 (the 30th percentile, age equivalent of 9:0), a Language Composite Score of 95 (the 37th percentile, age equivalent of 8:9), and a Writing Composite Score of 75 (the fifth percentile, age equivalent of 5:9).

Abilities Related to Comprehension of Miranda. The Comprehension of *Miranda* Rights measure is an objective method for assessing an individual's understanding of the elements of the standard *Miranda* warning. It requires the individual to paraphrase each of the four elements of the *Miranda* warning. On the CMR measure, Mark obtained a score of zero out of a possible eight points. The results of the CMR suggest Mark did not understand any of the elements of the *Miranda* warning.

The Comprehension of *Miranda* Rights, True or False Version (CMR-TF) consists of 12 true-or-false items in four sets of three items. Each set corresponds to one of the four components of the *Miranda* warning. The purpose is to assess a person's understanding of each element of the *Miranda* warning by ability to identify whether or not a particular preconstructed sentence has the same meaning as the *Miranda* warning statement. On the CMR-TF, Mark obtained a score of four out of a possible 12 points.

The Comprehension of *Miranda* Vocabulary (CMV) measure is an objective method for assessing an individual's understanding of six critical words which appear in standard *Miranda*

warning. On the CMV, Mark obtained a score of zero out of a possible 12 points. Results of the CMV suggest Mark did not understand key vocabulary words in the *Miranda* warning. When the language was simplified, he still could not define the key words. In response to multiple choice cues, he agreed that the phrase "talk to" was the same as saying words and a lawyer is someone who defends you in court. He thought questioning was unrelated to talking or answering questions. He agreed it was consistent with asking questions and it is something that lawyers and police officers do. He said it is not something that teachers or mothers do.

The Function of Rights in Interrogation (FRI) is a structured interview format. The interview questions occur in the context of visual stimuli (four standard drawings depicting relevant police, legal, and court procedures), followed by a paragraph to produce a context in which the subject is to respond. On the FRI, Mark obtained a score of 11 out of a possible 30 points. Results of the FRI suggest Mark did not understand the police might be interested in obtaining a confession or that they police might display emotional behavior consistent with the intention of dealing with the suspect as an adversary. He did not understand the main job of a lawyer or the role of a detained individual when meeting with a lawyer. He understood the police thought a suspect might have done something and they were interested in learning "what did he do." He understood a detained individual's lawyer might wish to discuss whether he committed a crime. He did not understand why a lawyer might need to know whether the detained individual committed a crime. He did not know a statement or confession would be used against a defendant in a court of law. He did not know the role of the police should the detained individual refuse to give a statement. He knew the police could not force a detained individual to talk. He did not know whether there would be consequences in court if a detained individual refused to give a statement. He thought that once the case reached court, a judge could compel a defendant to confess to a crime.

When I asked Mark to read the version of the *Miranda* warning used by the Metropolis Police Department, he read it in a halting manner. It took Mark nine minutes and 28 seconds to read the *Miranda* warning. He read it in the following manner:

"Do you understand that you had a right to remain silence? Do you understand that an an, Can I skip this word? Anything you say can and may be used against you in court or other p p? Do you understand that you have the right to talk to a law law lawyer before we aks you any questions and to have him with you during questioning? If you cannot afford a or other w wi other other wi (pause) a lawyer and you want one, a lawyer will be a asss ap a p (yawn) (puzzled look) um for you, and we will not aks you any questions until he was has been ap. If you do to answer now with or without a lawyer, you still have the right to stop the questioning at any time or to stop the questioning for the purpose, I mean, yup purpose, of co con (scratching his head) ummm a lawyer. You may waive of a and your right to remain silent and you may answer questions or make a statement without cosuting c su ting a lawyer a lawyer if you so dr whew deesh deesh. Do you understand each of these r rights? Do you wish to answer questions at this time?"

When I asked Mark to read his statement, he could not read it because he does not have the ability to read cursive handwriting.

INTERPRETATION OF PSYCHOLOGICAL ASSESSMENT RESULTS:

Mark was raised by his mother in Metropolis. She has been the primary parent. His father has had some involvement with him, but his visitation is infrequent. Mark has a good relationship with his mother's dating partner. He has an extended family support system. Based on his mother's report, Mark lives in a safe neighborhood and he plays with safe peers in the neighborhood. He is making academic progress, but he has a reading problem. He has no history of serious medical or mental health problems.

Mark's educational history is unremarkable. However, cognitive testing suggests his abilities fall in the "Borderline" range of functioning. He learns and understands less than about 90 to 95 percent of his peers. Achievement assessment results are consistent with the cognitive assessment results. The results suggest he currently is functioning in the five- to early nine-year-old age range of achievement, with the greatest deficits appearing in abstract conceptual reasoning skills, reading skills and writing skills.

To illustrate Mark's level of achievement, he can read basic one-syllable words and some two-syllable words. He did not show consistent ability to read words with three or more syllables. He comprehended only simple paragraphs of information that he read. His listening comprehension was stronger than his reading comprehension. His capacity for oral expression was comparable to children his age, but he had difficulty providing a narrative with descriptive information. For example, he used words such as "here" and "there" rather than identifying specific locations by their name or description. He did not elaborate or distinguish essential from unessential details. He did not resolve inconsistencies even in response to direct questions. He spelled the word things, "thigs," right, "Rigth," counting, "conting," and eight, "eagth." He has not mastered punctuation and basic grammar. When asked to write a paragraph describing a home he would like to build, he wrote one sentence with little detail and no punctuation. He can add and subtract two-digit numbers, and solve simple multiplication problems.

Mark did not comprehend the main elements of the *Miranda* warning, key vocabulary words in the *Miranda* warning, or the consistency or inconsistency of statements that were the same or different from the *Miranda* warning. He had a vague notion that the warning involved talking, police officers, and lawyers. Although he understood a lawyer might be interested in talking to a detained individual about a crime, he did not know what the lawyer might do with this information. He did not understand the meaning of the word "right." He did not understand the interest the police have in obtaining a confession, nor did he understand a suspect's potentially adversarial relationship with the police officers. He did not appreciate how to apply the information in the *Miranda* warning to the circumstances of an individual who might be a suspect in a crime. He did not understand that a defendant's right to remain silent extends to the courtroom. It is unlikely he was malingering a poor performance on the *Miranda* Comprehension measures. His performance was consistent with his level of intellectual functioning and his academic achievement. Based on the assessment results, it is unlikely he understood the meaning or significance of the *Miranda* warning on the day or days that it was read or told to him by the Metropolis police.

Mark's mother does not recall whether she or Mark were read the *Miranda* warning. She described herself as fatigued, deprived of food and in emotional distress during the period of time she was expected to act as an interested adult. She described herself as ill-informed of her son's arrest status. She said they were not given an opportunity to consult prior to the police questioning her son.

CONCLUSIONS:

1. In my clinical opinion, Mark has a deficit in his reading and writing skills and his overall intellectual functioning is limited compared to his peers.
2. In my clinical opinion, Mark did not understand the core elements of the *Miranda* warning.
3. In my clinical opinion, Mark's lack of understanding of the core elements of the *Miranda* warning is related to his lack of experience with the legal system, his low fund of knowledge, his intellectual limitations relative to children his age, and his deficit in reading and writing abilities.
4. Because Ms. Haas does not recall whether Mark was read the *Miranda* warning, her role in advising Mark concerning his rights is unclear. She described herself as fatigued, hungry, and in emotional distress when Mark was questioned by the police.

Courtney Rosenberg, Ph.D., ABPP
Assistant Professor of Psychiatry
Diplomate, American Board of Professional Psychology,
Specialty in Forensic Psychology

Psychological Evaluation Re: Comprehension of *Miranda* Rights

NAME:	Hillary Simpson	NAME:	Bart Laks
DOB:	September 17, 1966	DOB:	February, 15, 1984
AGE:	30 years 11 months	AGE:	13 years 5 months

DATE OF EVALUATIONS: September 8, 1997

LOCATION OF EVALUATIONS: Offices of Attorney Lisa Campbell

EXAMINER: John W. Smithers, Ph.D.

DATE OF REPORT: October 5, 1997

IDENTIFYING DATA AND REASON FOR REFERRAL:

Ms. Hillary Simpson and her 13 year-old son Bart Laks were referred for psychological evaluations by Attorney Lisa Campbell. Ms. Simpson was referred for an evaluation in order to assist in determining her competence to advise her son concerning his *Miranda* rights. Bart Laks was referred for an evaluation in order to assist in determining his competence to make a knowing, intelligent, and voluntary waiver of his *Miranda* rights. Bart Laks was arrested on August 16, 1997, on two counts of Murder and three counts of Arson.

STRUCTURE OF THE EVALUATION:

Prior to my evaluation, I informed all parties I interviewed that I am a psychologist, and that I was asked to evaluate Ms. Hillary Simpson to gather information concerning her abilities related to advising her son concerning his *Miranda* rights, and to evaluate Bart Laks concerning his competence to waive his *Miranda* rights. I informed them that the content of the interview, assessment results, and my observations would be shared with Attorney Campbell in the form of a psychological evaluation report, that the report potentially would be introduced into evidence in court, and that I might be asked to testify in court. I was provided with a copy of the version of the *Miranda* warning used in the Shelbyville Police Department jurisdiction; a copy of the statement given by Bart Laks to the Shelbyville Police Department on August 16, 1997; a copy of a memorandum from the Social Security Administration confirming that Ms. Simpson receives SSI disability and she is classified as mentally retarded; raw test data from Dr. Julius Hibbert concerning a recent psychological evaluation of Bart Laks; and Bart's school grade and behavior reports from C. Montgomery Burns Middle School in Shelbyville.

EVALUATION TECHNIQUES ADMINISTERED:*Ms. Hillary Simpson:*

9/8/97 Clinical Interview (1 hour)
 9/8/97 Wechsler Adult Intelligence Scale-Revised (WAIS-R)
 9/8/97 Woodcock-Johnson Psychoeducational Battery
 9/8/97 Comprehension of *Miranda* Rights (CMR)
 9/8/97 Comprehension of *Miranda* Rights, True/False (CMR-TF)
 9/8/97 Comprehension of *Miranda* Vocabulary (CMV)
 9/8/97 Function of Rights in Interrogation (FRI)

Bart Laks:

- 9/8/97 Clinical Interview (1 hour)
- 9/8/97 Comprehension of *Miranda* Rights (CMR)
- 9/8/97 Comprehension of *Miranda* Rights, True/False
- 9/8/97 Comprehension of *Miranda* Vocabulary (CMV)
- 9/8/97 Function of Rights in Interrogation (FRI)

Raw Data Provided re: Bart Laks:

- 7/17/97 Wide Range Achievement Test, Level 2
- 7/31/97 Wechsler Intelligence Scale for Children, 3e (WISC-III)
- 7/26/97 Bender Gestalt Visual Motor Test

RELEVANT BACKGROUND INFORMATION:

Ms. Hillary Simpson is a 30 (nearly 31) year old woman with two sons (ages 8 and 13) in her custody. She is twice divorced, and she supports herself with SSI disability. As indicated above, her current classification by the Social Security Administration is "mental retardation."

Ms. Simpson said she has an eighth grade education. She attended special needs classes in a special education classroom throughout her education. She said she did not recall repeating any grades, but she could not otherwise explain why she was age 17 in ninth grade. She became pregnant during the eighth grade school year. She left school in ninth grade at age 17 after she married.

Ms. Simpson said she was healthy during her childhood. She received no serious injuries and she never lost consciousness. Ms. Simpson said she has never been arrested. Her history of involvement with the court system is limited to having sought restraining orders at various times.

Bart Laks is a 13 year-old student in the 8th grade. He attended Montgomery Burns Middle School in 6th and 7th grades. He currently is placed in a special program for children involved with the legal system and for children with school infractions. Bart said his grades were good until last year. His early school records contain comments that he was bright but he craved attention. His grade reports from middle school indicate he earned grades ranging from A's to C's, with one D+ which he brought up to a final grade of C+. He was absent 28 times and tardy 4 times in 6th grade. He earned grades ranging from A's to F's in 7th grade. He was absent 24 times and tardy 11 times in 7th grade.

Bart said he was in two car accidents (once as a passenger with his mother and boyfriend, and once as a passenger with his godfather); however, he received no injuries and he never lost consciousness. He has no history of previous arrests. He recalled his father was arrested for drinking and driving five years ago.

MS. SIMPSON'S UNDERSTANDING OF THE CIRCUMSTANCES OF THE *MIRANDA* WARNING, THE CONFESSION, AND THE ARREST:

Ms. Simpson said she and her son were interviewed by the police on two occasions. She said she misunderstood what the police officers told her son. She said, " I thought the police told him he had to remain silent. . . I thought he couldn't have any attorney until later." She

said two police officers came to her home and said they “hadda go down to the police station and they hadda ask Bart some questions.” She said, “They put him in this small room with two cops and me and they started questioning him.” Ms. Simpson said the police officers did not read Bart his *Miranda* rights during their initial interview of him. They asked him questions “about the fire.”

Ms. Simpson said she, her son Bart, a police sergeant, and Officer Ned Skinner sat in the questioning room for about two and one half hours. She said Bart sat next to a police officer, who sat next to the second officer. Ms. Simpson was seated next to a table in close proximity to the second officer, and some distance from Bart. Ms. Simpson recalled leaving the room for a period of time to have a cup of coffee and a cigarette. She could not recall on which day she left the room for coffee and a cigarette.

Ms. Simpson said the officers were “nice for a good half hour,” and then they were “nasty. . . mean tone of voice.” She said the officers told her, “He ain’t telling the truth.” She said, “I told Bart to tell the truth. . . he said he didn’t do it.” The officers were “nice until they decided Bart was lying. . . they said, ‘You better tell us and tell us now,’. . . I just backed off. . . I didn’t know what to say. . . they were pressuring my kid.” She said the police officers threatened to “lock Bart up right now.” She said, “All I kept saying was Bart please tell them the truth so we can get out of here and go home.” After one and one half hours of questioning, Bart started “crying a few minutes.” She said Bart “cries when he tells the truth,” so, “I told them he was telling the truth then.” She said, “They were being real strict with him. . . they finally let us go home that night.” She said she and Bart did not discuss the matter at home. She said, “All I said was I hope you didn’t do it and I dropped it.”

At this point, Ms. Simpson jumped to the next day of questioning as she gave her account. She said the officers asked herself, her brother, and her ex-boyfriend Moe if they would like to go outside for a cigarette. While they were out smoking a cigarette the police “came for me, one of the cops, and said Bart was ready to make his statement. . . I went upstairs. . . they had moved him to the computer room. . . they had his statement already written out on the computer. . . they said they had half of it on the computer. . . you could see it anyway.” She said, “They typed the rest of his statement. . . they read it to me. . . I didn’t understand what they said.” Ms. Simpson said she repeatedly requested that the police allow her brother to enter the room because she was “illiterate.” The police would not allow her brother to be in the room.

Ms. Simpson said she could not remember when the police read Bart the *Miranda* warning. She said, “I don’t know, but they showed me a warrant for his arrest when I was in the hallway. She said, “The cop said to him. . . in the little room. . . ‘You just killed somebody, how do you feel now, there’s two people dead.’”

Ms. Simpson was asked to clarify what happened on the first day and what happened on the second day of questioning. She said on the second day the police called her. She told them to wait until her children returned home from school, and then she would bring Bart to speak to them. She could not recall how she got to the police station that night. She said, “They brought us upstairs into that little room and they started questioning him some more.” The same two police officers were present, as were Bart and herself. They sat in the room for about 10 to 20 minutes at which point she requested to use the telephone. She called her brother and he and her ex-boyfriend came to the police station. She said, “From there, they

started questioning him some more."

Ms. Simpson said, "From the get go I told them I don't know how to read. . . both days I said I wanted someone there with me. . . I told them I don't know how to read or write. . . they didn't say anything." She said her brother asked to speak with Bart and the police officers allowed him to do so for a few minutes.

Ms. Simpson again said after the cigarette break, she "saw the statement on the computer. . . they were questioning him about the fire. . . I guess they must have stopped in the middle because they came down quickly and said he was all ready to give a statement about what happened." The police took Bart's statement and then informed her they were "keeping him." She said, "They promised him he would come home with me if he made a statement; that's why he made his statement." She said, "They said, 'If you tell us the truth, we'll let you go home with your mother.'"

Ms. Simpson said "After the whole statement was done, they read it to me. . . I didn't understand his statement either. . .they had me sign the statement. . . Ned signed as a witness . . . I kept asking for my brother." She said, "They read *Miranda* in the other room--before he went in the computer room." She then said the police read the *Miranda* warning "in the little room...they didn't do it right away. . .they kept asking him questions. . .they showed us the warrant for his arrest, then they read him that. . .then I went outside." She then said she does not recall whether the police read the *Miranda* warning in "the little room," or whether they read the warrant. She said she was standing in the hallway while they read it.

When asked for clarification concerning when the police officers read the *Miranda* warning, Ms. Simpson said, "I think they read it to us because I said I don't know how to read. . . I asked for my brother." She told the police officer, "I don't understand what you're saying." The police officer asked whether she understood and she replied, "No." She said the police officer told her, "You must understand." She said, "I finally said yes because I was mad." She said they inquired about her understanding of the entire *Miranda* warning rather than asking specifically about each point in the *Miranda* warning. She said, "If they would have explained it, I would have understood and my kid would have never said nothing that day until we got a lawyer."

BART LAKS' UNDERSTANDING OF THE CIRCUMSTANCES OF THE *MIRANDA* WARNING, THE CONFESSION, AND THE ARREST :

Bart said the police came to his house at about 5:00 p.m. and asked him and his mother to go to the police station. He said the police told him they wished to question him, but he would be able to return home. They told Bart there was nothing to worry about. He said he was questioned for two to three hours at the police station. He said everyone sat in a circle, with Sergeant Wiggum and Officer Ned Flanders sitting in closer proximity to one another than anyone else. He recalled sitting between Sergeant Wiggum and his mother. He said Sergeant Wiggum and Mr. Flanders asked Ms. Simpson whether they had permission to talk with Bart. He recalled that his mother replied, "Sure." He said no one asked his mother any further questions and no one said anything about his rights.

Bart said the two officers told him, "We already know you did it; your friends ratted you out, so you might as well admit it." Bart did not admit to anything on the first day. He said his

mother advised him to, "Stop lying, just tell the truth." He told his mother he was not lying. The officers repeated that someone had "ratted on him." He said the officers initially used a regular tone of voice and "Then they started yelling at me, 'Stop playing <expletive>, we know you did it.'" He said, "They yelled for a half hour, they took turns."

Bart said on the following day, the police called his mother requesting she bring him in. After Bart ate dinner they left for the police station at about 5:30 or 6:00 p.m. He said the officers immediately took him into the same room. He could not recall the arrangement of the chairs. He said he does not recall them asking his mother's permission to speak with him prior to the questioning. He, his mother, Sergeant Wiggum, and Mr. Flanders were in the room for two hours. His mother "said nothing during the whole time. . . sat and listened to them." He said, "They asked the same questions over and over. . . never read me my rights." He said, "They were mean. . . yelling and swearing at me... told me if I wanted to play hard they could play hard too. . . told me I'm gonna find myself in jail." He said a fifth person, Officer Skinner, entered the room for ten minutes and "started swearing at me. . . spit on me. . . said, 'Don't look too [expletive] comfortable, this ain't no joke.'"

Bart said while the third officer was in the room, the other two officers left with his mother and asked if she wanted a cigarette. She joined Bart's uncle outside for a cigarette. While she was outside, Officer Skinner took Bart into the Lieutenant's office. Sergeant Wiggum returned and joined them. He said, "We all sat down; he turned on the computer; Wiggum read me my rights; after I heard my rights, he started typing my name and date of birth." Officer Skinner then told Bart they were going to take a statement. Bart said, "He said, 'What happened that night?' and I told him my statement and stuff." He said, "Before they finished my statement they said, 'If you say you were there we'll let you go home with your mom and you'll be all right.' I said I was there; Wiggum asked me if I wanted a soda and I said, 'Yeah'; Skinner walked out of the room; he came back in and said, 'We got a warrant out for your arrest so you're coming with us.'"

