

Legal Issues Affecting Mentally Disordered and Developmentally Delayed Youth in the Justice System

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This article provides a review of the ways in which the legal system affects youth with mental disorders and developmental delays. Youth who suffer from mental disorders present a special challenge to the justice system, both in terms of identification and treatment. First, a brief history of the juvenile court is provided, with a special emphasis on the conflicting missions of the court. Then, the ambiguity surrounding legal definitions of mental illness is briefly examined. Next, case and statutory laws and other legal provisions for addressing mental health issues for juveniles are reviewed for each stage of justice system processing – intake/pretrial proceedings, waiver of jurisdiction, adjudication, disposition, and treatment/monitoring of placement. Policy recommendations include a mandated right to treatment for juveniles suffering from severe mental disorders, and the extension of competence requirements and the insanity defense to the juvenile court. Suggestions for future research are also identified.

A thorough discussion of the mental health needs of juvenile offenders has to include not only the characteristics of mentally ill adolescents who commit crimes, but also the characteristics of the systems that deal with these adolescents. This article provides a review of the ways in which the legal system affects youth with mental disorders and developmental delays. It examines how the existing legal framework of the juvenile court affects the identification, processing, and treatment of youth with mental illness. It also discusses how a juvenile's mental illness might be relevant at each step of juvenile justice involvement. Nearly a decade ago, a review of these issues was included in *Responding to the Mental Health Needs of Offenders in the Juvenile Justice System* (Woolard, Gross, Mulvey, & Reppucci, 1992). This article provides an update on the issues identified in that earlier review and presents new issues that have emerged in the past decade.

Youth who suffer from mental illness present a special challenge to the justice system for several reasons. First, defining exactly which adolescents qualify as "mentally ill" is not straightforward. It is difficult to diagnose mental disorders in adolescence,

partially because many forms of mental disorder are just emerging during this period, and the signs of this emergence are often easily confused with transient problems of development. Second, even if recognized accurately, the complexity of the problems presented by these youth often makes effective treatment a formidable challenge. Finally, implementing methods for balancing community safety and due process safeguards for juvenile defendants with special treatment needs presents difficult demands on an already overburdened court. These complexities have challenged the juvenile justice system since its inception a century ago, and continue to do so; they now present challenges for the adult system as well as it is faced with rising numbers of juvenile cases.

Over the past several years, legislatures in several jurisdictions and the Congress have begun to specifically address some of the issues surrounding the mental health needs of youth in the juvenile justice system. As Cocozza and Skowrya (2000) note, "the mental health needs of youth in the juvenile justice system have received more attention at the Federal level in the past two years than in the past

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three decades combined” (p. 3). Although legal provisions in juvenile justice still do very little to ensure consistent consideration of mental illness as a factor at the different stages of decision-making regarding a case, recent legislation has attempted to improve the identification and treatment of youth with mental disorders.

The article begins with a brief history of the juvenile court, emphasizing changes over the past decade that have caused some commentators (e.g., Feld, 1997, 1999) to question the utility of a separate juvenile justice system. The ambiguity surrounding legal definitions of mental illness is also briefly examined. Then, the adequacy of case and statutory laws and other legal provisions for addressing mental health issues for juveniles are reviewed for each of the major decision-making points in the juvenile and adult case processing systems. Because of the variations in processing and legal procedures across states and jurisdictions, this discussion cannot cover issues of concern in all communities. Even this more general examination makes it clear, however, that substantial legal changes and research are needed to move this system closer to its ideal of providing protection to the community, while also providing justice and rehabilitation for juveniles.

HISTORY OF THE JUVENILE COURT

The lack of clarity regarding the relevance of mental illness to juvenile justice processing can be traced, at least partially, to the history of confusion about the court’s primary mission. Historically, the role of the juvenile court has been to rehabilitate young offenders through individualized justice. Benevolent rhetoric and informal, non-adversarial procedures characterized the optimistic juvenile system until after World War II (Tanenhaus, 2000). In exchange for relinquishing due process and other constitutionally protected rights afforded to adult defendants, minors were promised that the juvenile court would act in their best interests. During the first sixty years following their inception, juvenile courts were afforded almost unlimited discretion in making decisions concerning delinquent youth, with only the broad standard of “the best interests of the child” as a guideline. Although many states recognized that this guideline frequently entailed

treatment that might require diversion from the juvenile system to alternative programs, such as mental health services, legislatures and courts offered little guidance as to the exact nature of the treatment contemplated or its implementation. As long as the court was acting with sound discretion, in the child’s best interest, there was little need to address mental illness as a specific consideration. It would surely be one of many possible factors addressed by a thoughtful judge.

Faith in the rehabilitative ideal began to erode after World War II and since that time two waves of reform have dramatically changed the nature of the juvenile justice system (Reppucci, 1999). The first wave of reform began in the 1960s, when the Supreme Court recognized that the dual functions of protecting both the child defendant and the community were often incompatible (Worrell, 1985). In the four-year period between 1966 and 1970, the Supreme Court decisions in *Kent v. U.S.*, *In re Gault*, and *In re Winship* marked the end of the “benign neglect of the juvenile justice system” and extended to juveniles many of the constitutional safeguards that had previously been reserved for adults (Steinberg & Schwartz, 2000, p.13-14). Affording juveniles in delinquency proceedings many of the due process rights previously reserved for defendants processed in the criminal system (e.g., notice of charges, the right to counsel, the right to confront and cross-examine witnesses, the privilege against self-incrimination, the application of the “reasonable doubt” standard of proof for adjudication) resulted in what some have referred to as the “adultification” of the juvenile system (Altschuler, 1999; Steinberg & Schwartz, 2000). Notably, the Court declined to guarantee full adult rights to juveniles. The right to trial by jury (*McKeiver v. Pennsylvania*, 1971) and the right to bail (*Schall v. Martin*, 1984), for example, were denied to juveniles. Thus, the first wave of reform made the juvenile system more adult-like by offering certain due process protections to juvenile defendants, while stating that the jeopardy to young offenders in the juvenile system was not equivalent to that faced by offenders in the adult system.