Bart said Officer Skinner was seated at a desk in front of a computer. Bart sat next to the desk, and Officer Wiggum stood behind them. He said his mother remained in the hallway after she returned from smoking a cigarette. Bart said one third of his statement was completed when his mother returned. He said Sergeant Wiggum and Officer Skinner informed his mother they were taking Bart's statement and she said, "All right." Bart finished his statement and Officer Skinner read the statement to Bart while Sergeant Wiggum read the statement to Ms. Simpson.

Bart said, "They told my mother they had read me my rights; they read the rights to her that they had read to me." As he described the reading of the *Miranda* warning, Bart said, "They read a paper to me, they were leaving words out and putting words in." He said they did not give him a copy of the warning, but he could see it as they held it and read it to him. He said they read it to him only one time. Bart said Officer Skinner asked him whether he understood his rights and he said, "Yes." He also recalls listening as Officer Wiggum asked Ms. Simpson if she understood her rights. He said, "She said yes, but later on that night she said she really didn't understand it and I said I didn't either." He said, "They used the word attorney, not lawyer. I asked mom what an attorney was and she said, 'It's something like Jane Tolliver. . . an attorney.'" Bart said no one asked him or his mother whether they had any questions about the *Miranda* warning.

BEHAVIORAL OBSERVATIONS AND MENTAL STATUS OF MS. SIMPSON:

Ms. Simpson presented dressed in casual clothing. She spoke slowly and she had difficulty with word finding and with articulation. Her predominant mood was frustration, especially during the formal psychological testing. She said, "They gave me this test before and it's real frustrating." She gave responses suggestive of acquiescence (or the tendency to agree to things she does not understand) and limited assertiveness skills (difficulty understanding how and whether she is permitted to ask questions and seek clarification) . For example, she sometimes said, "Yes" and sometimes said, "I don't know," in response to complex nonsensical questions asked by the examiner, and she alluded to the fact that she felt compelled to enter into a romantic relationship with her ex-boyfriend because of his assistance with her son's bail.

ASSESSMENT RESULTS, MS. HILLARY SIMPSON:

Cognitive Functioning: On the WAIS-R, Ms. Simpson obtained a Full Scale IQ core of 69, placing her in the "Mentally Deficient" or "Mentally Retarded" range of intellectual functioning. Her obtained Verbal IQ score was 70, and her Obtained Performance IQ was 72. Relative to people her age, she currently is in the 2nd percentile of intellectual functioning.

On the Woodcock-Johnson Psychoeducational Battery, Ms. Simpson obtained a Reading Cluster Score of 451, which is a grade equivalent of 1.8 and an age equivalent of 7, and which falls in the less than 0.5 percentile relative to people her age. She obtained a Mathematics Cluster Score of 455, which is a grade equivalent of 2 and an age equivalent of 7 years 2 months, and which falls in the less than 0.5 percentile relative to people her age. She obtained a Written Language Cluster Score of 462, which is a grade equivalent of 1.8 and an age equivalent of 7 years 4 months, and which falls in the less than 0.5 percentile relative to people her age. She falls in the "Severe Deficient" range of achievement.

Abilities Related to Competence to Render Advice Concerning Miranda Rights: In the Comprehension of *Miranda* Rights (CMR) measure, four core items contained in the *Miranda* warning are read one by one to the examinee, while they read along on a card. After each item is read, the examinee is asked to explain what each item means. The examinee can score up to two points of credit for each correct explanation. The maximum score is 8 points. Ms. Simpson obtained a score of 3 on the CMR.

The Comprehension of *Miranda* Rights, True or False Version (CMR-TF) is a 12 item measure which assesses the examinee's ability to discern whether statements read to the examinee are the same or different from that contained in the *Miranda* warning. The examinee can score up to one point of credit for each correct response for a maximum score of 12 points. Ms. Simpson obtained a score of 7 on the CMR-TF.

The Comprehension of *Miranda* Vocabulary (CMV) is a measure of the examinee's understanding of six critical words contained in the *Miranda* warning. The word "entitled" was omitted from the administration of this measure to Ms. Simpson because the *Miranda* warning used by the Shelbyville Police Department does not use this word or an appropriate substitute. The examinee can score up to two points of credit for each correct word definition. Ms. Simpson obtained a score of 2 (out of a possible 10 points) on the CMV.

The Function of Rights in Interrogation (FRI) is a measure in which the examinee is

sequentially shown four cards depicting relevant police, legal, and court procedures. Each is accompanied by a brief scenario provided by the examiner in order to establish a contextual set for responding. The examinee is asked a total of 15 questions about the sets of stimuli. The examinee can score up to two points of credit for each correct definition for a maximum score of 30 points. Ms. Simpson obtained a score of 22 on the FRI. She often referred to her attorney in describing her understanding, suggesting she learned much of the information relevant to this measure after she hired her.

BEHAVIORAL OBSERVATIONS AND MENTAL STATUS OF BART LAKS:

Bart presented dressed in clothing typical of adolescents. He had a friendly demeanor and he occupied his leisure time talking to other people in the office. His mood was nervous and he showed signs of motor restlessness during the evaluation; however, he was cooperative with all assessment tasks. Because of the recency of Bart's school testing, the IQ test was not repeated. The raw data were relied upon from previous testing.

ASSESSMENT RESULTS, BART LAKS:

Cognitive Functioning: On the WISC-III, Bart obtained a Full Scale IQ score of 81, placing him in the "Low Average" range of intellectual functioning. His obtained Verbal IQ score was 79, and his Obtained Performance IQ was 87. Relative to adolescents his age, he currently is in the 10th percentile of intellectual functioning. Results suggest he has average attention and concentration skills; however, he likely performs poorly on material that requires abstract thinking, reasoning, and understanding of social nuances.

On the Wide Range Achievement Test, Bart obtained a Reading Score of 49, which is a grade equivalent of the end of 7th grade and which falls in the 50th percentile relative to adolescents his age. He obtained a Spelling Score of 22, which is a grade equivalent of the beginning of 6th grade and which falls in the 34th percentile relative to adolescents his age. He obtained an Arithmetic Score of 28, which is a grade equivalent of the beginning of 7th grade and which falls in the 30th percentile relative to adolescents his age.

Abilities Related to Competence to Waive Miranda: On the Comprehension of *Miranda* Rights (CMR) measure, Bart obtained a score of 3 out of a possible 8 points. On the Comprehension of *Miranda* Rights, True or False Version (CMR-TF), Bart obtained a score of 11 out of a possible 12 points. On the Comprehension of *Miranda* Vocabulary (CMV), Bart obtained a score of 6 out of a possible 10 points. He said he did not know the word "attorney" when the *Miranda* warning was read to him. He learned the word later. On the Function of Rights in Interrogation (FRI), Bart obtained a score of 22 of a possible 30 points.

INTERPRETATION OF PSYCHOLOGICAL ASSESSMENT RESULTS:

The assessment results for both Ms. Simpson and Bart are valid and interpretable. Neither Ms. Simpson nor Bart have a history of having been arrested and accordingly they would not have had a previous opportunity to hear or try to understand the *Miranda* warning. Ms. Simpson showed consistent effort during the assessment, and she expressed frustration when she had difficulty on the assessment tasks. She defended herself by pointing out that although she has problems (e.g., she cannot perform multiplication and division), she has ways of compensating for her deficits (e.g., by using a calculator). Her failures on tasks were not remarkable for

uniqueness or oddities which would lead one to suspect the presence of malingering.

For example, Ms. Simpson showed no signs of malingering as evidenced by the consistency of her effort and her scores across the various evaluation methods, her statements of concern that she might do poorly, and her statements defending the ways in which she uses compensatory methods (e.g., use of a calculator) to make up for her deficits. Her approach to various difficult test items was consistent with that seen in people who are not malingering. For example, she used trial and error approaches and she made naive statements in response to difficult tasks in a manner similar to those seen in people at the same level of intelligence.

In Bart's raw data, provided by a previous examiner, there are no signs of inconsistent responding. His scores on achievement testing are consistent with what would be expected based on his IQ test results, and there is no intrasubtest scatter on either test. Bart made defensive remarks about material he learned relevant to the *Miranda* subsequent to his confession; however, he did not attempt to feign ignorance of the material. For example, he pointed out he now knew the definition of the word attorney even though he did not know it at the time the warning was read to him.

Assessment results confirm that Ms. Simpson obtained a Full Scale IQ score consistent with mental retardation, and her achievement scores also are consistent with mental retardation. Results indicate her intellectual functioning is less than that of 97 percent of people in her age range. She has a low fund of information, a limited vocabulary, and severe difficulty with abstract thinking. Results suggest her repertoire of behavior in social situations is limited. Her mathematical skills are limited to addition and subtraction. Bart's intellectual functioning is at the low end of the "Low Average" range. He has difficulty with abstract thinking, reasoning, and understanding social nuances. It is likely he has difficulty discerning subtle social cues such as how to understand what is expected of him in subtle, complex, or ambiguous social situations.

Results of the Woodcock-Johnson indicate Ms. Simpson's achievement in reading, mathematics, and written language is comparable to that of a seven year-old performing at a first or second grade level. Her achievement in reading (which consists of word-letter identification, learning new words, and passage comprehension), mathematics (calculation and applied problems), and written language (dictation and proofing) is less than that of 99.5 percent of people in her age range. Results of the Wide Range Achievement Test indicate Bart is one to two years behind what is expected of youths his age with respect to academic achievement.

The specific measures of abilities related to competence to waive *Miranda* (the CMR, the CMR-TF, the CMV, and the FRI) used in this assessment have their basis in measures found to be valid and reliable in a standardized study of adolescents' and adults' understanding of the *Miranda* warning. One word, "entitled," was omitted from the CMV because the word had only one comparable substitute ("right") and that word already was contained in the CMV.

Ms. Simpson's CMR score is poor. The average score in the comparison sample was four points higher than her score. Ninety-seven percent of the comparison sample performed better than she did on this measure. When asked to explain, "You have the right to remain silent," Ms. Simpson understood there is a choice about whether or not to speak. She understood the choice pertained to the questions asked by the police. When asked to explain, "Anything you

say can be used against you in court," she repeatedly parroted the words "against you" but she could not define or explain what it meant. She said, "I'm not too sure on that. . . whatever you say, they can use against you. . . that's all I know." She did not associate it with self incrimination or the potential for negative consequences. When asked to explain, "You have the right to talk to a lawyer for advice before we ask you any questions and to have him with you during questioning," Ms. Simpson explained this meant she could tell a lawyer what happened and then the lawyer would tell the police what she said. She did not comprehend the advocacy role of an attorney. When asked to explain, "If you cannot afford a lawyer, one will be appointed for you before questioning if you wish," she thought a lawyer would be appointed for her when she went to court. She did not understand she immediately could request a lawyer at no cost. When probed further, she understood that she could stop talking during questioning, but she did not understand she could request an attorney at any time before or during questioning.

Bart performed worse than 97 percent of the comparison sample on the CMR. Compared to other 13 and 14 year-olds in the sample, his score was in the average range. When asked to explain, "You have the right to remain silent," Bart's response suggested he was directed or compelled to be quiet. When asked to explain, "Anything you say can be used against you in court," he replied if he said something "bad" to the judge, it would be held against him; however, he did not know what "held against" meant. On inquiry, he parroted the words "held against" several times in an attempt to explain it, but he did not associate it with self incrimination or the potential for negative consequences. When asked to explain, "You have the right to talk to a lawyer for advice before we ask you any questions and to have him with you during questioning," he said he did not know what an attorney was when he was questioned. His response suggested he believes the function of a lawyer is to sit beside him and explain things; however, he did not comprehend the advocacy role of a lawyer nor did he comprehend his freedom to ask advice from the lawyer. When asked to explain, "If you cannot afford a lawyer, one will be appointed for you before questioning if you wish," he understood someone would call a lawyer for him, but he did not understand the lawyer's services were gratuitous.

Eighty-two percent of the comparison sample performed better than Ms. Simpson on the CMR-TF. She thought the statements, "You do not have to say anything about what you did," "What you say might be used to prove you are guilty" and "You can have a lawyer now if you ask for one," were inconsistent with information contained in the *Miranda* warning. She said the statement, "If you don't have the money for a lawyer the court will appoint a social worker to help you," was consistent with information contained in the *Miranda* warning. Bart made only one error on the CMR-TF. He thought, "You should not say anything until the police ask you questions," was consistent with information contained in the *Miranda* warning .

On the CMV, Ms. Simpson's definition suggested "talk to" included only her unidirectional statements to people; however, she did not comprehend its association in the *Miranda* warning with seeking advice from an attorney. She described an attorney as someone who "stands up and talks for you." When asked for elaboration, her explanation implied that the attorney simply repeated what the client said. She did not comprehend the advocacy role of the attorney. She did not know the meaning of the word "appoint." For example, when asked to define "appoint," she said, "When somebody's making a point to you." She defined questioning as, "When they ask you questions what happened and why it happened. . . the cops and your lawyer." She could not define the word "right" without parroting the word. She kept saying, "You have your own rights." When asked for an example of a right, she said, "You can talk."

Bart understood that “talk to” involves bidirectional conversation. He defined a lawyer as someone who “sticks up for his client.” He defined “questioning” as “questions about the case they’re gonna charge you with.” When asked to define “appoint,” he said, “I have no clue.” He defined “right” as “What you can do and can’t do.” His definition did not involve the notion of constitutional protection of this privilege.

Both Ms. Simpson and Bart obtained scores of 22 on the FRI. In the comparison sample, the average FRI score was 23 for juveniles and 26 for adults. Neither Ms. Simpson nor Bart understood their communications with their attorney are privileged. Ms. Simpson continued to show a deficit on this measure in her understanding of the advocacy role of an attorney. She made errors consistent with the attorney acting as a spokesperson for the client without advocating on behalf of the client or providing legal advice to the client. Her responses suggested she believes although a client can exercise a right to remain silent, the attorney must repeat what the client tells him or her. Her responses also suggest she believes her right to remain silent does not pertain when the person asking questions is a judge. She believes she must answer any question posed by a judge. Bart’s FRI responses also show a deficit in understanding the advocacy role of an attorney. His responses suggest the must tell his lawyer what happened so his lawyer can in turn tell the judge. He believes the lawyer functions as a witness. He also believes he must answer any question posed by a judge.

Ms. Simpson’s limitations in understanding what took place prior to and during her son’s confession is reflected in her confusion about various details. As she gave her account of what lead up to the confession and arrest, Ms. Simpson had difficulty separating events in her memory, and she confused details from both of the days of questioning. For example, she confused in which room various aspects of the questioning took place, and she confused the reading of the *Miranda* warning with the reading of her son’s confession, and with the reading of the warrant for his arrest.

Ms. Simpson’s description of her behavior during the questioning suggests she believed her role was to advise her son to “tell the truth.” By her account, she was sitting in closer proximity to the police officers than to her son. Her placement in the room was consistent with her view of herself as one of his adversaries rather than his ally. Her description suggests she viewed the police officers as authority figures to whom it was her job to respond with compliance. For example, she said when police told her that her son was not being truthful, she responded by asking him to be truthful. When he made statements consistent with the desire to remain silent, she encouraged him to speak.

According to her description, although she did not specifically request an attorney, Ms. Simpson emitted behavior consistent with the desire for assistance. She repeatedly said she did not understand the content of her son’s statement. She told the police officers she could not read or write. She saw to it that her brother was at the police station during the questioning. She requested the presence of her brother while the police read her son’s statement to her, and while they read the *Miranda* warning. She initially said she did not understand the *Miranda* warning; however, in response to what she perceived as pressure from the police, she then said she understood the *Miranda* warning. Ms. Simpson’s account of what happened suggests her emotional state was one of confusion, frustration, and being upset during the questioning and the reading of the *Miranda* warning, thus exacerbating her limitations.

CONCLUSIONS:

1. In my clinical opinion, Ms. Simpson has general functional limitations of the type associated with a diagnosis of Moderate Mental Retardation. Based on observations of Ms. Simpson's behavior and the IQ and achievement test results, Ms. Simpson currently has a number of functional limitations. Her educational achievement is at the second grade level, and her intellectual abilities are in the 2nd percentile relative to adults her age. She has a history of special assistance in her academic studies and in her adult life. She was in special education due to learning problems, and she currently is on SSI disability with a classification of "mental retardation."
2. In my clinical opinion, Ms. Simpson's cognitive limitations interfered with her ability to understand the *Miranda* warning and to advise her son about his rights on the night of her son's arrest. Assessment results suggest she performed below average on specific measures of the content of the *Miranda* warning, and she did not understand key words in the *Miranda* warning. Her description suggested some of her correct responses resulted from information she learned after she hired an attorney. She showed a deficit in understanding what it means to have something held against you. She believes it is a lawyer's job to tell the police (and later the judge) what his or her client has confided. She had difficulty comprehending the issue of confidential communications or the role of advocacy in the attorney-client relationship. She did not know the meaning of the word appoint, and she failed to understand her right to request a lawyer for her son at any time during the questioning. Ms. Simpson viewed the police officers as authority figures in a position to offer her direction and advice about her son. She had difficulty understanding their adversarial relationship with herself and Bart. She followed their lead in attempting to convince Bart to "tell the truth." For example, results of the CMR-TF suggest she thought Bart was compelled to answer questions and to tell the truth. She did not understand that information he provided would be used to prove his guilt. Her account of the questioning, her son's confession, and his arrest suggests that prior to and at the time of the reading of the *Miranda* warning she did not understand her advisory role in relation to her son's rights, and her emotional state was one of confusion, frustration, and upset.
3. In my clinical opinion, Bart lacks abilities associated with competence to waive his *Miranda* rights. He has limitations in abstract thinking, reasoning skills, and understanding social nuances. On specific measures associated with comprehension of the *Miranda* warning, he did not understand core elements of the warning. He confused the right to remain silent with what he thought was a requirement to remain silent until questioned by the police, he could not explain what it meant to have something held against him, he mistakenly believes his lawyer must tell the judge what he says, and he believes he must answer any question posed by a judge. He did not know the meaning of the word "appoint" and he did not understand the services of his lawyer to be free.

John W. Smithers, Ph.D.
Assistant Professor of Psychiatry
Designated Forensic Psychologist

PSYCHOLOGICAL EVALUATION Re: Comprehension of *Miranda* Rights

NAME: Christopher Cowan
DATE OF BIRTH: August 9, 1978
CHRONOLOGICAL AGE: 18 years 3 months
DATE OF EVALUATION: November 7, 1996
LOCATION OF EVALUATION: Smalltown Jail
EXAMINER: Cynthia Pollack, Ph.D., ABPP
DATE OF REPORT: January 20, 1995

IDENTIFYING DATA AND REASON FOR REFERRAL:

Christopher Cowan was referred for a psychological evaluation by Attorney Kevin Robinson in order to assist in determining his competence to make a knowing, intelligent, and voluntary waiver of his *Miranda* rights. Christopher was interviewed at the Smalltown Police Department on May 13, 1996, and on May 14, 1996. He was arrested on the charges of Accessory Before and After to Murder and Illegal Possession of a Firearm related to an incident alleged to have occurred on May 10, 1996.

STRUCTURE OF THE EVALUATION:

Prior to my evaluation, I informed all parties I interviewed that I am a psychologist, and that I was asked to evaluate Christopher Cowan concerning his comprehension of his *Miranda* rights. I informed them that the content of the interview, assessment results, and my observations would be shared with his attorney in the form of a psychological evaluation report, that the report potentially would be introduced into evidence in court, and that I might be asked to testify in court. I was provided with a copy of the version of the *Miranda* warning used in the Smalltown Police Department jurisdiction; a copy of the statements given by Christopher Cowan and Robert Griffin to the Smalltown Police Department; other police records and witness statements concerning the alleged incident; and a copy of the May 26, 1996 Grand Jury of Smalltown County minutes concerning the alleged incident. I interviewed Mr. Peter Jenkins (Christopher's step-grandfather/adopted father), and Ms. Kelly Parker (Christopher's biological mother/adopted sister).

EVALUATION TECHNIQUES ADMINISTERED:

Clinical Interview (1 hour)
Wechsler Adult Intelligence Scale, 3e (WAIS-III)
Woodcock Johnson Psychoeducational Battery
Comprehension of *Miranda* Rights (CMR)
Comprehension of *Miranda* Rights, True/False (CMR-R)
Comprehension of *Miranda* Vocabulary (CMV)
Function of Rights in Interrogation (FRI)
Minnesota Multiphasic Personality Inventory, 2e (MMPI-2)

RELEVANT BACKGROUND INFORMATION:

When asked about his family background, Christopher said his grandmother took custody of him directly after his birth because his birth mother was only 15 when she gave birth to

Christopher. Christopher's biological mother said when she moved out of her parents' home at age 18, "My step-father wouldn't let me take Christopher. He said they had raised him." Although his grandparents did not formally adopt him, they raised him. Christopher refers to his grandparents as his father and mother. Christopher has four biological paternal half brothers and one biological maternal half sister, but he was not raised with his biological siblings. He did not meet his biological father or paternal siblings until he was age 12.

Christopher said he has four siblings in his adoptive family. His oldest sister (biological mother) is Kelly, who is age 37 or 38. Matthew is 36, Simon is 28, and Sandra is 27. His oldest sister left home to live on her own shortly after he was born. Christopher said he got along well with Matthew. He said, "Matthew tells me keep the faith." He said Matthew encourages him. Matthew has two jobs (one is at a warehouse). Christopher said Simon, "lived a tough life: He did drugs, he sold drugs. He did time too. But now he changed. He changed a lot. He works in the Oakmont. He talks to me. He gives me a lot of positive words. When I talk to him I feel happy." Simon is employed as an HIV AIDS counselor at the Oakmont. Christopher said he likes Sandra and he resided with her and her boyfriend in Georgia for about six months. Sandra has two twin children. She currently works in a clinic as a record keeper.

Christopher's grandfather said Christopher moved in with his mother when he was age 16. He had some emotional distress because he was adopted by his grandparents but his younger sister was not. His biological mother said, "He was jealous. Why couldn't I raise him?" He also stayed there because Christopher's grandmother continued to move back and forth between the Dominican Republic and Miami (she needed the warm climate of the Dominican Republic and the medical care in Miami for her illness). Christopher's biological mother, Kelly, works as a billing clerk in a clinic in Smalltown. Christopher described ambivalent feelings toward Kelly. He said his biological father, Mr. Randy Cowan, is, "All right." He said, "I'm not used to him." He said he is close to his biological paternal half brothers.

Christopher described a good relationship with his grandmother. He said, "There was a lot of love." When asked about his relationship with his step-grandfather, he said, "Same thing. I'm real close to him." His grandparents visit him in the jail. He described a harmonious family history with no physical abuse, sexual abuse or neglect. He said his parents did not have problems with alcohol. He said his grandmother suffered from a tumor. She had five operations. When Christopher was in third grade, the family feared his grandmother would die from the tumor. His grandmother passed away on September 4, 1995, six years after the operation. He said, "It was a big loss for me, a real big loss." Christopher's biological mother said when Christopher's grandmother passed away, "He was severely depressed; very withdrawn. He wasn't talking to the family." She said, "He wouldn't talk to people. He was really into himself. He didn't want to do anything. He was arrested when he was down at his lowest."

Christopher was raised in Miami for 11 years, then his grandparents relocated to the Dominican Republic for four-and-one-half years. His grandparents wanted to retire there; however, they moved him back and forth "four or five times" because of his grandmother's need for medicine that she could not get in the Dominican Republic. He had difficulty in school in the Dominican Republic because they taught school in Spanish only. His biological mother said, "People in the Dominican Republic make fun of Americans who learn Spanish in America." Christopher said, "I didn't like the Dominican Republic. I had to start over a new life, make new friends, meet new people, go to a new school. I was like nervous." He returned to Miami for good at age sixteen and one half.

With respect to his educational background, Christopher said he finished seventh grade (His grandfather and biological mother said Christopher finished sixth grade but did not graduate seventh grade.) He was held back in first grade in Miami, in sixth grade in the Dominican Republic, and in eighth grade in Miami. He left school in eighth grade. He did not recall why he was held back in first grade. Christopher's biological mother said Christopher had problems in math and reading. She said, "He was not a very smart kid. He couldn't spell well. He's not good at reading."

Christopher said in sixth grade he was held back because of problems in reading and spelling. He was held back in eighth grade because, "I was lazy, never did my homework, I was always late with my homework. I wasn't dedicated." In elementary school he earned average to above average grades. In junior high school, his grades fell to an average to below average level. He said he was never truant. He said, "My grandma was real strict about that, my grandfather too." He said he did not have conduct problems in school. He was never suspended. His grandfather confirmed that Christopher had good relationships with his teachers and he was not truant from school.

Christopher said he left school in eighth grade because, "I was in eighth grade. I moved back to the Dominican Republic, just to live, with my family. I tried being a wise guy. I went to school there, I didn't bring papers. I lied and said I passed eighth grade. They gave me a certain day to bring my school records. I was there a half-year. My papers arrived. They found out I didn't pass eighth grade. They told me if I did well there, they would keep me there (in ninth grade). I didn't do well. I was embarrassed. The teachers all liked me. The principal found out my grades were real low. He said they were going to have to throw me back in eighth. I didn't go to school no more, I just walked out. I never went to school again." Christopher's grandfather confirmed that Christopher had difficulty with school in the Dominican Republic. He said, "It was hard for him in the Dominican Republic because it was all Spanish." Christopher said after he returned to Miami he enrolled in classes to study for his GED. His biological mother said she helped him with homework when he studied for the GED classes. She said, "He was excited about school, but his job got in the way of studying because he was called to cover a lot." He attended classes at Smalltown Adult Education. He did not have an opportunity to take the GED examination.

Christopher has an occupational history. He helped his grandfather in his landscaping business two to three days per week. His first formal employment was at a store called _____. He worked as a cashier and a truck receiver for two to three months. He left the job because he did not have transportation to work. He then worked as a security guard for five to six months at Carlton in Smalltown. Christopher's grandfather said Christopher had no problems with his employment. He said, "Everybody loved him. He worked a lot of hours. He would work two shifts when they needed him. However, Christopher said he was laid off because of a mistake, "They caught me sleeping, so they let me go." (He said he worked at night, but he did not sleep during the day.) He was suspended from his job two weeks before he was arrested.

Christopher said he has no history of serious medical problems. He never sustained a head injury or lost consciousness. He has no history of mental health treatment. Christopher's grandfather said no one suspected that Christopher needed mental health treatment. However, when his grandmother died, "Christopher's life wasn't the same. I know that hurt him a lot." With respect to his substance use background, he said he first tried alcohol at age 16. He said, "I

don't drink. I hate alcohol." He tried beer at a party only one time. He did not use it again because it made him vomit. He first tried marijuana at age 16. His heaviest period of use included daily use. He smoked Philly blunts up to nine to ten blunts per day. His drug of choice is marijuana. He said, "You could say I'm married to marijuana. I'm a pot head." He said after his grandmother passed away, his marijuana use stopped and then it dramatically increased. His heaviest use occurred after her death. He said, "I would be high. I would smoke again. I felt nothing. I was quiet. I was always visiting her grave too." His last use was the day before his arrest. He also tried powder cocaine on New Year's Day and one or two other times.

With respect to his legal history, Christopher said he was accused of breaking into a house at age 11. He did recall having been read his rights. He was in the custody of the police for one-half hour to an hour. He was questioned by the police and then his biological mother bailed him out for \$25. He said, "I didn't call my grandmother because I knew she would flip." He defaulted on his court date because of a move to the Dominican Republic. Five years later, he was apprehended, but the case was dismissed. He was never placed in DYS. He was never the subject of a CHINS petition.

CHRISTOPHER'S ACCOUNT OF THE CIRCUMSTANCES OF ARREST, THE *MIRANDA* WARNING, AND THE CONFESSION:

Christopher said, "I didn't know nothing about what the police knew, that they arrested the murderer. That morning I called Jonathon Cresswell. He was sleeping. His mother picked up the phone. She said, 'Is your name Chris?' I said, 'Yeah.' She said, 'Yesterday the police came and picked up my son for questioning. They asked about you. If I were you I would go to the police station and say what happened.' She got her husband on. He told me, 'Go to the police station. They got Robert.'" Christopher said, "So then, that's when I went." I called my mother. I told her about what happened. She started crying. I said, 'I'm going to go to the police station.' I told her to meet me at the park. She picked me up. We went straight to the police station."

Christopher said, "I went and they asked me who are you here for. My mother was talking for me. She said, 'This is my son. He was involved with something that happened, a murder. He wants to talk to the guy who's taking the case.' So then the police officer called this officer. The officer showed up. And then they had us waiting for like a half hour until this other detective came. So then they brought me in the room. They offered me soda. And then they started questioning me."

Christopher said, "I've never been in a position like that in my life. I was scared. I told them what I knew." He said the police officers were "like saying words to scare me." He said they told him, "'If you don't talk you're going to do life. They're going to put the blame on you that you killed the kid.'" He said, "They would be friendly and then they would get upset." He said, "I was frightened. I was really scared." He said, "I was just frightened, I told them what happened." He said, "That was my first statement. I gave my first statement. Then they put me in the cell." He did not recall how long he was questioned by the police. He was placed in the cell for one day.

Christopher said, "The reason why I gave my second statement was, I was in the cell. We all were down there. They were all like screaming, calling my name, especially Robert. He was saying, 'If one of you guys is snitching, ratting me out, I know a lot of people in jail. If I find

out that one of you is snitching on me, I'm going to send your statements to other prisoners. They'll know you're a rat. You'll be done with.'" He listened to them "for a whole day or night--I don't know how long because I couldn't tell if it was day or night." He said, "Robert would call me, 'Chris, Chris, what did you say.' He was doing the same thing to Edwin." Christopher said he did not sleep all night. He said, "I couldn't. I was scared." He said, "That's when I asked for an officer. I asked to give another statement. I just threw everything on me. I was frightened."

Christopher said, "I said a lot of lies about myself because with a case like that, Robert said when I got to jail and they find out I'm a rat, they was gonna shank me and put me in PC--protective custody thing--that's where they got all the rapists and rats and stuff. I was really scared. I thought about it the whole night. That's when I came up and told a whole different story." He said, "I didn't want to get beat up. Especially upstate. I was scared. I never been in a situation like that." Christopher said he confessed to elements of the crime that he did not commit, including: (a) "I said I gave the pager number for Robert to get the gun;" and (b) "I said that the gun was mine. I said I was holding it."

He said during the second interview, the police officers accused him of having lied to them in his first statement. They asked why he was not truthful the first time. He said, "Even Robert's statement said Edwin gave him the gun. I didn't want to be looked on as a rat. Those people have problems in jail." He said, "They were just typing. They asked me questions."

Christopher said in the first police interview, he was shown a card with his rights. The police read it out loud to him. After reading all of his rights, they asked him if he understood his rights. Christopher said he understood his rights. He said, "I understood like the lawyer part, and that's about it. I said I understood I thought I was gonna go home. I just wanted to get things quick and get out of there." He said he was read his rights before he gave a statement. His mother was present at the time he was read his rights. She did not offer any advice about his rights. He said, "She didn't understand them herself." He said she left the room after he was read his rights. He said, "She said that she couldn't be here for the questioning. So she just walked out to the hall and sat down." She did not leave the police station until he was handcuffed. He said the police would not allow them to confer again after his mother left the room.

Christopher said in the second police interview, "I'm not sure, but I think they did. I think they read it to me." He does not recall whether they asked if he understood his rights. He said, "I just signed the card." He said, "I understood attorney and silent." He said he did not recall when he was read his rights on the day of his second statement. He said he was too frightened that he was going to jail for life.

When asked what he understood about his rights at the time of the police interviews, he said, "I had no clue. I mostly heard those words on the Cops shows. I never thought of it happening in real life. He said he thought the *Miranda* warning meant, "I was going to jail." He said he did not ask for a lawyer at any point. He said, "I didn't know I could just go get a lawyer and come with me. I thought I was going home to tell you the truth. I thought I was gonna say something, what I know about it, and just let me go."

Christopher said he did not know he was under arrest until he heard his mother crying. He said, "They told her the charges that I had. I heard her crying. They arrested me." He said he knew he was under arrest when "they cuffed me." He said he was handcuffed after he gave

his first statement. Christopher said he did not realize he was in police custody. He said, "I thought I was going home. I thought I could leave there. I didn't know I couldn't go home until I heard my mother crying." He said, "I don't know. I was alone. My mother left. I didn't know I had rights to do something like that. If I did, I'd have got a lawyer."

When asked if the police detectives used force during their interrogations of him, Christopher said, "Sort of. Because they were like, we want to know everything you did since you got up this morning. I don't care what it was. So I thought I had to sit there. They're cops. They're detectives." He said the police did not physically threaten him. He said, "They were saying if you don't say nothing, the charges that you're gonna do is 25 years. You're never gonna see the streets. I was like, 'wow.' I did get intimidated. I was scared." When asked if he believed what the police were telling him, he said, "Of course. I would have never given a statement. I would have just stayed shut." Christopher said he did not want the police to tape record his interrogations because he does not like the sound of his voice on audiotape. He said, "I heard myself singing on a recording. I sounded like a girl." He was afraid he would sound like a girl if he spoke on tape. He said, "It's embarrassing."

MS. KELLY PARKER'S ACCOUNT OF THE CIRCUMSTANCES OF CHRISTOPHER'S ARREST, *MIRANDA* WARNING, AND THE CONFESSION:

Ms. Kelly Parker said Christopher received a call from an individual advising him to go to the police station. She said, "I took him to the police station." She said upon arrival, they waited one half hour before speaking to the police. She said, "The police asked him about Edwin first. They said, 'We need to read you your rights.' They read them. They didn't ask if he understood." Ms. Parker said she was "nervous, with a tight stomach." She said, "I said, 'I don't think I want to hear what happened.' The two police officers said, 'You can step out.'" When asked if she or Christopher signed a *Miranda* card, she said, "They had him sign after they read them." She said, "The police had me sign one later."

During the police interrogation, Ms. Parker called some relatives. She became worried because, "It was taking a long time." When the police detectives came out of the interview room, she asked if she could go into the room. She said, "The officer said he'd ask Chris. He said it seemed like Christopher was doing okay. Everything was fine. He said he would ask Chris. He never came out." She said she asked another police detective in the hallway whether she could go in the interview room. She said, "He said, 'If they need you they'll let you know.'"

Ms. Parker said the police detectives brought her back into the room and asked her to sign Christopher's statements. She said, "I didn't want to know what was in the statement. He said, 'You have to sign here.' I signed. When we went outside, he said, 'We're going to have to charge your son with accessory after the fact. I found out the next day in court that he would be charged with murder before and after the fact.'"

When asked about her comprehension of *Miranda*, Ms. Parker said, "We've never been through that. You see it on TV. They arrest you anyway and if you don't talk, they beat you up. We didn't know you can keep your mouth shut and have a lawyer. How could we come up with the money for a lawyer? We didn't understand what they were saying, that he had a right not to answer the questions. We figured he had to answer them." She said, "Chris was scared. You could see it in his face."

POLICE RECORDS CONCERNING THE ARREST, THE *MIRANDA* WARNING, AND THE CONFESSION:

According to Smalltown Police Department Records, Christopher Cowan signed a sheet of paper containing the *Miranda* warning at 1:00 p.m. on May 13, 1996. His mother also signed the sheet of paper. Two officers witnessed the signatures (Detective Darnell Brown and Trooper Charles Phillips). At 2:09 p.m. Christopher Cowan signed the bottom of the form, declining to have his statement electronically recorded. His signature was witnessed by the same two officers. According to Christopher's May 13, 1996, statement to the Smalltown Police Department (at 2:10 p.m.), the *Miranda* warning was issued as follows:

"I have come to the Smalltown Police Station of my own free will, with my mother, to tell what I know about the shooting that happened on Pompano St. Thursday night. I have been read my *Miranda* Rights from a piece of paper by Det. Darnell Brown. On that piece of paper I have also been read that I have the choice of having my statement typed or electronically recorded. I have chosen to have my statement typed and Det. Brown is typing it for me. I have signed the bottom of the paper to have it typed. I have not been forced or promised anything in exchange for what I am about to tell these officers. In the room with me is my mother, Tpr. Charles Phillips and Det. Darnell Brown. As we are starting to talk about what happened my mother doesn't want to be in the room with us anymore and it's OK with me. My mom is going to wait for me in the hallway."

According to police records, Christopher then gave a statement to the Smalltown Police Department.

According to Smalltown Police Department Records, Christopher Cowan signed another sheet of paper containing the *Miranda* warning at 12:29 p.m. on May 14, 1996. His mother did not sign that *Miranda* warning. Two officers witnessed the signatures (Trooper Charles Phillips and Officer #617, signature illegible). At 12:32 p.m. Christopher Cowan signed the middle and bottom of the form affirming that he was informed of his right to a prompt arraignment (and his arraignment date) and declining to have his statement electronically recorded. Both signatures were witnessed by the same two officers. According to Christopher's May 14, 1996 statement to the Smalltown Police Department (at 12:25 p.m.), the *Miranda* warning was issued as follows:

"On Monday May 14, 1996 at approximately 12:25 PM Detective Humphries of the Smalltown Police Department and this officer spoke to Christopher Cowan in the Smalltown Police Department Criminal Bureau. Detective Humphries read a Smalltown Police Department form to Cowan advising Cowan of his *Miranda* warnings, his right to a prompt arraignment, and the opportunity to provide an electronically recorded statement. After each section of the form was read, Detective Humphries asked Cowan if he understood what was read to him. Cowan stated he did and signed his name under each section. "

According to police records, Christopher then gave a second statement to the Smalltown Police Department. According to the minutes of the Grand Jury of Smalltown County, dated Friday, June 23, 1996, Trooper Charles Phillips testified that Christopher Cowan was advised of his *Miranda* rights prior to questioning. He testified that the English language was not a problem for Christopher, that Christopher was sober. When asked whether Christopher's mother was present during the interview, Trooper Phillips testified, "She was present at first and for the

reading of the rights, and she decided she didn't want to sit in on the conversation and she waited out in the hall." Trooper Phillips did not offer further testimony or details about the *Miranda* warning or Christopher's demeanor during the interview. Trooper Phillips testified that Christopher was placed under arrest after he gave his first statement.

Trooper Phillips testified that Christopher was re-advised of his *Miranda* rights on May 14, 1996, and that he signed a waiver of his rights that day. He provided no further testimony or details about the *Miranda* warning or Christopher's demeanor during the second interview.

BEHAVIORAL OBSERVATIONS AND MENTAL STATUS:

Christopher presented dressed in institutional clothing. He showed no problems with self care skills. He described his mood as "alone some days, real depressed." His slow motor movements and sad facial expressions were consistent with his report of depression. He said, "Every day I feel scared." He copes by "making a lot of phone calls." He said talking to his family helps him to feel better. Prior to jail, his mood was both "happy" and "sad." He said he felt sad when he thought of his grandmother. He described no problems with regulation of his moods.

Christopher described no problems with the integrity of his thoughts prior to his arrests. He said, "I was always with my girlfriend and my best friend from the Dominican Republic." He described no perceptual distortions or disorganization in his thinking. He said, "I felt a lot of depression, I felt alone. I missed my grandmother a lot. That's when I started smoking a lot. A real lot." He said he had no thoughts of harm to self or others since his incarceration.

ASSESSMENT RESULTS:

Cognitive Functioning: On the WAIS-III, Christopher obtained a Full Scale IQ score of 77, placing him in the "Borderline" range of intellectual functioning. His obtained Verbal IQ score was 72 and his obtained Performance IQ was 83. Relative to his other subscale scores, he demonstrated weakness on the Vocabulary subscale.

On the Wechsler Individual Achievement Test, Christopher's composite standard score was 64, which is in the first percentile of functioning (ninety-nine percent of individuals his age score better than him). His composite score suggests he is functioning at an age equivalent of 11 years old. Christopher obtained a standard score of 78 on the Basic Reading subscale (7th percentile, age equivalent of 11:3), 65 on the Mathematics Reasoning subscale (1st percentile, age equivalent of 9:6), 69 on the Spelling subscale (2nd percentile, age equivalent of 10:0), 83 on the Reading Comprehension subscale (13th percentile, age equivalent of 11:0), 73 on Numerical Operations (4th percentile, age equivalent of 11:3), 61 on the Listening Comprehension subscale (0.5 percentile, age equivalent of 7:3), 94 on the Oral Expression subscale (34th percentile, age equivalent of 11 :9), and 64 on the Written Expression subscale (1st percentile, age equivalent of 8:0).