The second wave of reform came in response to a sharp rise in the juvenile crime rate between 1988 and 1994. In light of concern about juveniles “getting away with murder” and the assumed presence of new, very damaged and dangerous juvenile offenders (like

Willie Bosket; see Butterfield, 1995), legislators moved to make the juvenile system more transparently punitive and proportional. Several jurisdictions (e.g., Kansas, Virginia, Minnesota, Washington) revised their statutes to reflect the primacy of community protection and juvenile accountability in the enumerated purposes of the juvenile court. Washington, for example, became the first state to explicitly list punishment as a goal of its juvenile justice system, stating that the goals of adjudication in juvenile court are to “make the juvenile offender accountable for his or her criminal behavior; [and] provide for punishment commensurate with the age, crime, and criminal history of the juvenile offender” (Wash. Code Ann. § 13.40.010). In response to public pressure to protect the community from a supposed new juvenile “super-predator,” (DiIulio, 1995) all but six states changed their laws between 1992 and 1997 to make it easier to prosecute juveniles as adults (Snyder, Sickmund, & Poe-Yamagata, 2000). States also responded by enacting mandatory sentencing requirements and limiting the confidentiality provisions that were a cornerstone of the juvenile justice system (Torbet et al., 1996). Thus, like the reforms of the 1960s and 1970s, the second wave of reform made the juvenile justice system more adult-like. However, unlike the first wave of reform, the second wave was primarily concerned with punishment and the protection of the community rather than the protection of juveniles’ rights.

These developments have produced a court that is probably more conflicted about its mission than it was when the initial version of this article was published a decade ago (Woolard, Gross, Mulvey, & Reppucci, 1992). On the one hand, the court is rooted in a commitment to providing innovative, individualized interventions. On the other hand, it has to have a clearly heightened concern with ensuring the safety of the community and punishing offenders within expanded due process standards. For years, commentators have been questioning the ability of one system to accommodate these often conflicting goals (Mulvey, 1982; Worrell, 1985) and now, some are even questioning the wisdom of having a separate juvenile justice system at all (Feld, 1997, 1999).

The conflicting goals of the juvenile court are especially difficult to reconcile when considering youth suffering from mental disorders. Assessments

of culpability, competence to participate in court proceedings, and amenability to treatment are more difficult for youth with mental illnesses. At each step of the proceedings in juvenile and adult court, youthful offenders with serious mental illnesses may be affected differently than other offenders.

DEFINING MENTAL ILLNESS UNDER JUVENILE LAW

Determining when a juvenile offender is mentally ill is not a straightforward task. For one thing, the diagnosis of adolescents in general is less precise than the diagnosis of adults. Many forms of disorder only become apparent in late adolescence or early adulthood after disturbed behaviors crystallize into readily recognizable problems of daily living (Grisso, 1998). Even if symptoms do manifest themselves subtly before this time, normal adolescent development often confuses the picture of symptom constellations, making it difficult to determine such amorphous constructs as continued irritability or impulsive decision-making. In addition, adolescent behavior must often be interpreted in light of the social context in which it occurs (Kazdin, 2000). Adolescents are often in structured settings (e.g., schools, families) that create demands or expectations that interact with the behavioral patterns observed, making any attribution about individual causality regarding behavior more difficult.

These general problems with diagnosis become even more pronounced when one considers trying to assess symptoms and functioning in adolescent offenders involved in the justice system. The murky picture of what constitutes a disorder in adolescence and how it can be assessed effectively in juvenile offenders has thus produced widely varying prevalence estimates of disorder in this group. Estimates of diagnosable disorders in the juvenile justice population can be near 80%, or higher, if one includes learning, conduct, and substance abuse disorders (see Kazdin, 2000). However, it has been estimated that the prevalence rate of serious mental health disorders for youth in the juvenile justice system is at least 20% (Otto, Greenstein, Johnson, & Friedman, 1992).

Despite these inherent difficulties, several states are making a more concerted effort to identify and

treat adolescent offenders with mental health disorders and many states are using mental illness as a factor to be considered in decisions regarding transfer to adult criminal court. As a result, state legislatures have become more specific in defining “mental illness” and “mental disorder” than they were a decade ago. There is still, however, substantial diversity and inconsistency between states in defining mental illness.

As a rule, statutory definitions of adolescent mental illness are set forth in the general mental health provisions rather than appearing as a special consideration in juvenile proceedings. Representative of these laws is the Alabama statute, which defines mental illness as “a psychiatric disorder of thought and/or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life” (Code of Ala. § 22-52-1.1, 2001). In Arizona “mental illness, defect or disability means a psychiatric or neurological disorder that is evidenced by behavioral and emotional symptoms, including congenital mental conditions, conditions resulting from injury or disease and developmental disabilities” (A.R.S. § 13-4501, 2001). However, several states (e.g., Virginia, Delaware) specifically define mental illness within the juvenile justice legislation. In Virginia, the definition of mental illness specifically refers to abilities that are relevant in the juvenile justice context, such as the “judgment or capacity to recognize reality or to control behavior” (Va. Code Ann. § 16.1-336, 2001). And the state code of Colorado has mandated a procedure for bringing together a multi-systemic team of professionals to create a standardized definition of “mental illness” and “serious mental illness” that is to be used in the implementation of a new initiative to screen and treat mentally ill juvenile offenders.