Affective and Personality Functioning: On the Validity Scales of the MMPI-2, Christopher obtained an elevation on Scale F. The scale was elevated at a level that suggests an exaggeration of symptoms for three possible reasons: (a) a plea for help; (b) malingering; or (c) psychosis. The FB, TRIN, and VRIN scales were elevated, suggesting that reading problems and fatigue affected the MMPI-2 results. The TRIN scale suggests when Christopher was in doubt, he acquiesced to items. The clinical scales that were elevated on the MMPI-2 (Paranoia,

Psychasthenia, Schizophrenia, and Mania) suggest if Christopher was exaggerating his symptoms, he specifically was attempting to exaggerate a paranoid psychotic disorder. Given that his IQ falls in the Borderline range, it is doubtful he could exaggerate in such a sophisticated way. In addition, the possibility of malingering is further diminished because Christopher did not endorse symptoms of a thought disorder during his interview. Accordingly, it is likely Christopher is bothered by bizarre and unwanted thoughts, but he is fearful of admitting those problems except when it is unclear to him that problems or symptoms are associated with a thought disorder (many of the MMPI-2 items are not manifestly associated with a particular disorder). His F Scale is not exaggerated as highly as is seen in forensic populations such as those attempting to malingering a mental illness that would be favorable to an insanity defense. It is at a level more typical of inpatient psychiatric populations.

Nonetheless, because of possible reading problems, Christopher's MMPI-2 results are interpreted with caution. The Supplementary and Content scales are not interpreted because of the elevated FB scale. On the Clinical Scales, the profile (8-6-9-7) is suggestive of serious mental illness, with the most common diagnosis being Schizophrenia, Paranoid Type. Hallucinations, delusions, and extreme suspiciousness are common. Shyness, social withdrawal, and disabling emotional turmoil are common. Difficulty handling the responsibilities of everyday life is common. Individuals with this profile have difficulty distinguishing between real and imagined threat. As a result, they may feel anxious and tense much of the time. They have difficulty with thinking and concentration. Confusion, a slow stream of thought, and thought blocking are common. Some agitation, excitability, and grandiosity may be present.

Comprehension of Miranda: On the Comprehension of *Miranda* Rights (CMR) scale, Christopher obtained a score of 6 out of 8 possible points. He had difficulty defining what the phrase "used against you in court" meant, and he had difficulty identifying when a detainee has the right to consult with an attorney. On the Comprehension of *Miranda* Rights-Recognition (CMR-R) scale, Christopher obtained a score of 10 out of 12 possible points. He thought the statement, "What you say might be used to prove you are guilty," was inconsistent with the *Miranda* warning. He thought the statement "If you won't talk to the police, then that will be used against you in court," was consistent with the *Miranda* warning. On the Comprehension of *Miranda* Vocabulary score (CMV), Christopher obtained a score of 4 out of 12 possible points. He did not receive full credit for any of the vocabulary words. Two of the words he had difficulty defining ("interrogation" and "entitled") do not appear in the version of the *Miranda* warning used by the Smalltown Police Department. When asked the meaning of the word "questioning," Christopher said, "when they ask you questions." In general, his definitions of words were vague.

On the Function of Rights in Interrogation (FRI) subscale, Christopher obtained a score of 19 out of 30 possible points. Christopher had difficulty comprehending the intention of the police during an interrogation. He understood they wanted information about the crime, but he had difficulty understanding they might be seeking incriminating information. He understood the role of an attorney before an interrogation, but he had difficulty comprehending a detainee's right to silence during an interrogation. He understood that an admission of involvement in the crime might get the defendant into trouble, but he was unclear about whether the detainee was compelled to speak during police questioning. He did not know what would happen in court to a defendant who refused to give a statement to the police. He did not know if he would be obliged to testify in court if he refused to give a statement to the police.

INTERPRETATION OF PSYCHOLOGICAL ASSESSMENT RESULTS:

Christopher Cowan is a late adolescent boy who was informally adopted by his grandmother and step-grandfather. They resided in Smalltown, but moved back and forth between Smalltown and the Dominican Republic when Christopher grew into early adolescence. Because of the moves, Christopher's education was disrupted by his need to adapt to a different culture and a Spanish-only teaching system in the Dominican Republic. Between the ages of eleven and sixteen and one half, Christopher's education was disrupted by the moves. He graduated sixth grade. He attended seventh and ninth grades, but he did not pass those grades. He had reading problems, and in junior high school he lacked the motivation to consistently follow through on homework assignments. He left school because of his embarrassment that he was not keeping up with his age mates, and because the school system was going to place him back into eighth grade after he already attended ninth grade classes. Although he was described as a good worker, Christopher was not successful in maintaining employment.

Christopher had some emotional adjustment problems in adolescence. Although he loved his grandparents, he was confused about why he was adopted by his grandparents when his sister was not. He reportedly suffered from depression when his grandmother passed away. Based on his biological mother's report, Christopher was depressed over his grandmother's death at the time of his arrest. He withdrew and became somewhat mute. Based on Christopher's description, he was emotionally distressed and he abused marijuana heavily after his grandmother's death. Based on Christopher's report and my observations, Christopher remains grief stricken over her death. Christopher has no history of mental health treatment.

Christopher's legal history contains only one prior incident. He did not recall having his rights read to him at that time. He recalled hearing the *Miranda* warning on "cop shows" on television. He did not describe significant legal experience that would aid in his comprehension of *Miranda*. Christopher did not appear to malingering lack of comprehension of the *Miranda* warning at the time that he was administered the *Miranda* comprehension measures. Malingering lack of comprehension is detected primarily on the CMR-R. Because this is a "same/different" assessment, a chance result would produce at least fifty percent correct items. (Malingering typically results in a less than chance result.) Christopher's result on this assessment measure was greater than chance. In addition, there was a correspondence across measures in the type of items that he failed. Finally, because of the consistency in his results across the two measures, he does not appear to have malingered a poor result on the intellectual and educational assessments. His poor vocabulary skills are seen across all of the assessment measures.

Based on his description, Christopher decided to go to the police station on the advice of the parents of another witness. Records confirm that he went voluntarily to the police station. His mother accompanied him to the station. She remained with him until after the *Miranda* warning was read and then she left the room. She reportedly offered no consultation to Christopher concerning his *Miranda* rights. She did not ask for time to consult with him alone. She reportedly later changed her mind about wanting to be in the interview room, but she was unsuccessful in gaining re-entry into the room.

Based on Christopher's description, he was "scared" during the questioning. He said the police officers used words to scare him. He said he was frightened because the officers told him he might do life in prison if he did not talk to them and because "they" might put the blame on Christopher for the murder. He said the officers were both "friendly" and "upset" during the questioning. He thought he was obligated to answer their questions by virtue of their status as

police officers. His assumption that he must respond to their authority is consistent with his level of intellectual functioning. His mother said Christopher appeared "scared."

Christopher said he gave the second statement because he was in fear of the threats that he heard overnight in the holding cell. He was especially in fear because of the threats made by Robert Griffin. He said he did not sleep that night because he was "scared." He said he was in fear of getting beaten up in prison or being placed with rapists in prison. He gave the statement because he was "frightened." He said because of his fear of Mr. Griffin and his fear of retaliation in prison, he confessed to two elements of the crime that he did not commit.

Christopher said although he told the officers that he understood his *Miranda* rights, he did not fully understand his rights. He knew he had a right to an attorney, but he did not realize he could ask for one right away or at any point during the interview. He expected he would give a statement and then go home. He did not have the subjective sense that he was in police custody until he heard his mother crying. He did not realize he was under arrest until he heard his mother crying. He said at the time of the second interview, he was frightened of going to jail for life, so he did not focus on his *Miranda* rights. His mind was occupied with fear.

The police records do not contain information about the manner in which the *Miranda* warning was presented to Christopher Cowan. Christopher signed two *Miranda* forms. According to police records, the first one was signed one hour and ten minutes before the interview. The second form was signed four minutes after the interview.

The assessment results suggest Christopher understood some elements of the *Miranda* warning, but he had difficulty comprehending some key elements. For example, he had difficulty understanding at what point a detainee has a right to an attorney. He had difficulty understanding the impact of providing information to the police that incriminated himself. He did not know the consequences of refusing to speak to the police, but he thought it might be used against him in court. He did not know whether he had a right to protect himself against incrimination in a court of law should he be asked to testify. He did not know if he could be compelled to testify.

Assessment results suggest Christopher functions in the "Borderline" range of intelligence, with particular problems understanding vocabulary. His level of educational achievement is comparable to the average 11 year-old child, with some skills falling below that level. For example, his listening comprehension is comparable to the average 7 year-old child. These results suggest special precautions indicated for a seven to 11 year-old child would have been appropriate during the *Miranda* warnings and police interviews.

Reading problems affected Christopher's personality assessment results, but the results raise suspicion that he may suffer from symptoms related to a paranoid thought disorder. At the time of the police interviews, he reportedly was suffering from grief and depression over his grandmother's death. He showed signs of grief and depression during the clinical interview. His grief and depression likely contributed to emotional vulnerability at the time of the interviews. If he suffered from a thought disorder at the time of the interviews, his compromised mental state would further contribute to vulnerability during the interviews.

CONCLUSIONS:

1. In my clinical opinion, Christopher Cowan has deficits in his cognitive functioning which impaired his comprehension of some of the elements of the *Miranda* warning. Because of the pervasive and intractable nature of his deficits, it is likely his comprehension of *Miranda* was impaired at the time of the police interviews.

2. In my clinical opinion, Christopher Cowan suffered emotional distress at the time of the police interviews because of his grief and depression over his grandmother's death, because he was frightened over what he perceived to be verbal threats by the police officers who interviewed him, and because he was frightened over what he perceived to be verbal threats by Robert Griffin and others in the holding cell on the night between his first and second police interview.

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Psychiatric Report on Competence to Stand Trial and Need for Care and Treatment

CASE NAME: Hope Wood

REFERRED BY: Random County Juvenile Court

DOCKET NUMBER: 0000000000

PERSONS INTERVIEWED: Hope Wood (defendant); Arthur Taylor (father); Annette Johnson (stepmother); Virginia Wood (mother)

DATES OF INTERVIEWS: October 8, 12, 15, 19, 21, 24, 25, 26, 28, 2001

CLINICIAN: Marcus Welby, M.D

DATE OF REPORT: November 5, 2001

Hope Wood is a 10 year-old girl (b. 7/15/91) who was committed by the Random County Juvenile Court to the Suburban Hospital child psychiatry program on September 30 for evaluation of competence to stand trial under the authority of Chapter 000, ss. AA and BB of the General Laws. Her father is Arthur Taylor (35 years old) and her stepmother is Annette Johnson (43 years old); they live in Smallville. Her mother is Virginia Wood (31 years old); she lives in Washington, DC. Hope faces a charge of aggravated assault and battery and aggravated rape, stemming from allegations that she sexually assaulted her stepsister's infant son James on September 28, 2001, causing the infant to suffer very serious physical injuries which are expected to leave substantial residual deficits.

Evaluation of Hope by Dr. Smith at court after her arraignment on September 30 found her to have a history of mental health treatment and conduct problems, and to appear somewhat guarded. Dr. Smith also noted an "extremely limited understanding of the functioning of a court of law", and she recommended inpatient evaluation. This evaluation has included

1) Review of the following records:

- a. school records
- b. record of mental health evaluation and initial treatment at Regional Medical Center, July 2000
- c. records of medication treatment with Cynthia Steel, M.S., R.N., C.S., October 2000 to September 2001
- d. record of testing and other evaluation at the Downtown Hospital Learning Disorders Unit, September 24, 2000
- e. intake evaluation at Village Mental Health in early June, 2001
- f. camper evaluation, Valley View Summer Camp, August, 2001

- g. Smallville Police Department incident reports and notes of interviews with family members (including Hope) on September 28 at her home and at the Smallville Police Station
- h. Smallville Hospital medical records of James' treatment beginning September 30, 2001
- i. Dr. Smith's evaluation at court, September 30, 2001
- j. record of current hospitalization at Suburban Hospital, including admission notes, progress notes, test results, and a report of psychological testing conducted by Dr. Ruth Psyche on October 20, 2001

2) Telephone conversations with Dr. Smith (Random County Juvenile Court Clinic), Ms. Jane Wynne (Valley View summer camp), Dr. Jones (psychiatrist at the Metropolitan Boulevard mental health clinic, Washington, DC), Mr. Douglas Bilko (of the same clinic), schoolteachers Ms. Granger and Ms. Evans (Brown Elementary School in Smallville), Dr. William Field (Department of Youth Corrections Clinical Director), intake clinician Leslie Joyce (Village Mental Health), defense counsel Paul Bridge, Peri Mason, and Evelyn Burke, and Assistant District Attorney Roger Karp.

3) The following clinical interviews:

- a. Hope, and Hope and Mr. Taylor together at Suburban Hospital on October 8 (about two hours)
- b. Mr. Taylor and Ms. Johnson at the Random County Juvenile Court Clinic on October 12 (about two hours)
- c. Hope at Suburban Hospital on October 15 (about an hour)
- d. Mr. Taylor at his home in Smallville on October 20 (about 75 minutes)
- e. Hope at Suburban Hospital on October 21 (about 75 minutes)
- f. Ms. Wood by telephone on October 24 (about an hour)
- g. Mr. Taylor by telephone on October 25 and October 28 (total 25 minutes)
- h. Hope at Suburban Hospital on October 26 (about 90 minutes)

WARNING OF LACK OF CONFIDENTIAL COMMUNICATION:

The hospital record includes a well documented account of Dr. West, Hope's attending psychiatrist, warning Hope that she was in the hospital for court-ordered evaluation and that her communications would not be confidential; Hope voiced her understanding of that warning to Dr. West. In my initial interview with Hope I reiterated this warning to her, but (as noted below) she did not speak in this interview, and thus did not express her understanding of it. In my subsequent interviews with Hope I offered this warning again; she did appear to understand it, as she responded to my questions as to whether our conversation would be confidential by

saying, "No," and as to whom I would tell about what we talked about by saying, "The judge." She re-confirmed this understanding in a subsequent interview with Dr. West.

In my initial interview with Mr. Taylor I made the same explanation, and he acknowledged that what he said to me would not be confidential. Ms. Johnson's initial response to an inquiry about her expectations was that the interview would be confidential, but acknowledged the non-confidential nature of the court-ordered evaluation upon further explanation. I also made the same explanation to Ms. Wood in our telephone interview, and she said that she understood.

CLINICAL HISTORY:

The history provided here comes from records noted above and from interviews. It is presented here organized by topic. A brief summary of this history and other clinical data is provided later in this report, prior to the section on competence to stand trial.

Family history. Records indicate that Hope's mother's family has a history of substance abuse. Hope lived with her mother until she was about seven, and then moved to her father's care. She has reported to hospital staff that she had not seen her mother in four years, as her father had not allowed her to, but as detailed below, she appears to have seen her mother last in February of 2000. Current family constellation includes Mr. Taylor (34), his wife Annette Johnson (42), her mother Winona Johnson (62), and her six children ages 21 to 5, as well as Hope.

Mr. Taylor reported that he was born in Atlanta. His parents separated when he was quite young, and his mother moved to Washington to live with her mother. His mother was a strong and independent woman, who has worked for thirty years as the head cook in a hospital. His mother has two sisters, one who is currently caring for his grandmother in Washington, and another who lives in Alabama. He has a sister in Arkansas who has been married for 15 years and has four children; and a brother who is "a party guy," moving from job to job. Ms. Johnson reported that Hope's maternal grandfather is a distant cousin of hers, and there is considerable mental illness in that side of the family, with multiple cousins, aunts, and uncles with bipolar disorder, schizophrenia, and ADHD. Hope's maternal grandmother was alcoholic and lived on the street; her mother's two sisters also abused drugs and alcohol, "had sex with the neighborhood," and "had kids all over town."

Mr. Taylor explained that he and Hope's mother lived together in Washington until Hope was about three years old, and that for the first couple of years, things went okay. However, Ms. Wood had a young son who was about two years older than Hope; this child died in a car accident at the age of four when staying with his godparents. After this child died, "Things started to go down." Ms. Wood was "seeing someone else on the side," they were "arguing a lot," and eventually her mother and sisters "were all getting evicted" and moved in with them. There was "constant noise, people drinking; when her brother wasn't in jail he was stealing from the house." He recalled "waking up with beer cans all over the house," and he felt that there was nothing he could do. He felt that if he stayed, he (or someone else) would get hurt, and so he moved out as the "family was heading for destruction."

He noted that when Hope lived with her mother in Washington, DC, she continued to be exposed to drugs, sex, violence, alcohol, police, and generally unstable circumstances. Hope would sometimes stay with her mother's sister, who lived across the street from Ms. Johnson. Ms. Johnson characterized Hope's mother as "quite unstable, always pawning her off," and she

described Hope (who would come across the street to play with her children) as active, aggressive, sometimes a loner, and given to aggressiveness, lying, and stealing. Her daughter Frieda (now 11) was close with her for a while, but then they were not, owing to Hope's stealing from her. She also noted that Hope preferred to play with older children. She "knew something was wrong" with her, but she had no occasion to do anything about it.

After a few years, Mr. Taylor said he went to court to seek custody; when Ms. Wood didn't show up at court for the second hearing (at a time when Hope was in Mr. Taylor's care), Mr. Taylor received full custody. He said of Ms. Wood, "She knew it was time - she had no place, and she gave up." Hope lived with Mr. Taylor and Mr. Taylor's mother from the spring of 1998. Mr. Taylor and Ms. Johnson first became involved with one another in late 1998, and began living together in the middle of 1999. Hope preferred to spend time with Ms. Johnson and her children rather than being with her grandmother.

Ms. Johnson said when Hope came to her, she was lacking in structure and discipline. She had a lot of conduct problems in school, with aggressive, impulsive, and oppositional behavior; she was abusive to the dog, and put dirt in her teacher's drink. She continued to visit on weekends with her mother, but it was common that Ms. Wood would not bring her back at the end of the weekend, and that they had trouble finding her. She would look forward to her visits with her mother, but upon her return she "was totally different - stubborn - no one could tell her what to do." Ms. Johnson reported that she moved to the Metropolis area in April of 2000 as she has family here, and hoped that she could get more help for Hope. She lived in Milltown at first, and moved to Smallville in the summer of 2000. Mr. Taylor joined her in August from Washington.

Ms. Wood's account of the family history differed in a few important respects from that of Mr. Taylor. She acknowledged that she had developed a substance abuse problem after the death of her son, but she explained that she was introduced to drugs by Mr. Taylor, who had been using the entire time that they lived together (and had spent some time in jail when she was pregnant with Hope). She noted that she has three nephews with ADHD and a sister who has been treated for bipolar disorder.

Ms. Wood reported that Mr. Taylor did not work during the time they lived together, and that he was physically abusive to her during this time (though she explained that Hope probably did not witness this directly, as it would happen at night when Hope was in another room). She said that she tried to separate from Mr. Taylor, but he would "stalk me," following her to work and "constantly coming up behind me." After the death of her older son (in about 1993) she began using substances, and shortly after that she succeeded in having Mr. Taylor removed by calling Federal marshals; he was subsequently incarcerated for five years on charges including armed robbery (by her report). During this time (from when Hope was about two to about seven), Ms. Wood's drug use increased, and over time her life circumstances deteriorated. Hope became more anxious about Ms. Wood's well being and it was hard to leave her; she would not want to stay with Mr. Taylor's mother (even when Ms. Wood was homeless). Though when she first went to school (at age four or five) she did fine, later she had a hard time staying in school because of her anxious need to be with her mother.

When Hope was about seven, Mr. Taylor was released from prison, and Ms. Wood asked him to take custody of Hope because she could not care for her in her condition at that time. (Mr. Taylor confirmed this account when questioned directly after my conversation with Ms. Wood.) Mr. Taylor was sober at the time and agreed to take Hope in September 1999. After

that, Hope visited a few times with Ms. Wood; she would complain to her about how Ms. Johnson didn't like her, and that she was always being blamed for things that went wrong in that family, and "no one believed her." Ms. Wood said, "She hated it there." She noted that Mr. Taylor was sensitive to Hope's complaints, but was "in the middle, trying to keep the peace, but having a hard time." Ms. Wood was incarcerated about six months after Mr. Taylor took custody of Hope (early March 2000), and she has not seen Hope since then. After her release in April 2001, Mr. Taylor discouraged her from seeing, calling, or writing to Hope, since Hope was having such a hard time then that he felt contact with her mother might make her worse. Hospital unit staff have reported that Hope complains about life in her current family, saying she "hates it there." Treatment records indicate that Hope learned in April or May of 2001 that her mother had been in jail, and that this knowledge appeared to contribute to her deterioration at that time.