States also vary with regard to whether substance abuse, developmental disabilities and mental retardation are included in the definition of mental illness. A number of states specifically distinguish mental illness from mental retardation, developmental disability and substance abuse. For example, the definition of mental illness in Alabama “specifically excludes the primary diagnosis of epilepsy, mental retardation, substance abuse, including alcoholism or developmental disability” (Code of Ala. § 22-52-1.1, 2001). Meanwhile other

states, such as Virginia, specifically include substance abuse, while Arizona includes congenital mental conditions and developmental disability. Delaware’s juvenile code does not specify whether certain conditions are to be considered within its definition, but instead relies on what is considered to be a mental disease by the medical profession.

This lack of clarity regarding the statutory definition of mental illness reflects both the theoretical and practical confusion about the overlap of mental illness and delinquency jurisdiction. Delinquency jurisdiction is invoked by a juvenile’s actions, yet those same actions may often be seen as part of a larger constellation of mental health problems. There is no theoretical bright line indicating when the conceptualizations of mental illness are more or less appropriate than the law’s rubric of delinquency. Perhaps the difficulty in clarifying the relationship between mental illness and delinquency lies in the conceptual differences between the legal system, which typically considers behavior to be determined by free will, and the mental health system, which considers behavior to be caused by a complex interaction of factors.

INTAKE AND PRETRIAL PROCEEDINGS

In this section, we examine the ways in which mental illness may be relevant at intake and pretrial proceedings. We also summarize the legislation and case law that have implications for the processing of juveniles with mental illnesses at the early stages of juvenile justice involvement. Specifically, we discuss arrest decisions, waiver of *Miranda* rights, intake options, new mental health screening laws, and pretrial detention decisions.

Arrest

Regardless of differences across jurisdictions in policies and practice, all cases begin with two critical decision making points: referral and intake. Police are the primary referral source in delinquency proceedings and the existence of a mental disorder may play a crucial role in the decisions made by police. Police have to decide whether to arrest the youth, where to take the youth, and how to proceed in questioning the youth. Decisions to arrest are often

times highly discretionary and may be influenced by the presence of a mental disorder.

It may be that the presence of a mental disorder does not have a uniform effect on the arrest process. Many youth with disabilities lack the communication and social skills that are required to make a good impression on arresting officers (Burrell & Warboys, 2000). Thus, because of the impairments associated with clinical dysfunction (e.g. impulsiveness, deficiencies in interpersonal problem solving skills), adolescents with mental disorders may be more likely to be arrested than are other youth who engage in delinquent activities (Kazdin, 2000). At the same time, adolescents with more severe, and easily recognizable, mental disorders may be referred out of the juvenile justice system when possible by police officers. It is an open question about how the presence of different types of mental disorders may influence the outcome of an adolescent's encounter with police. Nonetheless, it seems reasonable to speculate that more subtle forms of disorder may put an adolescent at increased risk for arrest and processing, while more severe forms of disorder may precipitate a "front end" referral to mental health agencies for actions that could technically be considered criminal.

Waiver of Miranda Rights

Prior to questioning, police must ascertain whether a youth is capable of making a "knowing, intelligent, and voluntary" decision to waive his or her *Miranda* rights (*Miranda v. Arizona*, 1966). The Supreme Court in *Fare v. Michael C.* (1979) expressly declined to give juveniles greater protection in waiving their *Miranda* rights than adults, essentially rejecting the view that developmental differences between juveniles and adults necessitates special protections. In deciding on the admissibility of a confession, most courts follow *Fare* and use the "totality of the circumstances" test, which most tend to apply very conservatively (Feld, 2000). Certainly, the presence of a mental disorder could compromise a youth's ability to make a "knowing, intelligent, and voluntary" decision. Juveniles suffering from mental illness or developmental delays may have impairments in cognitive functioning, attention, or memory that could compromise their ability to understand and appre-

ciate the significance of waiving their *Miranda* rights (Grisso, 2003).

Some states have decided to provide extra protections to juvenile defendants to assure that they are afforded the privilege against self-incrimination and the right to counsel at the time of questioning. Several states, either by case law or by statute, require the presence of an "interested adult," such as a parent, or consultation with an attorney before a juvenile is allowed to waive his or her rights (e.g., Vermont, Massachusetts, Indiana, Connecticut, Arkansas). Iowa does not allow the waiver of counsel at interrogation for a juvenile under 16 years of age without the written consent of a parent. Wisconsin has gone a step further and requires that juveniles have an attorney present at interrogation and do not allow juveniles to waive the right to counsel, even with parental consent.

States that provide extra protections for juveniles support the contention that youth lack the comprehension to understand *Miranda* warnings and consider juveniles to be vulnerable to the coercive pressure of police interrogation tactics (Feld, 2000). The extra safeguards may also protect juveniles suffering from mental illnesses who might be prone to waive their *Miranda* rights. However, some critics of parental consent laws contend that parents and children do not always share common interests and that parents are often inadequate advisors because they do not fully understand the legal situation (Feld, 2000; Grisso, 1981). Research indicates that parents actually increase coercive pressures by encouraging their children to waive their rights (Grisso, 1981), which has led some researchers (e.g., Grisso, 1981) to recommend a per se rule against the waiver of *Miranda* rights for young adolescents. Except in the state of Wisconsin, which requires the presence of a lawyer, there are currently no provisions in the law that account for the possibility that parents may not protect the rights of their children.

Intake

All cases involving juveniles are typically initiated by filing a petition through a special juvenile justice agency. In most states, the intake officer has discretion as to whether the petition should be filed as a delinquency matter or some alternative child welfare disposition, such as "child in need of

services.” It is also usually within the intake officer’s discretion to dispose of the action informally (if the charge falls below a certain level of seriousness). The complaint can be kept on file and the child’s family simply notified of the incident or referred to other social service agencies. Alternatively, the youth may be sent to a special diversion program, especially if it is a first offense. An intake officer may refuse to file a petition if there is no probable cause; the filing would not serve the best interests of the child; or some agency other than the court could deal with the matter more effectively. However, there are no clear guidelines for this determination and the decisions are largely discretionary.

Based on the impairments associated with various mental illnesses, it could be that youth with mental disorders are processed rather differently at intake. These youth may be more prone to behave impulsively, less able to delay gratification or resist temptation, and less likely to fully understand the nature of the decisions regarding available alternatives (Kazdin, 2000). As a result, their presentation and involvement in making the decision about possible diversion may put them at risk for continued processing at this point. Also, considering the increased vulnerability of youth with mental health disorders to police interrogation tactics that may include promises of leniency and an expedited return home in exchange for cooperation, these adolescents might require extra protections to ensure that they are “knowingly and intelligently” exercising their rights (Feld, 2000). Finally, given the continued problems of handling the disruptive behaviors of adolescents with mental illnesses, the type of parental relationships seen in these families may be qualitatively different from those in families with “just” antisocial adolescents. Having an adolescent with severe mental health problems may make parents significantly more likely to seek out help from official agencies or more wary of involvement with services that have not proven effective in the past. Any of these factors could have a marked influence on how decision makers see the adolescent offender and his/her situation, and thus create the situation in which adolescent offenders with mental health disorders are processed differentially in their initial contacts with the system.

Mental Health Screening Laws

In response to the increased awareness of the mental health needs of juveniles, several jurisdictions have mandated (e.g., Wisconsin, Virginia) or are in the process of developing (e.g., Colorado) new screening mechanisms to ensure that youth with substance abuse disorders and mental health needs are identified (Reppucci & Redding, 2000). Typically, the brief initial screening is conducted at intake and, when necessary, juveniles are referred for more extensive evaluation. It has been recommended that screening occur as soon as possible in the process and that youth with serious mental health problems be diverted from the justice system (Cocozza & Skowrya, 2000). However, even when appropriately identified, many youth are likely to remain in the juvenile justice system because entry into the system is often a prerequisite for eligibility for certain mental health services.

Some localities are developing screening mechanisms and plans for addressing mental health issues among youth involved in the juvenile justice system that go beyond the specific mandates in the state code (e.g., Wraparound Milwaukee, see Kamradt, 2000). However, many communities do not have established guidelines for screening and continue to rely on the judge or other agency representatives to recognize mental health problems. Even in states that mandate screening, the guidelines for conducting the screening can be vague. For example, the Virginia code only states that upon entry to a secure facility, the “staff shall ascertain the juvenile’s need for a mental health assessment” by gathering “information from the juvenile and the probation officer as is reasonably available and deemed necessary” (Va. Code Ann. § 16.1-248.2, 2001). The Massachusetts Youth Screening Instrument-2 (MAYSI-2) was developed specifically for the purpose of screening youths, at entry points in the juvenile justice system, for potential mental, emotional, or behavioral problems (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001). The MAYSI-2 is the most promising screening tool because it was designed to take no more than 10 minutes to administer, requires no special clinical training to administer or interpret, and has demonstrated reliability and validity.

Although a potentially significant first step, mandated screening alone is not enough. Clearly, screening has to be part of an integrated effort that provides systematic case identification as well as follow up services with more professionally trained personnel and community service systems. Laws that provide for mental health screening, without consideration of the administration of services, including funding issues and the need for interagency collaboration, are likely to be insufficient. They too often put probation and detention staff in the awkward position of knowing that a youth has a mental health disorder, but not having the resources to address the problem.

Pretrial Detention

Prior to adjudication, some juveniles will be held in a pretrial detention facility. Pretrial detention standards in the majority of states are based on three justifications: detention for the protection of the juvenile, detention if the juvenile is likely to flee the jurisdiction while charges are pending, and detention if the juvenile poses a danger to the community (Grisso, Tomkins, & Casey, 1988). Continuing detention may also be deemed appropriate where adequate supervision is otherwise unavailable or the juvenile requests protection.

The practical effect of these general criteria is that there is systematic bias in the types of juveniles who are kept at facilities in the first place and the length of time that they spend in placement. There is compelling information that racial disproportionality occurs in the detention process. Data from 1997 indicate that, although, African-American youth made up 15% of the youth population, they constituted 26% of all juvenile arrests and a whopping 45% of the juvenile population in secure detention (Snyder & Sickmund, 1999). This disproportionality has led to concerns about the role of the detention process as a conduit for services for underserved minority youth. One study found significant differences in officers' attributions about the causes of crime between White and minority youth, which, in turn, contributed to differential assessments of the risk of reoffending and to sentence recommendations (Bridges & Steen, 1998).

Although the average stay in detention is generally only 2-3 weeks, youth who stay longer

(often times several months) are usually adolescents with complicated placement needs, not necessarily those charged with more serious offenses (Butts & Adams, 2001; Woolard, et al., 1992). Adolescents with mental health problems are thus exceptionally susceptible to extended detention stays, especially in facilities where mental health screening and services are not available. Many of them remain underserved because of the complications of getting integrated care from the mental health, drug and alcohol, and juvenile justice systems.