Mr. Taylor currently works as a nurse's aide at a health care facility near his home in Smallville. He finds this stressful, as he is often with people who are seriously ill, including some young people who have suffered traumatic injuries. He noted that he has gained some understanding and support from nursing staff there regarding Hope's difficulties. Ms. Johnson does not work outside the home. Mr. Taylor described his situation now with Ms. Johnson's family as "sometimes difficult" in light of what has happened, but "being married and being good church people has helped." James' mother was hospitalized psychiatrically for about a month following James's injury, but he said that she is now "doing better" and will be going to work soon. The other children go to school; Mr. Taylor noted that the children tend to be "slow" and "don't like authority." The family attends the Mount of Olives Church in Metropolis.

Ms. Wood reported that she is working, is on probation, has completed substance abuse counseling, has been sober since March of 2000, attends church regularly, and is currently in treatment with a psychiatrist; Dr. Jones confirmed that she is his patient. She suffered substantial depression during the time she was incarcerated, and she had experiences with "highs" when she was drinking. She has been prescribed lithium, though she is not taking it currently as she had side effect problems. Ms. Wood has petitioned the court to regain custody of Hope, and Mr. Taylor said there is going to be a hearing on this matter in mid-November. Mr. Taylor indicated that he is not sure whether it would be good for Hope to see her mother again, but that he would need some assurance as to her reliability if he were to support renewed contact.

Hope said that her favorite people in the family are her mother and father. She does not remember moving from her mother's care to her father's. She complained that she feels she can never think about her mother. She does not have a picture of her, but she does remember what she looks like. She recalled playing video games with her, watching TV together, and having her put her to bed and read to her.

Developmental history. Mr. Taylor said that Ms. Wood did not appear to be using substances during her pregnancy with Hope, and that her labor and delivery were without problems; Hope weighed seven pounds, six ounces, and "seemed to be a normal baby." Neither of them had any difficulty taking care of her as an infant; she walked at about ten months and began talking around the same time. After she began to move around she was "into everything," and Mr. Taylor said that she did not respond to discipline especially well.

Ms. Wood noted that Hope is her second child, born when she was twenty-one. She was not using substances when she was pregnant, and had no problems with her pregnancy,

labor, or delivery. Hope was a calm, happy baby, who was not hyperactive, but was sociable and "got along well with everyone." Her early development was unremarkable. She said Hope was not overactive or impulsive as a toddler; she responded to supervision and did not need extraordinary punishment.

School history. Hope is noted to have had school problems in her preschool years; her kindergarten record suggests that her learning in kindergarten was mixed, and that she once bit another student, leaving marks. Her grades in first grade were C's and D's; she had multiple conduct problems resulting in official reports, including fighting, pushing another student into a toilet, pulling down her pants (and those of others) to show and look at their genitals, and telling a boy on the school bus she would suck on his penis. Her grades in second grade were all D's, and she transferred schools twice that year. She was failing in third grade, and was expected to be retained, but she left in April. She was rated satisfactory in respect for authority, but needed to improve in obeying rules, respecting other students, listening, following directions, and completing work. Mr. Taylor reported that the schools constantly disciplined Hope, and would call in Mr. Taylor in response to Hope's misbehavior, but never did undertake an evaluation or special education services.

At the Brown Elementary School, Hope was noted to "need improvement" in her overall conduct over the course of third grade, and to be weak in "social habits", specifically "courteous - considerate" and "works-plays well with others." Her work habits and academic achievement were all rated satisfactory plus, or better. Ms. Granger (her third grade teacher) described Hope as hyperactive (especially if she had not taken her medication), and sometimes as lethargic (either from too much medication or from not sleeping at night); but as competent in her schoolwork, and generally not aggressive or disruptive in her conduct. She recalled only one event in which she had been at all aggressive or angry, in which she wrote nasty comments on a school picture about individual classmates with whom she had had a problem on the playground. However, she noted that this had been short-lived, and that she calmed down on her own and tried to fix the damage. Ms. Evans had Hope in school for only 9 days this year; she described her as likable, conscientious about getting her work done, and bright. She noted that she was hyperactive and distractible, but that she did not have problems with the other children, and did not fight.

At a two week summer camp in August of 1999 Hope was rated outstanding on almost all qualities, and very good on the rest. She was described as "a happy kid", "a breath of fresh air", and "by far the best all around camper of the summer. She knew the difference between right and wrong and was always willing to try new things." She was noted to "get frustrated ... once but [counselors] let her have her moment as it was the only time she ever did anything bad." This is a camp program for inner city youth, many of whom have child protective service involvement; but it does not especially cater to children with mental or developmental disorders or conduct problems; its evaluations often include critical comments, which Hope's did not. During her stay at this camp, Hope continued on the same medication she had been taking previously, but instead of taking her Effexor all at once (112.5 mg), she took it in divided doses (37.5 mg at each meal).

Hope said that she had fun at camp, recalling a couple of kids with whom she had made friends; and she said that she had been happier there than at home. Within the hospital she has not taken part in school classes because she has been on constant observation, but her teacher said that she works eagerly on papers she gives her; she generally accepts criticism without difficulty, though sometimes she "shuts down."

Trauma history. Hope was reportedly exposed to criminal behavior, sexual activity, domestic violence, and physical punishment by her father (with a belt and switch) and by her father's grandmother (with a switch), but reportedly never severely enough to leave marks. As noted above, Hope has experienced disrupted attachments and a sense of being an outsider in her family. She was noted in an intake at Village Mental Health to have been sexually abused by a cousin in early childhood. However, the basis for this report is unclear. When I asked Ms. Joyce what Mr. Taylor or Ms. Johnson had reported specifically as a basis for this note, she said that she could not recall specifically. When I asked Mr. Taylor about it, he said that he was not familiar with any account of Hope having been sexually abused. Ms. Mason reported that Ms. Wood had also told Mr. Bridge that she did not know of any history of sexual abuse. When I asked Hope if she had ever been sexually molested or abused, she became very agitated at the question, was angry at being asked, and claimed briefly not to understand. She then denied ever having any such experience.

Treatment history. Mr. Taylor and Ms. Johnson noted Hope's early conduct problems, including hurting a dog and picking up dirt to put in a teacher's coffee at school. They reported that they took Hope for help at a local mental health center, where she was begun on Ritalin, and recommended for a special education evaluation. Mr. Bilko reported that he saw Hope one time (April 9, 2000) for an evaluation, and heard a variety of concerns from her father and stepmother. These concerns included that Hope had school problems including poor attention, concentration, and conduct; aggressive behavior with other children and with animals; urinating and defecating outside the house; and a history of witnessing sexual behavior in her mother's home. She was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder, and dysthymia, and was recommended by the clinic child psychiatrist for treatment with Ritalin. Mr. Bilko said that medication was not begun at that time, however, and that Hope did not return for a scheduled follow up in a month.

Ms. Johnson moved to Milltown at around this time. Hope attended school there for a month or two, and began to have behavior problems; she was expected to be evaluated the next year, but the family moved to Smallville. Ms. Johnson said that Hope was seen for counseling for a few months at the Regional Medical Center in the spring and summer of 2000. The RMC record shows an evaluation visit by Ms. Johnson in July 2000, and a single play therapy session a week later with Hope, in which she showed "good concentration" and "seemed somewhat depressed." A few other appointments were made, but not kept. The evaluation noted the history presented here as well as symptoms of enuresis (until shortly before that time), nail biting, and difficulty speaking when under stress. The record refers to Ms. Johnson as Hope's foster mother; it indicates that Hope was abandoned by her mother in her aunt's care, that her aunt gave her to Ms. Johnson, and that Hope had been taking Ritalin since March of 2000 with a good response.

Hope was seen for neurological and psychological evaluation at the Learning Disorders Unit at Downtown Hospital in August of 2000 (where again Ms. Johnson was referred to as her foster mother, and her father's whereabouts were characterized as unknown). Hope was noted to have ADHD, and was recommended for special attention at school as well as medication. She repeated grade three at the Brown Elementary School, where (according to Ms. Johnson) she was expected to have a special education evaluation, but where the school said "without the paperwork they couldn't do anything." She continued to misbehave, and her teacher told Ms. Johnson that "every day with her was a battle."

She began taking medication (Adderal and Clonidine, under the care of Ms. Steel in Smallville) in the fall of 2000; Ms. Johnson said that she also began having counseling with Mr. Gray of Village Mental Health in January of 2001, but the treatment record includes no mention of this. Mr. Taylor and Ms. Johnson said that Hope did not appear to be getting any better, and over time appeared to be becoming more depressed and to be isolating herself further. Her dose of Adderal was increased, and Effexor was added as well. Her behavior at school got worse, and she continued to lie and steal. According to Ms. Johnson, "She seemed to have highs and lows."

In May Hope became more labile, agitated, kicking the dog, being aggressive to others in the family, and sleeping with knives under her pillow. She shaved her eyebrows and part of her head. Ms. Johnson took her for a crisis evaluation, and was encouraged to put knives out of Hope's reach. She went to summer school in July, but was asked to leave because of her hyperactivity. She went to overnight camp for two and a half weeks in August, where Ms. Johnson said, "I guess she was okay, I never heard anything about it." In the late summer, Hope reportedly wandered off with a stranger, and was missing for long enough to cause her family considerable concern. When she returned, she claimed that she had simply gone to McDonalds, that she had been interested in playing softball, and that nothing untoward had occurred. At the end of August she showed more aggressiveness with the dog. She told her father, "I love the devil, the devil is my boyfriend." She was noted to throw rocks and to have hurt other children. On September 11 she was seen "putting a stick in the dog's rectum." A neighbor remembered her "terrorizing the dog... the dog would bark and then Hope would yell and the dog would yelp or cry and then start barking again." She was taken to a crisis visit with Ms. Steel on September 28, and at that visit she was prescribed Tenex and sent home. That night James was injured and Hope was arrested.

According to the records of Cynthia Steel (clinical nurse specialist in Smallville), Hope began treatment with her in the fall of 2000. She was noted to be hyperactive, distractible, to have "a problem with [her] mood", to have trouble going to sleep, and to have a history of aggressive conduct problems. She was diagnosed with both PTSD and ADHD; she had begun treatment with Adderal, and her dose was increased to 20 mg twice a day; Clonidine was added at bedtime to help with sleep. She appeared initially to become less impulsive in response to these changes. In December she was noted to be anxious and "very quiet all the time" and to be aggressive to people and animals. Clonidine was added in divided doses during the day, and she showed initial improvement in anxiety and aggressiveness, though she was tired in school.

In February she appeared more anxious and sad, and Effexor 37.5 mg was added to treat anxiety symptoms. In March her mood seemed to improve but her conduct in school was noted as "yelling and screaming and distracting", and she continued to appear anxious; she was also noted to be wetting her bed. In April her teacher noted that she did not work well with other children, and had bad conduct and manners, but no major temper outbursts. Effexor was increased to 75 mg a day. In May she was noted to continue having problems with attention and conduct in school, stealing money, and to be tired in school.

In June she was noted to have shaved her head and eyebrows, and to be stealing and lying. She had a crisis evaluation at Village Mental Health and then was seen for intake the following week. (She did not keep subsequent appointments there despite multiple phone calls from the agency, and the case was closed on July 19.) She appeared depressed and was

having crying spells. Effexor was increased to 112.5 mg per day. She was said to have hid a knife under her pillow, and to have "just learned where her mother is." Ms. Steel encouraged her family to enroll her in psychotherapy. In July she was noted to continue to steal, and to be up at night, but later in the month she was noted to be much improved. In late August she was noted to have gone off with a stranger to play ball. On September 28 she was seen by Ms. Steel who noted that she was "out of control" having "put a stick up dog's rear end x 2 ... stealing other children's things - mood swings - acts like nothing bothers her - disruptive in school - picks at mouth." She told Ms. Steel, "I've been bad - lying - stealing." Her daytime Clonidine was changed to Tenex. She was expected to begin psychotherapy within the next few days. Ms. Steel indicated by phone to Dr. West that other members of the family are involved in treatment at the same agency, and that she had urged the family to pursue more frequent visits and additional therapy, but they did not comply.

Mr. Taylor said that he was not entirely sure how to understand Hope's condition. He noted that Hope has been diagnosed with ADHD and hyperactivity, but that "no one's really had any definitive idea." His own understanding is that Hope is "emotionally disturbed, she lacks trust in people" and is easily let down when people are not consistent with her. He said that Hope has sometimes been "like any other kid," but that she has always been too much "to herself," preferring to be alone even when she seemed otherwise to be in a good mood. She has enjoyed playing outside, and always seemed to be making friends with people the family didn't know. She seemed to make only one good friend in school. He reported that they had considered taking out a status offense petition.

He said that Ms. Johnson sometimes complains that he shows favoritism towards Hope and against her boys. He said that she may think he is "too hard" because of his military background, but, "I try to teach children not to be lazy - don't lay around, help out. Her kids are crybabies." He noted that, in contrast, Hope (despite her problems) is willing to work and help out in the house and yard. He feels that it has been helpful for Hope to give her positive attention, and they enjoy going to the park together and playing ball. Hope's medicine "may have made her more relaxed" and pay better attention; he noted that before taking it, in school "her eyes were all over the place."

He feels that now Hope needs "really, really intense therapy. She wants to trust someone, to know people aren't going to leave her. She wants to be a normal little girl and she doesn't know how." He would not want Hope to "come out the way she went in," and that she would need to have her "mind disturbance and hearing things" dealt with. He noted that if Hope were to be released from custody, he could not bring her back to the family, and would have to take her somewhere else; he "would not want to put them or her" through the stress of having her return to the family. He noted, "When a child has a label, she gets treated bad even for the smallest things, even in the family." Hope acknowledged that there has been discord in the family concerning her bad behavior, and that she has sometimes been too readily blamed for things; but she did not offer any specifics or speak spontaneously on the point.

HOSPITAL COURSE:

Hope has been on constant one-to-one supervision during the hospital stay, and has mostly spent time in her room. She has tolerated this level of restrictiveness without major explicit complaint, has related reasonably well with her one-to-one staff people, and has consistently spoken of liking it in the hospital. Though she has related spontaneously with unit

staff around activities and school, she has consistently been more guarded and resistant in clinical interviews, especially in response to unstructured open questioning about emotional experiences.

Her mental status was unremarkable on admission, though she complained briefly of past auditory hallucinations upon admission, and from time to time since then; she hears someone speaking her name and calling her stupid, telling her to shut up. Admission nursing assessment noted a history of headaches and sleep difficulty. Progress notes characterize her manner generally as blunted and avoidant, but with intermittent problems with being oppositional, occasionally tearful, and sometimes quite agitated. She was noted to have trouble sleeping at times, and to grind her teeth at night.

She made some vague threatening comments in the first week of her stay, threatened to strangle herself with a torn sheet, and voiced anxiety about being supervised in the bathroom by staff. During her second week she had multiple episodes of auditory hallucinations of being taunted and called stupid, sometimes associated with head banging. She was noted to wail and cry after her constant observation staff was switched from a favored staff to a different one. When she expressed a liking for that female staff person, calling her her "girlfriend", the staff person explained to Hope that she was simply a staff member, and in response to this she became extremely agitated, saying to her, "I hate you, you don't like me," then holding her head, covering her face, thrashing on her bed, and putting her fingers in her ears. She acknowledged having had auditory hallucinations during this outburst. Hope has been noted by staff to show marked and intense feelings of possessiveness and jealousy towards particular staff.

She continued to cry on and off throughout that shift, and she threatened to strangle herself with a sheet. She voiced feelings of sadness at missing her father and her mother; she reported auditory hallucinations, threatened to bang her head, and proceeded to do so. She indicated that she bangs her head in an attempt to eliminate the hallucinations. She complained of being unable to go to sleep because of fear of hearing voices, and was noted to be tearful. She complained of voices insulting her mother, and was described as tearful and "running around out of control, screaming, hyper, loud, doesn't know what she is feeling." Staff prevented her from banging her head. On the next two days she was noted to be loud and oppositional in the early morning, but otherwise calm. Several days later she was noted to be making sharp objects by tightly folding paper, and stabbing stuffed animals with them; she was told not to, and the "paper nails" were taken away. Later on the same day she became frustrated when the Legos she was playing with were taken away, and she began banging her head with severe agitation, crying, and loud threats to kill staff members; she noted that she was hearing voices at the time. Still later she was noted to be laughing and to appear happy, but later still she was banging her head again.

My last interview with her was on October 26; she became agitated in that interview in response to questions about the events which led to her admission, though she appeared to calm down after I stopped the interview. Later that evening, she became quite severely agitated, making loud and explicit threats to another patient on the unit. In the several days since then, she has continued to show intermittent periods of agitation.

On admission she continued on Effexor (antidepressant medication) 75 mg a day and Clonidine (blood pressure medicine used to reduce agitation and impulsiveness) 0.05 mg twice a day and 0.1 mg at bedtime; her dose of Adderal (stimulant medication) was changed on

admission from 20 mg twice a day to 10 mg three times a day. She has taken Benadryl (sedating antihistamine) as much as twice a day on an "as needed" basis to help with anxiety. Because of concerns that her increasing Effexor dose might have contributed to her behavior problems prior to admission, her Effexor dose has been gradually reduced, and was 20 mg once a day on October 26. She has not shown any clear change in mental state with this reduction. Her hallucinations have continued intermittently, and her manner has continued to be variable; staff have noted that at some times when she becomes very agitated, her entire state appears changed, as though she were a different person. She was begun on Zyprexa (antipsychotic medication) 2.5 mg/day on October 26.

MENTAL STATUS:

Appearance/Behavior/Relatedness. Hope presented as a casually dressed and groomed small African American girl with braces on her teeth, who was frequently pulling at her lip. For my first interview with her, I was introduced to her by hospital staff and we were shown to a quiet office. She had been working on math problems, and was hoping for a chance to play video games; thus she was not happy at the interruption. She explained this, and then said that she was not talking. She proceeded to spend about an hour drawing a picture, not speaking spontaneously, and not responding at all to any questions. Her manner was petulant and angry. She made little eye contact, other than an occasional guarded, sidelong look. Her drawing of a face was noteworthy for her beginning with eyes, nose, and mouth, and then (after pausing with some apparent puzzlement) filling in the outline of the head; for very intense, careful, focused, and deliberate drawing, with multiple erasures; and for the apparent significance of the final image, which was a face with an intense angry grin, sticking its tongue out, and wearing a "Guess?" T-shirt. When she was done with this picture and we stopped, she spoke with other staff members about playing Nintendo, but remained very determined in her refusal to speak with me. When I returned to speak further with her along with Mr. Taylor, she sat fairly still on her bed, responded to questions, and then spoke with some spontaneity.

In the second interview I sat with her in her room. She began by expressing her reluctance to talk, but was moderately responsive to questions and occasionally spontaneous. She was intermittently distracted by activity outside the room. She became more spontaneous in her expression after she began lying on the floor and speaking while she threw a stuffed animal up and down. As she spoke of the events which led to her arrest, she intermittently spoke in an uncharacteristically deep voice, and shortly after that she became increasingly expressive and loud, with her speaking intermittently interrupted by singing, by brief high-pitched screaming, and by reciting spontaneous poems (including content of being chased and tortured, and running away) in different voices which were difficult to interrupt. When we were briefly interrupted for her to take her scheduled 4 PM medication, she claimed that she had taken it at 3:30 (she had not), responded to the nurse's question as to how she was doing by saying, "Bad", and indicated that she wanted to stop talking. When I said we had a few more minutes, she continued to laugh and rhyme, perseverating, and became louder and louder, responding to any attempt to interrupt her by becoming more agitated, pressured, and loud. She completed a long riff on the name "Jackson" by saying, "I got nothing more to say Jackson!", but then she began again and would not speak further with me.

In the third interview she related more calmly, sitting in her bed and responding to questions, but not speaking spontaneously. When I told her I had received her camper evaluation and that it was very positive, she smiled broadly, asked if she could read it, took a

long time doing so, and then refused to give it back. When other children were screaming outside her room, she got off her bed and opened the door, yelling in an irritable way for them to be quiet. Later she noticed a schoolteacher in the hallway, and got up to express her disappointment to her that the teacher had not given her any work to do that day; she spoke with other hospital staff then about her schedule for the rest of the day, in a manner notable for its spontaneity, warmth, and enthusiasm, which was in marked contrast to her manner within the individual interview. As the interview proceeded, she complained about answering questions, and said, "I'm not going to sit here and talk all day, lose all my breath."

In the fourth interview she again was very reluctant to talk, saying that she was too tired and had lost her voice. However, when offered a written exercise to work on concerning trial competence issues, she accepted it with some enthusiasm, completed it, and was able to carry on discussion about it for about forty-five minutes with some spontaneity. Later, however, when asked other questions about her history in a more familiar and unstructured open interviewing style, she became agitated, put her hands over her ears, and complained about the endless talking.

Mood and affect. Asked to describe her current mood, Hope said, "I don't know." She did not respond when asked about her usual mood, though she did say that she has fun playing Nintendo and playing outside. She said that she sometimes has good moods, and that she doesn't know about bad moods. When she told the other children to be quiet, she was clenching her fists, and she acknowledged feeling angry. She said that she feels angry when people ask her to talk about James. She could not answer about how long this feeling lasts or what she does about it; she said, "I just feel mad, 'til that person gets out of my face, or I'll hurt them." She asked, "Why do we have to talk about things that make me mad?" She complained with some pressure about having had to do psychological testing, but she could not articulate how it made her feel. She did not respond to my question about how she feels when she thinks about her mother, though she has told hospital staff that she misses her and feels sad. She did not convey feelings of sadness in her interviews with me, but her affect was noteworthy for its intensity and for its variation. Her emotions did not change in a rapid labile manner, but did vary quite dramatically from time to time, over a range including quite tense withdrawal, angry agitation, raucous hilarity, mild irritability, and pleasant enthusiasm. As noted above, she has repeatedly voiced suicidal ideation and threats to others during the course of her hospitalization.

Speech and thought. Hope's speech observed with unit staff was normal in pace, productivity, volume, and prosody. In her interviews with me her speech was usually slower, more cautious, and somewhat halting, but it showed marked variability (as described above). At times of greater agitation its pressured, disjointed, perseverative quality suggested disorganization in her thought process, though she denied any subjective abnormality in her thinking. She denied having any intrusive thoughts or dreams about the events involving James. She spontaneously reported (in the first interview with her father, "Sometimes I hear things, they tell me ' I hate you - you're stupid, you're retarded.' " The voice "sounds like a big man" with a loud, deep voice, which she hears inside her head, on both sides. She said that in response she tells it "No", but she can't make it go away. It sometimes goes away on its own, and sometimes keeps her from sleeping; it sometimes leads her to bang her head. She said that she had this experience in the past, probably going back to the summer, but she was not sure how far back.

Mr. Taylor presented as a casually but neatly and appropriately dressed and groomed African American man who related in a calm, careful, and deliberate manner, in general conveying a sense of concern for Hope’s problems but of some caution regarding the evaluation process.

Ms. Johnson presented as a casually dressed and groomed African American woman of early middle age who related responsively and with some spontaneity in the initial interview, especially in describing Hope’s problems and her efforts to obtain help for her. When I arrived at Mr. Taylor’s and her home for the second interview, Mr. Taylor said she “didn’t feel much like talking” that day, and she only joined this session for a few minutes at the end.

RESULTS OF SPECIAL DIAGNOSTIC CONSULTATIONS:

CT scan of her head, EEG (waking and sleeping), gross chromosome analysis, physical and neurological examinations, and routine blood tests (including thyroid function tests) conducted during this admission were all within normal limits. These results suggest the absence of any active neuropathological, epileptic, or metabolic process contributing to Hope’s emotional and behavioral problems.

Projective testing of emotional functioning conducted at Suburban Hospital found Hope to be somewhat withdrawn and avoidant, especially regarding material with emotional content, especially concerning aggressiveness. Testing showed evidence of her misperceiving her environment and having compromised reality testing. “In unstructured, ambiguous situations, she tends to distort stimuli and interpret the world in ways that differ from other children her age. Even in obvious situations, though her perceptions are accurate, they tend to be idiosyncratic and unconventional.” She was noted not “to see relationships as positive and does not anticipate pleasant interactions with others.” She did not show much empathic sense for others’ feelings. She appeared to rely on denial and counterphobic responses as defenses. She did show explicit anxiety about bedtimes, which was associated with being put to bed by males. She expressed concerns suggesting she feels damaged, and about being ridiculed and teased by others. Testing results in summary suggested general guardedness, distorted perception, lack of investment in relationships, and disorders of attachment and trust.

Psychometric testing at Downtown Hospital in August 2000 included the WISC-III, finding a verbal IQ of 79, performance IQ of 84, and full scale IQ of 80 (the low end of the Low Average range). She showed variability among subtests, with relatively low scores on comprehension (reflecting relative weakness in social judgment) and block design and object assembly (reflecting difficulty with time limits, perceptual organization, and trial and error learning). She did not show obvious problems with hyperactivity or distractibility in this test. On other tests she showed problems with distractibility on more complex tasks; difficulties with sequential memory; variable mild difficulties with auditory discrimination and memory; good visual integration; and generally average academic achievement except for some mild relative weakness in reading comprehension.

Routine achievement testing in school in her second year of third grade in Smallville (Iowa Tests of Basic Skills) found the following national percentile ranks:

Reading vocabulary	52	Reading vocabulary	60
Reading comprehension	48	Reading comprehension	34

Reading total	50	Reading total	48
Spelling	98	Language- capitalization	60
Math - concepts	36	Language - punctuation	67
Math - problems	70	Language - usage/expression	81
Math total	55	Sources - maps & diagrams	65
Social studies	58	Reference material	65
Science	11	Sources total	63

Taken together, these scores indicate slightly better than average academic achievement compared to other third graders, with relative weaknesses in conceptualization and comprehension.

Similar testing (Stanford achievement) in second grade in Washington showed achievement about twenty to thirty percentage points lower than these levels.

BRIEF CLINICAL SUMMARY AND DIAGNOSTIC OPINION:

Hope is a small 10 year-old girl with a family history of mental illness and substance abuse; reportedly normal early development, but uncertain temperament in toddlerhood; exposure to disrupted attachments, domestic violence, sexual activity, and possible sexual abuse in early childhood; loss of contact with her mother and a developing sense of being scapegoated within her step family in recent years; a history of hyperactivity, attention problems, and conduct problems in school and at home in her early school years (and more especially at home in recent years); specific problems of sexual provocativeness in her early school years, aggressiveness with other children, and cruelty to animals; cognition marked by low average tested IQ in 1990 but mostly average school achievement; a history of treatment over the past year with medicines for hyperactivity and distractibility, depression, and impulsiveness; and an uncertain response to treatment, as her course over the past year has included apparent worsening dysphoria, emotional instability, enuresis, sleep difficulty, and intermittent aggressiveness.

During her stay in the hospital she has been noted to complain of self-persecutory auditory hallucinations dating back to before her admission. She has shown quite marked variations in her emotional functioning and behavior, including some pleasant spontaneity around schoolwork and recreation; some periods of extreme agitation associated with disorganized thinking, hallucinations, head-banging, and threats against herself and others; and an overall guardedness in dealing with emotional issues. Her mental status has been noteworthy for variability, for relatively consistent intolerance of sad affect, and for the intensity and apparent discomfort of her intermittent auditory hallucinations. Psychological testing confirms impairment in reality testing, poor tolerance of dysphoric emotion, and guarded avoidance.

Some uncertainties remain about details of Hope's history, the potential importance of which is unclear. The nature and extent of her exposure to domestic violence and the quality of her attachment to her mother are not clear. Her sexual provocativeness in her early school years, her sexual cruelty to the dog, her anxiety about being put to bed by males, and her agitated antagonism on being asked if she had ever experienced sexual abuse are all consistent with a history of suffering sexual abuse; but they do not specifically indicate that she has been sexually abused, and they may stem from other sources. It is not clear what (if anything) may have happened to her when she was missing for a brief time in August or September. The exact

nature of the deficits of Ms. Johnson's children remains unclear, as is the specific nature of Hope's difficulties in getting along with them and with Ms. Johnson.

The hospital treatment team has offered provisional diagnoses of Psychotic Disorder Not Otherwise Specified, Attention Deficit Hyperactivity Disorder, and Mood Disorder Not Otherwise Specified. The lack of specificity of these diagnoses reflect appropriate continuing uncertainty as to the true nature of Hope's mental disorder. This uncertainty exists in part because of the uncertainties in her history, in part because of the complexity of interactions among abnormalities in her development and various environmental influences, and in part because of the fact that at her age it is difficult to predict into what specific type of course her disorder will evolve.

The single condition which best accounts for Hope's history and variety of symptoms is Post Traumatic Stress Disorder. This is a somewhat tentative diagnosis because of the residual uncertainties about the nature of Hope's early life experience, but it would account for her emotional guardedness, avoidance and tension; for her intermittent agitation and hyperarousal; and for her hallucinations and the dissociative quality of her altered voices and manner when she assumes different emotional states. In assessing hyperactivity and distractibility in childhood it can be difficult to distinguish between manifestations of PTSD (with intermittent hyperarousal, preoccupation, and dissociation) and ADHD; that Hope has a reported strong family history of ADHD may mean that she does have an independent disorder of temperament characterized by a consistent propensity for hyperactivity and distractibility independent of her trauma history and its repercussions, but this is essentially impossible to determine. Her irritable mood, sleep problems, and self-deprecatory hallucinations over the past year suggest that she has suffered from depression along with PTSD; her behavioral and emotional instability could prove to be early manifestations of a developing bipolar disorder, but it is probably too early to make this diagnosis other than as a tentative speculation. Hope also meets diagnostic criteria for conduct disorder.

ADDITIONAL CLINICAL INFORMATION RELEVANT TO COMPETENCE TO STAND TRIAL:

In this court a criminal defendant may be found incompetent to stand trial if he or she lacks a rational and factual understanding of the charges against him or her, or a sufficient present ability to consult with his or her attorney with a reasonable degree of rational understanding. The question of how the issue of competence to stand trial applies to a juvenile delinquency or juvenile waiver proceeding in this court is not fully clear from the statutes, and has never been the subject of appellate review.

Hope and her family conveyed the following regarding these issues:

UNDERSTANDING OF THE LEGAL PROCESS:

Charges and potential consequences. Hope told Dr. West that she is "charged with a crime - I am charged with assault and rape." She added that she knows James is badly hurt. In speaking with me she first explained that she was "under arrest for hours" before she went to the courthouse and then to the hospital. She said that she understood that the people involved with the court are interested in helping her, and she suggested that her having been sent to the hospital is consistent with this understanding. She said that she will not be in trouble for this offense, as she was only arrested for a short time. She does not expect to be locked up,

but instead expects to stay in the hospital for repeated periods of forty-five days. Then she expects her aunt to come from the South and take her to live with her there. She said that if anyone messes with her aunt, they will have to deal with her father. She said that she could not think of any other possible outcomes to the case. She said that her father would allow her to go, and indeed is planning to come along with her. A progress note reports that she told a staff person that she expects to go south with her aunt, but she likes being in the hospital, and she expects that when she leaves she will misbehave so that she can come back.

In a subsequent written worksheet (which I prepared for this purpose), Hope filled in blanks expressing her understanding that she was arrested for "rape", that the charge against her is "hurt", that she is the defendant, that she will have to return to court, and that the worst thing that could happen to her would be that she would go to jail. On the same exercise, she checked off "hospital, youth corrections, adult prison" as places she could possibly be sent as a result of the case; she did not check home, another family, a residential school, or camp as potential outcomes. She marked the following statements "false": "I will be able to go home whenever I want to," and "The judge doesn't have the power to lock me up."

Mr. Taylor was not aware of the options available to the court, and did not have any idea what to expect. Hope said that her father has not talked with her about this.

Trial process. In the written exercise, Hope first answered the question, "What is the purpose of a trial?" by saying "I don't know." After some discussion she understood that a trial is like an argument between two sides, which a judge (or maybe a jury) will listen to and decide who is right. When asked again after a break about this point, she said a trial is "like an argument, and figure out who's telling the truth about the case."

Though she did understand that it was possible that she could go to jail or prison as a result of the current charge, she was not familiar with the juvenile waiver process. After brief instruction on this point she was able to explain that a judge would hold a hearing to decide whether she would "stay in juvenile court" or "go to adult court," and she understood that only if she went to adult court could she then go on to prison. She understood that the judge would hear from witnesses (see below), but she was not very clear on how the judge would decide the issue. After some discussion she was able to repeat that the judge could send her to adult court if he found that she was dangerous, and if "he thought I wouldn't learn to be better" from treatment in a juvenile placement; but she had no idea how the judge might go about deciding those questions.

Roles. Hope initially said that she did not know why she has a lawyer, or what her lawyer's job is. She recalled that in the courtroom were her lawyer and another lawyer "who told the judge what happened." In the third interview she said that her lawyer's job is to help her in court, and that the other lawyer is against her. The judge "makes orders about where they're going to put me and what's going to happen." When asked if the judge could decide whether she could go to another state or not, she said, "How could the judge tell me whether I could go down South - she's not my mom or my dad, not even for one second!"

In response to some very brief instruction, Hope learned that her role in court is that of the defendant; the name of the lawyer who "tells what happened" is the prosecutor, and that person's job is also to show the court what the defendant did wrong; and the judge listens to witnesses and decides what happened. Asked the function of a jury, she said, "I don't know

nothing about jewels." A brief effort to correct this misunderstanding about vocabulary was unsuccessful, but a more detailed effort in the following interview led her to recall TV shows where a group of people sits on the side and listens. After some discussion she understood that a jury is a group of "probably ten or twenty" people, who listens to the trial and decides "who's right." We did not discuss the issue of deciding between a jury and a bench trial.

In a written "fill in the blanks" exercise given in the final interview, Hope filled in "prosecutor" as "the lawyer working against me"; she filled in "be on my side" as "my lawyer's job"; she filled in "make the orders" as "the judge's job." In addition to her lawyer, she marked "my father" and "my mother" as "people on my side," and did not mark the judge, her stepmother, the prosecutor, the jury, or the police. She marked "the judge" and "the prosecutor" as "people against me", and did not mark her father, mother, stepmother, the jury, or the police.

Ms. Mason noted that though Hope considers her a friend and ally, and knows in general that her role is "to be with her in court and talk with her and help her," she does not seem to have any differentiated understanding of what Ms. Mason's job as her lawyer actually entails. She said that when she met with Hope on October 27 (the day after my last meeting with her), Hope did not have a good idea of the role of the prosecutor.

Evidence. Asked what the role of the police were in court, Hope said, "To make sure nothing happens." She defined a witness as a "person who tells if a person is lying or telling the truth." She did not initially know who would question a witness, or who would listen to the witness. In the written exercise Hope filled in "tell the judge the truth" as "a witness's job." Hope's definition of the term "confession" was "talk," and she said that she was not sure if there had been a confession in her case (despite the ample police accounts of her having admitted to assaulting James).

Pleadings and findings. Hope was initially unfamiliar with her options as to pleading. After quite brief instruction to which she attended and responded well, she was able to say that her options included pleading guilty ("I did it"), not guilty ("I didn't do it"), and not guilty by reason of insanity ("I did it but I was crazy and couldn't help it"). In a subsequent interview she recalled the first two of these options spontaneously, but did not remember the third. She was not able to answer spontaneously questions about what would happen in response to various pleas, but after some discussion she understood (both immediately and on being questioned again later) that after a plea of not guilty, the judge would not simply believe the defendant, but instead would "have a trial, to find out if they're telling the truth." Asked how the judge would find out, she said first, "By asking the prosecutor what she did," but when asked further, she said that the judge would not necessarily believe the prosecutor, since the prosecutor "might lie." I explained that if the plea is not guilty by reason of insanity, then the trial would be about questions of mental illness.

When questioned again after a break of a little over an hour, Hope showed incomplete retention of these concepts. She said that if the defendant pleads guilty, "Then there's a trial about if she's really guilty or not." If the defendant pleads not guilty, "Then there's still a trial about if she's telling the truth." If the defendant pleads not guilty by reason of insanity, "Then the prosecutor makes a deal and there's not going to be a trial. The deal would be about going to youth corrections or a hospital."

COLLABORATION WITH COUNSEL:

Communication and trust. Hope said that her lawyer's name is Peri Mason, and shrugged, "She's all right." She said that she can talk with her, and told me that she had told Ms. Mason everything she had told me. Mr. Bridge said that Hope had been initially reluctant to speak with Ms. Mason about the events leading to the assault, and sat with her fingers in her ears as she tried to discuss it with her. She was noted to be tearful following this visit. Mr. Bridge told me that in a subsequent conversation with Ms. Mason, Hope had spoken more willingly, and had conveyed a bit of information about the alleged offense. Ms. Mason had indicated that Hope was bright and able to communicate, though it was not clear that she was yet fully informed as to the specifics of the legal proceedings; she also had concerns about her depression and potential for self-harm.

In the written exercise, Hope marked "my father," "my mother," and "my lawyer" as people she "can probably get good advice from." She did not mark her minister, stepmother, friends, doctor, or the prosecutor.

Mr. Taylor said that Hope's lawyers appear to be helpful, and are working hard to gain Hope's trust.

Ms. Mason reported that she has met with Hope three times at the hospital and spoken with her a few times on the telephone. In the first meeting she barely spoke at all. In the second meeting she spoke "in bits and pieces" about the events of the night of September 28, but was not been able to offer a sequential, coherent account of these events to her. In the third meeting she indicated that it was important for Ms. Mason to understand what happened in order to help her, and Hope became more agitated and avoidant, and then threatening to other children and verbally abusive to staff; she did not offer any further information about the events in question, but she was able to calm down and discuss her expected appearance in court coming up in November. She has communicated with some spontaneity with Ms. Mason when speaking about Nintendo games, and has been somewhat distracted from other conversation by her games and her stuffed animals. She has shown a special concern with the reliability (or lack of it) of others' promises.

Ms. Mason noted that she has provided special education tutoring with young children in the past and is generally comfortable with children and successful in communicating with them. Though Ms. Mason said that, in general, Hope appears to consider her an ally and friend, Hope has been quite limited in her communications with her. She noted that Mr. Bridge will be trial counsel, but that Hope has never met him.

In her interviews with me, Hope offered an account of the events of the night of September 28, both spontaneously and then in response to questions; this account was moderately detailed but was somewhat disjointed and clearly incomplete. This account is included in my separate, sealed report on criminal responsibility, and will not be provided here (to avoid any concerns about self-incrimination). Though I do not know (and did not ask specifically) what Hope conveyed to Ms. Mason regarding these events, her accounts of the very limited extent to which Hope has spoken to her about them suggests that what Hope has been able to convey to her thus far about the events in question is also limited, and may even be more limited than what she told me.

Decision making. Hope was unfamiliar with the term “plea bargain,” and with the concept of negotiated settlement. She was familiar in general with the concept of “good deals” and “bad deals”, and said that if she were offered the chance to stay in the hospital in exchange for a guilty plea, that would be “a good deal.” However, she averred that this would be a good deal even if she had to stay in the hospital for the rest of her life; she did not seem to appreciate the meaning of “the rest of your life,” as her discussion of this hypothetical included comments about what she would do when she went home. When asked if it would be a good deal if the prosecutor offered a commitment to youth corrections in exchange for a guilty plea, she said this would be a bad deal; however, the reason she gave for this judgement was, “‘Cause I hate the prosecutor - she’s a *bitch!* I offer her a good fist, if she’s lying on me!”

Mr. Taylor noted that the detectives did warn Hope and him that Hope did not need to talk, and that he had encouraged Hope to tell them what happened; but that the detectives then questioned her in a leading and “tricking” manner, as police tend to do.

Attention and conduct. Ms. Burke reported that Hope’s arraignment was a fairly informal proceeding at which she appeared somewhat puzzled but comported herself appropriately. In general, Hope appears to respond better in structured situations than in unstructured ones, and would probably not be disruptive in court. However, she has also showed consistent evidence of finding it difficult to tolerate discussion of her alleged offense. Therefore at present she may be expected to be at somewhat increased risk for irritability, avoidance, and impairments in attention and participation in court, in response to explicit discussion of the allegations against her.

OPINIONS REGARDING COMPETENCE TO STAND TRIAL:

Mental disorder. As reviewed above, Hope suffers from marked difficulties with emotional instability, guardedness, depression, distractibility, and intermittent disorganization in her thinking and perception.