In sum, the identification of mental illness can occur at a number of points in the initial phases of juvenile justice processing. This factor is a consideration in the waiver of *Miranda* rights, the diversion of a juvenile from the justice system to the mental health system, and detention. Until recently, there was only the judgment of involved professionals available to ensure proper consideration of this factor, but new screening laws that have been enacted within the past decade have introduced some formal procedure into the formerly discretionary process. (See Grisso et al., 2001, for recent developments on screening and assessment tools.) The next step is to build these advances into an integrated system of sound identification and coordinated service provision.

WAIVER OF JURISDICTION

In this section, we briefly describe the various mechanisms by which a juvenile may be waived to adult criminal court and examine the ways in which waiver mechanisms affect youth with mental disorders. We also consider the possible effects of participation in adult court for juveniles with mental illnesses.

Depending on the age of the juvenile and/or the seriousness of the committing offense, a youth may be transferred out of the juvenile justice system. (Note that 13 states use 16 or 17 as the age limit for juvenile court jurisdiction. In these states, all 16 or 17 year-olds are processed as adults, regardless of the seriousness of their offense.) During the past decade, legislatures have been rapidly enacting new laws designed to make it easier to prosecute juveniles as adults. There are currently three legal mechanisms that allow for the transfer of juveniles to the adult

system – judicial waiver, statutory exclusion, and concurrent jurisdiction. Most states use a combination of two or more of these mechanisms.

In judicial waivers, a transfer hearing is held and it is the juvenile court judge who makes the decision to transfer the youth to the adult criminal system. Prior to the early 1990s, most states relied almost exclusively on judicial waiver provisions. Currently, 45 states and the District of Columbia have some type of judicial waiver provisions, but only 5 states rely exclusively on the traditional discretionary judicial waiver process (Dawson, 2000; Snyder & Sickmund, 1999).

Typically, judicial waiver is limited by age, offense, and “lack of amenability to treatment” criteria (Snyder et al., 2000). Several jurisdictions specifically include mental illness as a factor to be considered in the waiver decisions (e.g., District of Columbia, Virginia) and many others include factors that would allow for the consideration of deficiencies associated with mental illness, such as “the extent and nature of the physical and mental maturity of the child” (Code of Ala. § 12-15-34, 2001) and “the juvenile’s mental and emotional condition” (A.R.S. § 8-327, 2000). In most jurisdictions, mental illness is only one factor to be considered in the waiver decision and a determination of mental illness does not preclude transfer.

Revisions and expansions of statutory exclusion provisions are the fastest growing mechanisms for transferring youth out of the juvenile system. Under statutory exclusion, the state legislature takes some of the decision-making out of the hands of judges by enacting laws that exclude certain young offenders from juvenile court jurisdiction based on their age and/or the seriousness of their offense. States may define the upper age of juvenile court jurisdiction as 15 or 16, thereby excluding all offenders who are 16 or 17 years-of-age. More commonly, states exclude older youth who have been charged with serious offenses, often those that would be considered felony offenses. Twenty-eight states use some type of statutory exclusion provision (Snyder & Sickmund, 1999). About half of the states do allow for a reverse waiver process, whereby judges in the adult system can send a juvenile back to the juvenile court (Torbet & Szymanski, 1998). In the reverse waiver process, the criteria are generally the same as in the typical waiver process,

but the juvenile has the burden to show the judge that the case should be sent back to the juvenile court.

Concurrent jurisdiction or prosecutorial election provisions allow the prosecutor to decide whether to file certain offenses in juvenile or adult court. Unlike judicial waiver, decisions made by the prosecutor are not subject to judicial review and there are no due process requirements. The decision of the prosecutor is highly discretionary and there are no specific guidelines regarding the manner in which mental illness should be considered. Fourteen states and the District of Columbia use concurrent jurisdiction (Snyder & Sickmund, 1999).

Appellate decisions reflect a passive stance on all three types of transfer mechanisms (Frost Clausel & Bonnie, 2000). With regard to judicial waivers, the vast majority of rulings in all states have upheld the judge’s decision, whether or not the decision resulted in a waiver to criminal court (Frost Clausel & Bonnie, 2000). Statutory exclusion laws, which have been challenged on the grounds that they violate due process and equal protection, have been uniformly upheld. However, recent decisions in Delaware (*Hughes v. State*, 1994) and Washington (*In re Boot*, 1996) indicate that reverse waiver may become a necessary feature of statutory exclusion laws because they allow for some opportunity for individualization (Frost Clausel & Bonnie, 2000). Until 1995, circuit and state courts uniformly upheld prosecutorial election statutes, finding that in the absence of discrimination based on suspect factors such as race, the decisions of prosecutors should not be subject to review by the courts (e.g., *Woodard v. Wainwright*, 1977; *People v. Thorpe*, 1982). Then in 1995, the Utah Supreme Court struck down a prosecutorial election provision, holding that it violated Utah’s equal-protection provision because the “selection process for beneficial treatment is arbitrary and standardless” (*State v. Mohi*, 1995, p. 998). It is still too early to determine whether *Mohi* signals a new direction that will be followed by other courts or a single aberration in a long line of cases supporting concurrent jurisdiction.

At this stage, if youth with mental health disorders have not yet been diverted out of the justice system, they are subject to the automatic transfer laws of their state, and if they fit the age and offense criteria, they will be tried in the adult criminal system (unless the adult court judge decides that the case

should be waived back to the juvenile court). The role of mental health issues in the judicial decision-making process regarding waiver back to juvenile court is unclear. Statutory exclusion laws are more likely to result in criminal adjudication of youth with mental illnesses who might previously have been screened out in the waiver process by the juvenile court judge (Bonnie & Grisso, 2000).