Understanding of proceedings. Hope shows a rudimentary understanding that she is charged with a crime and that she faces a legal proceeding with potentially aversive consequences for her. She has shown a consistent understanding of the nature and seriousness of the offenses with which she is charged, but her understanding of the potential consequences has been inconsistent. She has shown a basic understanding of the trial process (as an argument between two sides to determine what is true), but her appreciation of details of the process (especially concerning her plea options and their consequences; the presentation and nature of evidence, especially concerning her statement to the police; and the specific roles of both prosecuting and defense attorneys) has been incomplete and inconsistent. Her understanding of the waiver hearing process includes a basic appreciation that she may face either juvenile or adult proceedings and penalties, and that a judge will decide this based on how well she can be expected to learn from juvenile intervention.

Collaboration with counsel. Hope recognizes Ms. Mason as a friend and ally, but does not have a well-developed understanding of how Ms. Mason may be expected to help her, or of what she herself needs to be able to do to help Ms. Mason to do her job. She has never met Mr. Bridge, and can be expected to have some difficulty establishing initial communication with him, in light of her overall guardedness. It appears likely that Hope has not so far been able to provide a complete account of the events in question. Hope’s understanding of her plea options is limited,

and her decision making about even simple hypothetical negotiated settlements was irrational.

Both Hope's parents appear to be poorly informed about the potential outcomes of the case, and about options for Hope's defense. Furthermore, Hope's mother has re-opened the question of Hope's legal custody, and is currently in an uncertain situation regarding her access to Hope and ability to counsel her.

Summary of opinion. Hope's level of understanding of the proceedings is quite basic, and includes some inaccuracies and significant incompleteness. Though she has a basically positive relationship with her lawyer, her ability to communicate with her lawyer about the details of the alleged offense and about complex defense issues is substantially impaired by her guardedness and by her vulnerability to emotional disorganization. Whether Hope's relative deficits in understanding and substantial deficits in collaboration are significant enough that she should be considered unable to take part fairly in the delinquency proceeding is beyond my expertise as a psychiatrist, for two reasons.

First, it is not clear what the actual demands of this trial process may prove to be, so I cannot offer any summary conclusion as to Hope's overall ability to meet those demands. (For example, if the anticipated process were to be a negotiated solution resulting in Hope's treatment needs being met, with clear, appropriate, and uncontested contributions from her parents on her behalf, then Hope's own contributions to the process might appropriately be expected to be limited; but if the anticipated process will include an adversarial proceeding concerning either fact issues or mental state issues, Hope's participation would presumably need to be more substantial.)

Second, the ultimate determination of how much capacity a defendant needs to have in any of the specific areas concerned in order for any trial process to be fair is not a clinical determination. It is a determination of an appropriate standard for fairness in the legal process. Such a determination can only be made by a judge, based on the overall circumstances of the individual case.

Remediation. If Hope were to be found currently not competent to stand trial, she could in my opinion be expected to learn the details of the trial process in a matter of weeks, in response to specific teaching. I would not expect that her mental disorder would pose a substantial impediment to this learning, though it would likely contribute to some intolerance of extended lessons, some intermittent disruption in the learning process, and a need for a longer total time than would be needed without the disorder. I would expect that her ability to develop a relationship with her lawyer of sufficient comfort and trust to enable her to discuss the difficult issues in the case in a rational, consistent, and productive manner, with appropriate family involvement, would take considerably longer (from several months to a year or more). Such progress would depend on her disorder being more successfully treated than it has been so far, enabling her to be less guarded, unstable, avoidant, and irrational; and it would depend on clarification of her family circumstances, so that she can count on reliable support over time from one or both parents.

OPINIONS REGARDING CARE AND TREATMENT:

The hospital treatment staff is of the opinion that Hope is mentally ill and that failure to retain her in the hospital would lead to a likelihood of harm. I completely concur with this

opinion, based on the description of her mental disorder offered above, and on her continuing hallucinations, marked emotional instability, and threats to self and others, in addition to the specifics of the allegation against her in this case. The Suburban Hospital is prepared to receive Hope back from court for continuing treatment

The appropriate authority for returning Hope to Suburban Hospital depends on the legal proceedings, as follows.

Competent/continued. If the court determines that Hope is competent to stand trial and the case is continued for adjudication, then Hope can be returned to the hospital on a voluntary basis, where she will remain in the same secure status she has had thus far. The hospital has submitted a petition for voluntary remand to be used in this event.

Competent/adjudicated. If the court determines that Hope is competent to stand trial and she is adjudicated delinquent, then I would recommend that the court order her to return to Suburban Hospital for a further pre-sentencing evaluation, under the authority of Ch. 000, s. C. In the likely event that she would need to remain in the hospital following that evaluation, she would be subject to further civil commitment per Ch. 000, s. D; such commitment could be undertaken along with probation supervision or following a commitment to youth corrections.

Competent/adjudicated NDRI. If the court determines that Hope is competent to stand trial and she is adjudicated not delinquent by reason of insanity, then the court can commit her back to Suburban Hospital under the authority of Ch. 000, s. D or s. F. The s. E commitment can be ordered by the court without need for a hospital petition, and is for a period not to exceed forty days; however, the total commitment period for combined AA and E commitment is not to exceed fifty days, and therefore a E commitment at this point should be for no more than ten days. A s. F commitment would be for a period of six months, and requires the hospital to petition for the commitment; it can be renewed by court order yearly thereafter, if the involuntary commitment standard continues to be met. Suburban Hospital has submitted a petition for s. F commitment for this purpose.

Incompetent/dismissed. If the court determines that Hope is not competent to stand trial and the case is dismissed, then I would recommend that Hope be returned to Suburban Hospital under the authority of Ch. 000, s. D. The s. F petition may serve as the initiating basis for this commitment.

Incompetent/continued. If the court determines that Hope is not competent to stand trial and the case is continued, then I would recommend that she be returned to Suburban Hospital under the authority of Ch. 000 s. E (for ten days, as above), or Ch. 123 s. F (for six months, as above). Commitment under s. E is on the court's initiative without a petition; commitment under s. F requires a petition, which Suburban Hospital has submitted for this purpose.

Detention. If the court does not agree that Hope should be returned to Suburban Hospital and elects to have her detained instead, it is my understanding that the detention authority would place her either in a non-secure shelter facility, or in a secure detention facility with adolescents. In my opinion, neither of these options would meet Hope's clinical needs, and she would likely deteriorate and need hospitalization in any event.

Longer term treatment. If Hope were committed under the provisions of s. D, she would be

eligible for discharge upon a determination by hospital staff that she was sufficiently treated that she no longer met the threshold for involuntary commitment, though legally she could be retained in this hospital as a voluntary patient if her custodial parent were to request it and the hospital were to agree. If she were committed under the provisions of s. F, she would also be eligible for discharge upon a determination by hospital staff that she was sufficiently treated that she no longer met the threshold for involuntary commitment; however, in that event the District Attorney would be a party to the matter, and could object to the hospital's determination of eligibility for discharge.

Marcus Welby, M.D.

***City Juvenile Court
100 Main Street
City, State 00000***

Clinical Report on Competence to Stand Trial

CASE NAME: Bobby Carlisle
PROBATION OFFICER: Steven Ford, City Juvenile Court
DATES SEEN: September 15 & October 8, 2001
CLINICIAN: Michael Berman, M.D
DATE OF REPORT: October 14, 2001

Bobby Carlisle is a 14 year-old boy (b. 11/11/87) who lives in XYZ Suburb and attends the Carver Middle School. He is before the City Juvenile Court on a charge of indecent assault and battery, stemming from an allegation that he touched a girl inappropriately on a school bus. He was seen in the spring by Dr. Montgomery at the City Juvenile Court Clinic regarding competence to stand trial, and he is currently re-referred for updated evaluation of competence to stand trial. Evaluation has consisted of:

- 1) Review of Dr. Montgomery's previous court clinic report and of Bobby's hospital record from Elmhurst Hospital (records were also requested from Presbyterian Hospital, City Medical Center, Dimock-XYZ Suburb Counseling, and St. Joseph's Children's Hospital, but have not been received).
- 2) Telephone conversations with Bobby's attorney Robin Matthews and with Department of Mental Retardation caseworker Danielle Keating (I left a message for Dr. Sanchez but the call was not returned).
- 3) Clinical interviews with Bobby and his mother on September 15 and with Bobby alone on October 8, at the City Juvenile Court, totaling about three hours.

Prior to beginning the interviewing I explained the purpose of the evaluation and its lack of confidentiality to Bobby and his mother. Bobby said that he understood that the judge and lawyers would learn what he said in the evaluation, and said that if there was something he didn't want people to know, he would not say it.

CLINICAL HISTORY:

Bobby has a maternal family history of depression and alcohol abuse, and experienced significant fetal alcohol exposure throughout his gestation. His early motor development was good, but his language development has been problematic. His early speech was marked by stuttering. From about age four he had a preoccupation with matches which reportedly came close to causing serious fires. This abated spontaneously at about age eight (along with his stuttering); at that time (by mother's report) his aggressive and impulsive behavior got worse. He has demonstrated hyperactive and disruptive behavior in school and at home from preschool years, and problems with impulse control and aggressive conduct with resulting conflict with mother, sister, and peers. His judgment in dealing with peers has been poor; he has shown

interest in having friends, but has been consistently victimized without appearing to learn how to behave or whom to avoid. He has been overactive, distractible, and forgetful in school.

In recent years his family has raised concerns about Bobby's safety and their own, because of his impulsiveness and aggression. He has had difficulty in the past maintaining himself in after school and summer programs because of his behavior. He has been involved for a few years in treatment (primarily psychopharmacological, with some counseling) at City Medical Center, and has been treated with a variety of medications including Wellbutrin, Ritalin, Cylert, Tenex, Prozac, and Elavil, without (apparently) any definitive benefit. He was most recently hospitalized in early October of 2001 at Presbyterian, because he had been increasingly agitated and aggressive. His current medications include Tenex and risperidone (for impulsiveness), and Depakote (for emotional instability). (His mother noted that an additional medicine had recently begun at Presbyterian, but she was not sure of the name, and the name she offered [Tomex] was not one I knew or could find.) He has been involved for case management with the Department of Mental Retardation, but Ms. Keating (who recently took over the case) was not sure what specific services he or his family were receiving. His mother has reportedly been abstinent from alcohol for twelve years and maintains steady employment.

Past psychological testing (October 2000) found a full scale IQ of 65 (verbal 62, performance 73), consistent with overall mild mental retardation, especially in language related areas. He has shown consistent serious difficulty both with expressive and receptive language functions. His attention is adequate for simple stimuli, but when tasks become even moderately complex, he is not able to maintain attention and becomes more impulsive. His school functioning has been poor both in learning and in conduct.

During his first year, Bobby was noted to have spells with characteristics of seizures (sudden angry outbursts followed by periods of unresponsiveness), but these did not continue past age 18 months. A neurological evaluation at Children's Hospital in 1999 found no basis for concern about organic brain pathology. CT scan of the head in 2000 was normal. Bobby has suffered from asthma, and has had many injuries and broken bones as a result of his reckless behavior.

MENTAL STATUS:

Bobby presented as a large, somewhat overweight African American early adolescent boy who related in a pleasant and cooperative but very passive manner. He frequently yawned and seemed tired, and maintained a general demeanor of dull, bland puzzlement through most of both interviews. He offered almost no spontaneous speech, and was responsive to questions only with one or two word answers, or with an occasional sentence. It was common that he did not respond to questions at all until he was prompted with multiple choice options. His responses to such questions were consistent over time, suggesting that they were valid indicators of his thoughts; but these responses may at times have reflected his perception of what was expected.

In general his affect was calm and showed little variation, and he appeared to be somewhat sedated. He did show indications of explicit anxiety when considering the possibility of going to jail, and of embarrassment when discussing the specifics of the charges against him. He became somewhat less responsive and more oppositional in a subtle and passive way after about an hour of the second interview, when speaking of dispositional options; he replied "Yes" when asked if he was tired. He offered little enough spontaneous speech that it was not possible to determine the presence or absence of disorganized thought or bizarre thought content or perception from his speech; but he did not describe any such abnormalities, and he did not manifest any of the signs of agitation or emotional instability which commonly accompany disordered thought or perception.

In the second interview he recalled having met with me before; he did not remember my name accurately, though he said he was confident he was right. He did remember his doctor's name, but not the names of the medications he takes. He was able to recall three complex items perfectly both immediately (showing good attention for simple, rote material) and after twenty minutes (showing good short term memory retention). He could say the names of the days of the week in order both forwards and backwards, showing good attention. He did not know the first month of the year, and when primed with "January" he listed nine of the remaining months with only one out of order. He could give reasonably detailed, concrete directions for getting from the courthouse to his home by public transportation.

SPECIFIC CLINICAL INFORMATION RELEVANT TO COMPETENCE TO STAND TRIAL:

In this state's courts a criminal defendant may be found incompetent to stand trial if he or she lacks a rational and factual understanding of the charges against him or her, or a sufficient present ability to consult with his or her attorney with a reasonable degree of rational understanding. The question of how the issue of competence to stand trial applies to a delinquency proceeding in this state is not fully clear from the statutes, and has never been the subject of appellate review.

Bobby and his mother conveyed the following regarding these issues:

UNDERSTANDING OF THE TRIAL PROCESS:

Charges. Bobby initially claimed to have no idea what the court process was about, though he acknowledged that it stemmed from "something that happened," and that he was embarrassed to provide any further details. In the second interview, however, he said that he is in court as a result of being said to have "touched a girl." He explained that it is considered wrong to touch someone "in a private area," he pointed to his lower abdomen saying, "Like down there," and responded with a nod when asked if he is accused of touching a girl in a private area.

Potential consequences. Bobby knew that he had been arrested as a result of this charge, and has had to appear in court on several occasions. He noted that one consequence of this is that he has had to "see a whole bunch of different people." At several points he indicated an awareness that he could be locked up or sent to a secure facility as a result, and he showed familiarity with and anxiety about the possibility of being on the sex offender registry.

Ms. Matthews indicated that though Bobby may have a rote understanding of the theoretical consequences of the delinquency proceeding, he appears to maintain a naive view that it is an essentially benign process in which people will try to help him; he does not appreciate that the prosecution is fundamentally against him.

Ms. Carlyle conveyed a very clear and explicit understanding of the proceedings and potential consequences, and as she reviewed them with Bobby, Bobby attended carefully; when she spoke of the possibility of Bobby being locked up, Bobby's nostrils flared, his eyes opened wider, and he stared open-mouthed for a few moments, suggesting considerable anxiety at this possibility. He then said that he thought he would not be going to jail, though he could not explain why not.

Roles. Bobby was initially vague on the question of what actually happens in court, other than that "people get helped out." In the first interview Bobby had difficulty articulating the roles of the various people in court. He knew that Ms. Matthews was his lawyer, and that the judge was there to "listen" and to "figure out who's right and who's wrong, between the lawyers and the kids." He recognized the prosecutor as "a blond lady lawyer [who is there] to help the girl." He added that she "says things that might be bad for me." In the second interview, he volunteered that of the "bunch of people" he has had to deal with, some are "trying to help me

out - like my lawyer" and others are "trying to help the girl out." He could not offer details of how the girl was helped.

Evidence. Bobby conveyed a basic understanding that the judge would listen to people's stories and decide who to believe. He was familiar with the term "witness", defining it as "people there who saw it." He could not answer whether the girl might be a witness.

Pleadings and findings. Bobby showed a spontaneous understanding that he could offer either a plea of guilty (meaning "I did it") or innocent (meaning "I didn't do it"). He did not spontaneously understand that a plea of not guilty would not simply be believed, but would lead to a hearing. However, he was able (after instruction) to say that if he were to plead innocent the judge would then hear evidence ("ask somebody else"), and he showed a basic understanding of the hearing process ("judge listens and decides who's right"). He said that the judge would decide "if you're guilty or not" and then "if you go to jail or not."

CAPACITY TO COLLABORATE WITH COUNSEL:

Communication and trust. In the first interview Bobby was aware that Ms. Matthews works "in the court", and with some support and explanation from his mother, he recalled that her job is to help him in the court. He said that he would follow her advice, and that if she told him not to talk, he would not. In the second interview he identified her explicitly as his lawyer, and said that she would be the one person whose advice he would rely on.

Bobby declined to provide an account of the events in question, even after I assured him that I would not include that account in my report, but was asking only in order to assess his memory and capacity to recount the events. He said that he did not want to talk about it, but that he does remember what happened, and that he has told Ms. Matthews about it.

Decision making. Bobby showed a good spontaneous understanding of the concept of bargaining. He said (in response to questioning) that \$20 for a popsicle would be a bad deal, whereas \$1 for a pair of sneakers would be a good deal. Getting a candy bar in exchange for making all the beds in the house for a week would be a bad deal, since it would be "not good enough for me"; getting a day without homework in exchange for getting 100 in six tests would be a good deal; having to stay after school for four hours if he failed to read six books would be a bad deal. Bobby said that it would be a good deal if he pled guilty in exchange for a promise that he would not be locked up, but if pleading guilty meant that he would be identified as a sex offender and everyone would know, then it would be a bad deal, as he would be very embarrassed.

In the first interview (with his mother) Bobby indicated that his mother's advice would be his most important direction in making decisions; he noted that if his mother told him to trust Ms. Matthews, he would. In the second interview (by himself), when asked whom he would ask for advice in court (especially if he were uncertain as to whether a deal was a good one or not), he said, "Robin," and he said that he would accept Ms. Matthews' advice even before that of his mother.

Ms. Matthews noted that Bobby is extremely passive and compliant in his dealings with her, and she has strong doubts as to his capacity to make any autonomous decisions. He seems consistently to focus on pleasing others and to respond to questions with the answer he believes is desired or expected; he does not demonstrate any autonomous detail or understanding that would enable her to be confident that he is able to think for himself. She noted that Bobby's mother (in her experience) appears to be fairly dominating in her interaction with Bobby; this may help to make up for Bobby's lack of understanding, but it also appears to undermine Bobby's own engagement in the process.

Ms. Carlyle was somewhat skeptical about Bobby's assertion that he would rely on her for advice, as she noted that he actually tends to be somewhat oppositional to her advice in ordinary matters around the house. However, she also said, "When he is scared, he comes running for help."

Participating in and withstanding the stress of a hearing. Ms. Matthews raised serious concerns as to Bobby's capacity to testify in his own behalf, should that be necessary. In addition to noting his general paucity of expressive language, she noted that in the accounts of the events in question which he has offered her, there have been inconsistencies sufficient to raise questions as to the adequacy of his recall and ability to offer a valid account. Furthermore, she noted that Bobby's apparently weak understanding of the true adversarial nature of the proceedings, along with his general difficulties with attention and impulse control, have made it impossible for her to instruct him effectively in what he should and should not say as a witness.

OPINIONS REGARDING COMPETENCE TO STAND TRIAL:

Mental Deficits. Bobby suffers from mild mental retardation, from specific deficits both in expressive and receptive language, from deficits in attention interfering with abstract reasoning and judgment, from poor social judgment, and from impulsive and aggressive conduct, all with consistent manifestations from early childhood. These multiple developmental deficits appear likely to stem at least in part from fetal alcohol exposure. Treatment has consisted primarily of psychotropic medication targeted at reducing impulsiveness and emotional instability; it appears to have been only intermittently successful in helping Bobby to contain his behavior, and only marginally successful in improving his ability to learn.

Specific Capacities. Bobby manifests a consistent awareness that he faces legal proceedings relating to being accused of having touched a girl inappropriately. He has shown a consistent basic awareness that these proceedings put him at risk for aversive state action, but he does not have any detailed understanding of what the specific ranges of potential consequences might be, and he does show some minimization and avoidance of potential aversive consequences. However, he has shown consistent awareness that these consequences potentially include being locked up and being on the sex offender registry. He demonstrated a basic awareness that the court hears evidence and determines the facts, and decides on disposition. He trusts his lawyer and would follow her advice. He had a basic understanding of the process of negotiation and showed some consistent judgment in his consideration of a few simple possible points of negotiation in the current case.

Despite these basic capacities, Bobby's difficulties in using language and in maintaining focus in coping with complex issues can be expected to present some significant problems for the legal process. It is not clear that he would have sufficient language skills or focus to be able to be effective in giving testimony on his own behalf, which might (depending on other evidence) prove to be critical in defending against the current charge. Despite his rudimentary understanding of dispositional options, his vagueness, inconsistency, and difficulty coping with complexity raise questions as to his ability to understand or competently agree to details of community treatment as conditions of probation supervision.