Once in the adult system, juveniles are treated like adults, and this equality does not necessarily serve them well. Juvenile cases in the adult system typically take longer to come to trial, during which time defendants may be detained in a jail or detention center, where mental health services are limited (Bishop & Frazier, 2000). The judges in the adult criminal system are less experienced in dealing with juveniles and are less likely to recognize mental health problems among youth, especially since the characteristic features of mental illness are different in adolescents than in adults (Bishop & Frazier, 2000). For example, adolescents with attention disorders may appear, to a judge who is unfamiliar with adolescents, to lack respect or concern for the outcome of their cases. Most importantly, once in the adult system, opportunities for effective rehabilitation and mental health services are virtually nonexistent. In the majority of states, juveniles are housed with the general adult population, where generally fewer than 10% of prisoners are engaged in any type of counseling or treatment program (Fox & Stinchcomb, 1994; Steadman & Veysey, 1997). One cannot realistically expect that youth with mental disorders will receive treatment in an environment where there is minimal provision of mental health services.

It should also be noted that, when juveniles are transferred to adult court, they are held to adult standards for judging the role that mental illness might have played in the commission of an offense. Developmental theory suggests (Scott, 2000), and preliminary research has begun to confirm (e.g., Fried & Reppucci, 2001), however, that adolescents, as a class, may be arguably less culpable for their crimes because they are less developed psychosocially and the interaction between mental illness and psychosocial development may be a very relevant consideration in assessing culpability in adolescents. Although decisions to engage in criminal activity have not yet been studied among

juveniles with mental disorders, research in the area of adjudicative competence suggests that, at least in some legal contexts, mental illness is associated with poorer decision-making skills (Cowden & McKee, 1995; Grisso, 1997; Lexcen, 2000; Lexcen & Reppucci, 1998; McKee & Shea, 1999). Juveniles with certain mental illnesses can be expected to be more vulnerable to peer influences and less likely to anticipate future consequences of behavior, two issues that are considered to be critical in adolescent decisions to engage in delinquent behavior. With regard to culpability, it seems reasonable that juveniles suffering from mental illnesses might be held to lesser standards than adults, but currently there is no legal provision that takes into account the possibility that the effects of mental illness on criminal activity might be different for adolescents than adults.

ADJUDICATION

In this section, we review the legislation, case law, and research that have implications for the adjudication of juveniles with mental health disorders. Specifically, we explore the following topics - adjudicative competence, competency evaluations and restoration services, and the applicability of the insanity defense for juveniles.

Adjudicative Competence

A specific question which may be raised at the outset of the adjudicatory phase is the issue of the juvenile's adjudicative competence. This issue has taken on new implications in an era when juveniles have been subjected to harsh punishment in juvenile court and increased use of transfer to adult court (Bonnie & Grisso, 2000). Not all states explicitly address the competency issue for juveniles and it has never been addressed by the Supreme Court. Currently, 28 states and the District of Columbia have either statutes or case law pertaining to competence as it is applied in juvenile court (Redding & Frost, 2002). Only Oklahoma has decided that competency is not required in juvenile court, although another 22 states have not addressed the issue (Redding & Frost, 2002). If it is specifically noted, the adult standards set forth in *Dusky v. U.S.* (1960) and *Drope*

v. Missouri (1975) are usually used in the juvenile court. Once transferred to adult criminal court, all juveniles are held to adult standards of competence. Only Virginia and the District of Columbia have statutes requiring that the juvenile court judge find that juveniles be competent as a prerequisite to transfer (Redding & Frost, 2002). Courts in at least two other states (Michigan and Alabama) have indicated that adjudicative competence should be considered in transfer decisions.

According to the Supreme Court, in order for a defendant to be considered competent to participate in proceedings, he or she must have “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” (*Dusky*, 1960) and the capacity “to assist in preparing his defense” (*Drope*, 1975). Bonnie (1993) has set forth a legal framework for evaluating the competence related abilities of a defendant. According to Bonnie there are two components to adjudicative competence – the competence to assist counsel and decisional competence. Decisional competence involves cognitive tasks beyond those required to assist counsel, including the capacity to think rationally about alternative options and the capacity to express a choice. Recent research (Grisso et al., 2003) suggests that several higher reasoning abilities may be limited in younger juveniles, and therefore it seems reasonable to speculate that these abilities could well be limited in youth of all ages with mental illness.

In the legal sense, competency does not refer specifically to the presence or absence of mental illness per se, but instead refers to the juvenile’s capacity for rational understanding. Since mental illness is not equivalent to, but may or may not be associated with, lack of competence, children who are mentally ill can still be found competent. Likewise, someone who is found incompetent is not necessarily mentally ill, although a few states (e.g., Florida) require that a defendant have a mental illness or mental retardation in order to be considered incompetent (Redding & Frost, 2002). There is concern that because mental illness is subject to greater error in identification for adolescents than for adults, some youth with substantial competence related deficits may incorrectly be regarded as

competent (Bonnie & Grisso, 2000). According to Bonnie and Grisso:

The early form of [adolescents’] disorder may be responsible for deficits in capacities associated with the standard for adjudicative competence, yet may not be identified as the cause of the deficits if criminal courts are using as a guide the severity of disorders that they are accustomed to associating with adjudicative incompetence in adults... [Therefore,] there is cause for concern that when mental disorders are responsible for youth’s deficiencies in their abilities to participate in their adjudication, the mental disorder itself will not be identified. This puts adolescents in general in a position of greater risk of inappropriate finding of competence because courts and clinicians assume that a legal finding of incompetence must be predicated on a diagnosis of severe mental disorder, even if this is strictly true as a matter of law only in some states. (p. 87)

Developmental immaturity may also affect the competence related abilities of juvenile defendants, especially those with mental disorders. For example, younger adolescents tend to focus on short-term consequences, which could affect their ability to weigh rationally their options in the same way they would when they reach adulthood. In fact, recent findings suggest that younger adolescents may be less competent decision makers than adults in a variety of legal settings (e.g., Grisso et al., 2003; Woolard, Fried & Reppucci, 2001). In one study using a sample of 136 juveniles who were referred for pretrial competency evaluations, Cowden and McKee (1995) found that youth below the age of 15 were significantly less likely to be evaluated as competent. Only about a quarter of the juveniles who had severe mental illness were deemed competent. Grisso (1997) has suggested that there be a presumption of incompetence for youth under 14, but no state has adopted such a presumption. In fact, few statutes or appellate decisions even recognize developmental immaturity as a basis for adjudicative competence (Bonnie & Grisso, 2000) and there is no consideration given to the fact that mental

disorders in adolescence and psychosocial immaturity may together create a situation in which competence is substantially compromised. Thus, despite the potential commonsensical consideration of developmental factors in assessing competence, there is no statutorily based mandate to do so.

Competency Evaluation and Restoration

Competency hearings may be requested by the prosecution, the defense, or the judge. Typically, it is the defense attorney who requests the evaluation because he or she has the most contact with the youth and the greatest motivation to do so. The judge usually follows a request for a competency evaluation with an order for a professional evaluation. Most states have guidelines as to who can conduct the evaluation, where and when it should take place, and what is to be included in the report to the court. Once a juvenile has been found incompetent, the goal is to restore competence so that the adjudication can proceed in a timely manner. Competency restoration may simply be a matter of teaching the defendant information about the legal proceedings or may involve treatment of a mental illness if the youth's deficits stem from symptoms of a treatable disorder (Barnum, 2000). Because the issue of competence has a very short history in the juvenile court; states have little experience in providing competency restoration services to juveniles.

Florida has the most comprehensive system for restoring competency in juveniles and has collected the only systematic research on the subject (McGaha, Otto, McClaren, & Petril, 2001). Of the 361 juveniles determined to be incompetent in Florida between May 1997 and August 2000, 30% were mentally ill and 40% had mental illness and mental retardation. Most (71%) were eventually restored to competency and returned to court. Eight percent of youth with mental illness and 34% of youth with mental illness and mental retardation were determined to be unrestorably incompetent. The average time spent in restoration treatment was five-six months, but only half of the youth received any of their restoration services in a residential placement and 83% of youth received at least some portion of their restoration services while living at home. What is to be done with juveniles who are found to be

unrestorably incompetent is an issue that many states have yet to resolve. The issue is further complicated if a juvenile could possibly be found incompetent due to immaturity. If this is the case, it may be that time, maturation and experience are the only effective means of restoring competence (Barnum, 2000). Paradoxically, however, if juveniles are per se incompetent because of developmental reasons at the time they committed a crime, they are not having competency restored because it never existed in the first place, which raises issues of fairness and justice.

The Insanity Defense

The insanity defense raises a different issue than the capacities addressed in an adjudicative competence inquiry. Incompetence and insanity refer to two distinct connections between mental disorder and criminal adjudication. While incompetence refers to a respondent's mental state and capacities at the time of adjudication, insanity refers to his or her mental state at the time of the offense (Bonnie & Grisso, 2000). The insanity defense is founded on the principle that intent is a key component of culpability and that the capacity of the accused to understand the nature of his or her actions and to exercise free will must therefore be central considerations in determining criminal responsibility. In light of the extensive line of cases holding that a denial of the insanity defense to an adult defendant violates his or her right to due process and fundamental fairness, the issue necessarily arises as to whether a denial of the defense to a juvenile deprives him or her of fair treatment under the juvenile justice system. Clearly, the insanity defense would be available to a juvenile who is being tried in an adult criminal court where the insanity defense is recognized.

Given the series of Supreme Court opinions that extend to juveniles many of the due process guarantees afforded to adults, there is a credible foundation for the argument for extension of the insanity defense to respondents within the juvenile justice system (Harrington & Keary, 1982; Heilbrun, Hawk, & Tate, 1996). Although, in *Medina v. California* (1992), the Supreme Court determined that it is not a constitutional right, all but three states (Utah, Idaho, and Montana) provide criminal

defendants in adult court with the right to an insanity defense. When applied to youth in juvenile court, only nine states explicitly provide the right to juveniles (California, Illinois, Iowa, Louisiana, Montana, New Jersey, New Mexico, Nevada and, Wisconsin), while many have yet to rule on the issue (e.g., New York, Florida, Arizona, Maryland, Connecticut), and others have declined to extend the right to juveniles (e.g., Virginia, Michigan, Ohio, Arkansas). Virginia has recently decided that although an insanity defense may not be raised in juvenile delinquency proceedings, a juvenile's mental illness or insanity could be considered during disposition after the juvenile has been adjudicated delinquent (Va. Code Ann. § 16.1-280, 2001; *Commonwealth v. Chatman*, 2000).

The primary argument against extending the right to an insanity defense in juvenile proceedings is that the juvenile court is intended to be rehabilitative, and therefore, juveniles with severe enough mental disorders to meet the legal definition of insanity would be provided with treatment even if they were adjudicated delinquent (Pollock, 2001). Clearly, it is still an open question whether the jeopardy faced by juvenile defendants in an increasingly "adult-like" juvenile court justifies the right to assert the insanity defense.

DISPOSITION

In this section, we summarize recent legislative changes in sentencing options and how these changes may impact youth with mental disorders. The assessment of amenability to treatment and the prediction of future dangerousness are influential in determining a youth's disposition. Therefore, we briefly examine research in these areas that is particularly relevant for youth with mental disorders.