Whether these specific deficits are substantial enough that Bobby could not take part fairly in the delinquency proceeding is beyond my expertise as a psychiatrist, for two reasons. First, it is not clear what the actual demands of this trial process may prove to be, and so I can't offer any summary conclusion as to Bobby's overall ability to meet those demands. Second, the ultimate determination of how much capacity a defendant needs to have in any of the specific areas concerned in order for a trial to be fair is not a clinical determination. It is a determination of an appropriate standard for fairness in the legal process; such a

determination can only be made by a judge, based on the overall circumstances of the individual case.

Capacity for Remediation. Bobby's course appears to have marked by some intermittent variation in his irritability and focus. In the second of these two interviews (conducted after his recent hospitalization at Presbyterian) his focus and responsiveness was marginally better than in the first. It is reasonable to expect some mild waxing and waning in these general capacities over time, but (in light of his course so far) it is not reasonable to expect any substantial improvement over the near future in his overall cognitive functioning, in his language abilities, or in the strength of his relationship with his attorney. It is possible that with improvements in his overall plan of education and treatment he might show some significant gains in language functioning and conceptual focus over the longer term future, but this is very difficult to predict one way or another.

CONSIDERATIONS REGARDING CARE AND TREATMENT:

Bobby does not present currently with the specific combination of mental disorder and risk to self or others which would warrant acute psychiatric treatment in a hospital or other acute care facility. However, there may be some improvements possible in his overall treatment plan in the community.

The Department of Mental Retardation can help provide in-home training for Bobby's family in behavioral management, which might help to contain Bobby's behavior better in that context. Given Bobby's cognitive deficits, his apparent vulnerability to exacerbation of his distractibility and irritability by stimulating environments, and his poor peer skills and vulnerability to negative peer influences, his overall growth and development might be fostered better in a school that is smaller and calmer than Carver, and that included specific skill building treatment in peer relations. Ms. Keating suggested that adjudication of the current charge against Bobby might be important in determining appropriate services for Bobby, since some school and after school programs may be reluctant to admit him until the issue of whether he poses some sexual risk is determined.

Michael Berman, M.D.

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Competence to Stand Trial Report

CASE NAME: Diego Alvarez
DATES SEEN: September 11 & 23, 1997
CLINICIAN: John Jones, M.D
DATE OF REPORT: September 25, 1997
NEXT COURT DATE: October 30, 1997

Diego Alvarez is a 16 year-old boy who was committed to Lakeview State Hospital on August 4 by the Somerset County Juvenile Court after having been found incompetent to stand trial. He faces charges of aggravated rape and sodomy, allegedly having forced himself sexually on a neighborhood girl on two occasions.

CIRCUMSTANCES OF ADMISSION:

Diego is from a Spanish-speaking Mexican family, and he has a history of special education involvement. His attorney had raised concerns about his ability to understand and take appropriate part in the legal proceedings. The court originally ordered a competence to stand trial evaluation by its court psychologist, Dr. Santiago; that first evaluation was conducted in Spanish and English under my supervision by Dr. Santiago. She concluded that Diego's cognitive difficulties would present serious impairments to his trial capacity. The court raised questions about the implications of Dr. Santiago's report, and I provided a second report offering clarification and specific additional recommendations to the court. This report indicated that Diego was not likely to improve sufficiently to be competent to stand trial in the short term; it also concurred with other recommendations for long-term specialized residential care, and recommended interim placement with the Department of Human Services. At court on August 16, DHS indicated that it did not have an appropriate interim placement to offer pending long-term residential placement. The court found Diego not competent to stand trial and ordered hospitalization. A second hearing on Diego's competency to stand trial will be held on October 30, 1997, and this evaluation is prepared at the Juvenile Court's request to aid in that determination.

SOURCES OF INFORMATION:

This evaluation is based on the following sources:

1. Dr. Santiago's report and discussion with Dr. Santiago of her findings and conclusions.
2. Past clinical reports obtained from Children's Resource Center, St. Jude's Children's Hospital, Longwood Hospital, and the Somerset County Department of Human Services.
3. Review of hospital record and consultation with treatment staff at the Lakeview State Hospital.
4. Clinical interviews with Diego at Lakeview State Hospital on September 11 and 23, 1997.

As noted in my report to the court dated XYZ date, review of previous records yields the following relevant clinical data, in summary.

Diego suffers from a chronic illness (tuberous sclerosis) which involves the development of abnormal tissue in various parts of the body including the brain. His illness includes an abnormal EEG and epileptic seizures, and psychological testing has demonstrated clear and consistent impairments that suggest damage in the left frontal and temporal regions of the brain.

Psychological testing has consistently demonstrated verbal functioning at the low end of the mildly mentally retarded range (VIQ in the low fifties). Some past testers have suggested that his true level of functioning might be higher than this, and that tests might not be assessing him adequately because he is bilingual. However, Dr. Santiago, who is bilingual herself and an expert in bilingual assessment, indicates that his overall language functioning is not indeed higher than these tests have shown, regardless of language. Diego also shows significant problems with short-term memory, and specific assessments of his social and emotional maturity indicate that he is quite delayed in these areas as well.

Dr. Santiago's specific questioning of Diego regarding his understanding of the nature of the delinquency and transfer proceedings against him shows very marked impairments in his basic understanding of the nature of an adversarial proceeding, as well as in his capacities to learn and retain even the most basic information.

Clinical history is noteworthy for past indications of suicidal behavior and of serious impairments in family supervision, and for more recent indications of tantruming and of aggressive conduct problems. Past evaluations have been consistent in making strong recommendations for placement in a very structured, full-time residential treatment program with a specialized capacity for treating mentally retarded adolescents with conduct problems.

NONCONFIDENTIALITY WARNING:

Before interviewing Diego the first time I explained to him that what we talked about would not be secret, and that I would tell it to the court. When I asked him to explain this back to me (to demonstrate his understanding), he said nothing, and stared vaguely past me. When I asked him if I would tell anyone what we talked about, he shook his head no. I repeated the warning and then asked him if I would tell the judge what we talked about; he shrugged his shoulders, apparently indicating that he was not sure.

Before the second interview (at which Dr. Drake, his primary therapist, was present), I reminded him of the same warning, though he indicated that he did not remember having spoken with me before. After explaining the lack of confidentiality to him, I then asked if he thought that I would keep secret what he told me. He appeared puzzled, but nodded his head yes. Further attempts to clarify this part at the start of the interview yielded only blank looks and the appearance of greater anxiety, which he was able to acknowledge in response to questions from Dr. Drake. In the course of this interview, with Dr. Drake's support, Diego was able to be significantly more communicative than he was in his initial interview with me. At the conclusion of this interview, I asked him again whether he thought I would tell anyone what we had talked about; with a thoughtful and serious demeanor, he shook his head no. I asked if he remembered what I had told him about telling the judge; he shook his head no. I told him again that I would tell the judge what we talked about; he said, "Okay." I asked again if I would tell anyone; he said, "No." I asked if he thought I would tell the judge; he said, "Yes."

HOSPITAL COURSE:

Consultation with Dr. Rasco and Dr. Drake (Diego's primary clinicians) and with other program staff, and review of the hospital record, indicate that Diego had considerable difficulty adjusting to the hospital program. Though efforts were made to tailor a program to his specific needs, he continued to be confused and overstimulated by the complexity and demands of this program, which is designed for patients with mental illness rather than for those with retardation and organic psychological deficits. He has not shown signs of the sort of psychiatric disturbances for which this sort of hospital program is ordinarily appropriate. In addition, he tended increasingly to be victimized by taunts from other patients, contributing to his confusion and agitation. He has become hypervigilant, provocative, and increasingly assaultive in

response, leading in turn to the need for physical restraints. Despite these difficulties, he has not shown any indications of any sexually aggressive behavior during this hospitalization.

During the last two weeks of the hospitalization, his behavior has shown noteworthy improvement. He is described as more talkative, energetic, and cheerful, and less fearful, withdrawn, agitated, and impulsive. He is noted to have been able to respond with more consistent success to a structured behavior management program based on simple rewards. Medication changes towards the end of the period of hospitalization (see below) appear to have contributed to these changes. However, it is clear that he has over time been able to establish a warm and supportive sense of personal connection with at least some of the hospital staff, and it is likely that these comfortable attachments have also contributed significantly to the improvements in his mood and behavior.

RESULTS OF SPECIALIZED CONSULTATIONS:

Neuropsychological testing was conducted on September 7 by Dr. Susan Miller. Results were consistent with previous evaluations, finding substantial cognitive deficits, especially in language and short-term memory, consistent with overall functioning at about a 5 to 8 year-old level developmentally. Recommendations were for placement in a residential setting with instruction in a substantially separate classroom situation.

Diego has been seen to have a few small fits while in the hospital. Some of these have included the characteristic tonic-clonic movements and reduced consciousness and confusion generally characteristic of epileptic seizures; others have not included these characteristics, and so may have been either smaller seizures or possibly "pseudoseizures", i.e., a form of learned behavioral disturbance that patients with epilepsy sometimes develop as a consequence of having genuine seizure activity. His seizures have not involved any important medical complications.

Neurological consultation by Dr. Pitt led to an increase in his dose of carbamazepine (Tegretol, an anticonvulsant which also has antidepressant and mood stabilizing qualities) within the last two weeks. This change has coincided with notable improvement in Diego's mood and behavior. Though Dr. Pitt's note is not yet available, he reportedly also recommended a gradual reduction in Diego's dosage of primidone (Mysoline, a barbiturate anticonvulsant) in the hope that reducing this drug might help improve his cognition somewhat.

MENTAL STATUS:

Diego presented as a tall adolescent of medium complexion who was casually but appropriately dressed and groomed. His behavior was remarkable in the first interview for his generally vague manner and minimal responsiveness, complaints of feeling sleepy, and ultimately sitting perfectly still and nonresponsive with his head in his hand. He described his current feelings as "tired, sleepy." He was able to repeat a few single words and numbers, a series of three numbers, and a series of three single syllable words. He was not able to repeat longer series of numbers or words, and when asked to repeat after a few minutes the series that he had originally repeated, he did not respond. When offered alternative possibilities in a multiple choice format, he did not respond to two and answered yes (incorrectly) to one. He appeared to understand that he is in a hospital (in that he answered "yes" when asked if this was a hospital, after answering "no" to whether it was a farm or a school). When asked why he is in the hospital, he said, "to learn, to work." When asked how he was sent here, or if he recalled being in court, he did not respond.

The second interview was conducted about two and a half weeks after the increase in his Tegretol dose, and after he had been fairly consistently described as less irritable and more engaged for about ten days. In this interview, with Dr. Drake present, he continued to be only

minimally responsive to questions from me, and to appear blank and anxious; he explicitly acknowledged feeling quite nervous in response to a question from Dr. Drake. He smiled warmly in response to her reminders of the conversations that they had had in the past week, and he was quite attentive to and apparently enthusiastic about her support. In response to the use of simple drawings as a way to orient him to specific questions about the legal process, he became slightly more explicit in his responses to questions in this area. However, he explained fairly directly that when he is nervous, he often prefers to be silent and to stare into space.

INFORMATION SPECIFICALLY RELEVANT TO COMPETENCE TO STAND TRIAL:

This information is based in part on Dr. Drake's accounts of conversations between her and Diego, and in part on Diego's direct communications in his interview with her and me together on September 23. In this interview he was initially unresponsive to questioning. However, in response to her reminding him that they had talked about the allegations and about his once having seen a trial on television, and in response to my drawing some simple pictures of a courtroom scene, he was able to begin to talk with some specificity regarding the issues below.

Understanding of the charges. During the initial weeks of his hospital stay, Diego tended to avoid talking about the circumstances of his hospitalization. He was described as seeming sad when the issue of the charges against him was raised with him, but it was not clear whether his sadness had something to do with the case, or simply with his having been told that he should not expect to be returning home.

Toward the end of his hospital stay, Diego had several conversations with Dr. Drake which demonstrated some more specific understanding. Dr. Drake reported that he seems to understand that he is charged with rape, though it is not at all clear that he understands what this word means. She said that he told her that it means "punching someone in the face", and when she asked him if it had anything to do with sexual activity, he said no. However, from his account to her of the victim's allegations, and of his own account of the events in question, it did appear to be clear that he understood that one important element of the case concerns a dispute between him and the victim regarding sexual activity between them. He indicated in our interview that if the victim's story is determined to be true, then he could go to jail. He indicated that if the story is determined not to be true, he would then not go to jail, but that he could still go to "residential", and he voiced anxiety at this prospect.

Understanding of the trial process. By placing figures in the picture of the courtroom scene, Diego was able to identify the judge as the person who bangs a hammer on the desk, and who decides whom to believe. He characterized the girl (the victim) as telling her story to the court, in response to questions from two lawyers and the judge. One lawyer sat at a table on one side of the courtroom with the girl; this was her lawyer, and was there "to help her." The other sat at a table on the other side of the courtroom with Diego; his job was "to help me." He said that the story the girl would tell would include bad things about him; his lawyer would help him by asking her whether what she was saying was really true. In this account he demonstrated an implicit understanding of the concept of pleading. Regarding other kinds of evidence, Dr. Drake noted that in a previous conversation they had discussed the possible role of blood testing in the case, and Diego had shown some simple understanding that he, the victim, and the baby would all need to be tested, and that the results would have some significance. In this interview, he alluded to blood tests, but he could not explain their purpose or significance.

Regarding the specific features of the transfer hearing process, Diego seemed initially puzzled by the idea that some judges were for children and others for grownups. However, he did voice the idea that age 18 might have some importance in the legal process. He was not able otherwise to discuss or show any understanding of the transfer process.

Ability to collaborate with counsel and withstand the stress of the trial process. As noted above, Diego has a basic understanding that his lawyer is there to help him in a process of questions and answers concerning a dispute. When asked what he would do if the girl were to tell a story in court that was not true, he replied, "I tell my lawyer." He has explained in some detail his own account of the events leading to the charges in conversations with Dr. Drake, suggesting that with adequate support and comfort, he might be able to communicate similarly with counsel.

IMPRESSIONS REGARDING COMPETENCE TO STAND TRIAL:

Diego suffers from a chronic neurological illness, one consequence of which is mental retardation. Repeated evaluations have consistently demonstrated overall cognitive functioning in the five to eight year-old range, with language functioning more impaired than non-language functions. The fact that repeated evaluations over time, conducted in both Spanish and English, have been so consistent in these findings, suggests that this is a valid assessment of his abilities. It is not very likely either that further Spanish evaluation would yield different results, or that gradual reduction in primadone dosage will result in any marked improvement in cognition. Cognitive deficits also include important difficulties with attention and with memory functioning.

In addition to his delays in cognitive development, Diego has also shown some symptoms of anxiety and depression, which appear to have remitted within the past few weeks. It is important to note that although his impulse control and relatedness appear to have improved along with this symptomatic improvement, his basic cognitive ability remains the same. Furthermore, he continues to demonstrate significant anxiety and tendency to withdraw in the face of dealing with strangers, especially regarding his legal involvement.

Despite his deficits, Diego has now been able to demonstrate that he has a basic, simple understanding of the fact that he is the subject of a legal proceeding stemming from an event the substance of which is in dispute; that this proceeding could result in his going to jail; that there are two sides to the dispute, each of which is represented by a lawyer; and that the judge will be involved in resolving the dispute by determining what is true. He does not appear to understand the trial process beyond these simple basics. He does not currently appear to understand even the basics of the transfer hearing process.

Because of his emotional immaturity and anxiety, as well as because of his cognitive impairment, effective communication with counsel will present special challenges. It is very likely that he will not be able to communicate effectively with his lawyer concerning this case without spending considerable time helping him to become comfortable and familiar with the lawyer personally, and with the legal context. It would also very likely be necessary to use special aids in helping Diego to communicate, such as pictures, dolls, and toys, similar to what would be useful in helping a child of approximately kindergarten age to communicate. Because of his memory problems, it would be necessary to offer frequent reminders about important information, and not to rely on him to remember things on his own.

In my opinion, because of the likely problems that Diego will have in becoming sufficiently comfortable with counsel and with the legal process to consult effectively with his attorney, he remains not competent to stand trial. However, despite his cognitive delays and memory impairments, in my opinion he could be considered to be competent to stand trial in a juvenile adjudicatory proceeding, if he were offered sufficient support and preparation along the lines suggested above. In my opinion he is not competent to take part in a transfer hearing, because of the significantly greater complexity of the decisions that are required of a defendant in this specific proceeding; and it is doubtful in my opinion that he can develop reasoning capacities that would be sufficient to respond to that level of complexity.

NEED FOR CARE AND TREATMENT:

While in the hospital, Diego has not demonstrated signs of the sort of explicit mental illness for which this sort of hospital program is ordinarily helpful. Furthermore, he appears to have suffered from anxiety, increased confusion, and impulsiveness as a result of exposure to the high level of activity and stress that tends to prevail in this unit for acutely mentally ill adolescents. I would strongly recommend against his being returned to the hospital, and in fact I would encourage any efforts to arrange for him to be discharged to a more appropriate placement even before the expiration of his s. 16a commitment period.

Long-term placement should be in a highly structured, full-time residential treatment program for cognitively impaired adolescents. His medical condition should not present any special complications in this regard; he will require the sort of intermittent assessment of his neurological status and seizure control that would be appropriate for anyone with epilepsy. Pending access to such a long-term program, I would recommend placement in a well-supervised specialized foster placement, able to provide a calm, structured environment appropriate to his developmental impairment. The progress that he has made in the final weeks of this hospitalization in areas of engaging with staff and becoming more pliable and well-controlled are especially hopeful signs regarding the likely success of such an interim placement.

Hospital staff have consulted at length with representatives of DHS, the school department, and DMR, concerning access to and funding for appropriate long-term residential placement. Although DHS has been involved with the family for a number of years and has sought residential treatment for Diego this year, DHS has indicated that it has exhausted its options with regard to residential programs. In light of Diego's improvement during the final weeks of his hospitalization and current relative stability, it would appear to be quite reasonable for DHS and the school department to arrange sharing of the cost of placement, pending Diego's becoming eligible for longer-term services from the Department of Mental Retardation.

John Jones, M.D.

APPENDIX C

Worksheet for Exercise on Analyzing Competence Evaluations

Exercise Worksheet

PART A

Analyzing Competence Evaluations

Complete the following questions as a group.

Site sections of the report to support your answers to each question:

1. Did the examiner accurately state the legal question at hand?
2. Did the examiner know and understand the legal standard for competence (to waive *Miranda* rights or to stand trial)?
3. Did the examiner describe the legally relevant functional abilities to the question at hand? If yes, indicate in the report where the examiner described them. If no, list the legally relevant functional abilities that must be assessed to answer the question at hand.
4. Were the psychological tests administered and the tests' interpretations age-appropriate for the child evaluated? What, if anything, did these tests tell you about the child's legally relevant functional abilities?
5. *(If reviewing a Miranda waiver evaluation):* Did the evaluator adequately account for the unique situational demands of the interrogation in question in determining whether the child was competent to waive his/her *Miranda* rights?

6. (If reviewing a *Miranda* waiver evaluation): Did the evaluator adequately discuss how causal factors (i.e., cognitive or developmental deficits, emotional disturbance, learning disabilities, mental disorders, etc.) may or may not have interfered with the child's ability to understand the interrogation and decide whether to waive *Miranda* rights?

7. (If reviewing a *competence to stand trial* evaluation): Did the evaluator understand the distinction between competence to assist counsel versus decisional competence?

8. (If reviewing a *competence to stand trial* evaluation): Did the evaluator adequately account for the unique situational demands of the prospective trial in determining whether the child was competent to stand trial?

9. (If reviewing a *competence to stand trial* evaluation): Did the evaluator adequately discuss how causal factors (i.e., cognitive or developmental deficits, emotional disturbance, learning disabilities, mental disorders, etc.) may or may not interfere with the child's ability to assist counsel both before and during the trial? To make decisions regarding his/her defense and the case overall?

10. Are there other methods and/or tests for assessing the legally relevant functional abilities that the examiner did not employ? If yes, list them here.

Understanding Adolescents

! A Juvenile Court
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Supplement

*LITERATURE REVIEW:
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Compiled by Professor Robert E. Shepherd

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