Legislation Regarding Sentencing Options

Reflective of the "tough on juvenile crime" attitude, some states have altered their juvenile codes to include incapacitation, retribution, and deterrence as legitimate focal points for juvenile justice (Steinberg & Schwartz, 2000). This represents a fundamental shift from the traditional purpose of juvenile court dispositions, which were based on

rehabilitative ideals. Accordingly, dispositions have become less individualized and more offense-based (Sickmund, Snyder, & Poe-Yamagata, 1997).

As part of the political rhetoric that includes slogans such as "adult time for adult crime," several legislatures have also made changes to the sentencing options available in the juvenile court. In the first half of the 1990s, 25 states changed or added laws giving courts new sentencing options for juveniles (Sickmund, Snyder, & Poe-Yamagata, 1997). Between 1992 and 1995, 15 states and the District of Columbia added mandatory minimum periods of incarceration for juvenile offenders. For example, a 1993 Louisiana statute mandates that for certain serious violent felony-grade delinquent acts juveniles must be sentenced and placed in a secure facility until age 21 with no possibility of parole or probation.

Other states have adopted blended sentencing statutes. Although varying from state to state, many have adopted sentencing statutes, which make it possible for the juvenile court judge to impose a sentence that will extend past the juvenile court's jurisdiction, at which point they may be transferred to the adult correctional system (e.g., Massachusetts, Rhode Island, Texas). Therefore, in these jurisdictions, even when a youth remains in the juvenile system for adjudication, he or she may end up with an extended sentence resulting in incarceration as an adult.

The de-emphasis on individualization in sentencing determinations has particular implications for juveniles with mental disorders who commit serious crimes. Juvenile court judges are still vested with wide discretion when making sentencing decisions in minor delinquency cases. In such cases, mental illness may be identified by a mental health professional or there may be a history of mental health involvement to alert the judge of special needs that the youth may have. Although empirical evidence about the optimal matching of juvenile offenders and treatment alternatives is lacking, judges in minor delinquency cases can use their best judgment to ensure that the most appropriate treatment is provided. However, if a youth with a mental disorder commits a crime for which a minimum sentence is required, the judge has a more limited range of sentencing options, which might prohibit mental health treatment. Even if the judge were to have full discretion in sentencing, she would

still find herself in a bind because mental health facilities are not prone to taking violent juveniles and juvenile justice institutions are not well equipped to handle serious mental health concerns (Woolard et al., 1992). Some states (e.g., Delaware, West Virginia) have attempted to deal with this dilemma by creating departments responsible for both juvenile corrections and the provision of mental health services to youth.

Amenability to Treatment

Determinations of amenability to treatment are central to many decisions made in the juvenile justice system, including sentencing decisions. Assessment of an individual's amenability to treatment is complex and requires an understanding of the individual's personal characteristics, the context in which the individual is embedded, and the treatments that are available (Mulvey, 1984). With regard to personal characteristics, mental disorder and developmental stage are particularly important to consider in selecting treatment options and determining amenability to treatment.

The critical role of contextual factors in treatment cannot be overemphasized. Assessment of amenability to treatment hinges, in part, on the resources that are available to the juvenile. In a community that lacks resources for rehabilitation, a juvenile is less likely to be considered amenable to treatment (Mulvey & Reppucci, 1988). Some believe that it is unethical to find that a juvenile is not amenable to treatment due to a lack of services available in the community (Kruh & Brodsky, 1997). However, the reality is that evaluations of amenability to treatment reflect not only the juvenile's willingness to change, but also the environmental and system level factors, which are often beyond the juvenile's control. And most courts have found that there is not an obligation to create services that do not exist (Slobogin, 1999).

The role of mental health professionals in determining amenability to treatment is to help the courts by providing information about programs that are most likely to be successful with a specific individual, taking into account contextual factors along with the juvenile's willingness to change. The presence of a mental illness will influence decisions about possible treatment options, and will certainly complicate the potential impact of treatment and the

match of the juvenile with appropriate resources. Determining goodness of fit between the juvenile and possible treatment options is critical to the evaluation of amenability to treatment, and should be one of the primary goals of research on amenability to treatment (Kruh & Brodsky, 1997).

Prediction of Future Dangerousness

Determinations of future dangerousness are also central to sentencing decisions in the juvenile court. Psychologists are often called upon to determine whether a specific individual is at risk of harming himself/herself or another individual. Two decades ago, Monahan (1981) concluded that when clinicians predicted that a person would be violent, they were accurate no more than one in three times. Recent reviews suggest a more optimistic view of the ability of clinicians' to predict violence (e.g., Menzies, Webster, McMain, Staley, & Scaglione, 1994; Monahan, 1992). The use of multiple criterion measures and the focus on short-term predictions are two recent improvements in the research on violence prediction (Monahan, 1996). Unfortunately, most of the existing research on the prediction of violence has been conducted with adult samples leaving mental hospitals. What is known about the development of violence suggests that prediction of future violence may be different, and more difficult, for adolescents than adults (Ewing, 1990).

Although risk assessment research with youths lags behind the research on adults, significant advances have been made in recent years in identification of risk and protective factors (Reppucci, Fried, & Schmidt, 2002) and the development of assessment measures (Grisso, 2003). Actuarial tools that use a combination of risk factors to provide probability estimates of future violence in youths are currently being developed and validated. One such instrument is the Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2002), which includes dynamic risk and protective factors in the prediction. The assessment of risks and needs forms the basis for the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 1999), which has been used extensively in the Ontario juvenile justice system. A similar instrument, the Early Assessment of Risk List (EARL-20B;

Augimeri, Koegl, Webster & Levene, 2001) is available for boys under 12, and has been modified for use with girls (EARL-21G; Levene et al., 2001).

Although the public posits a strong link between mental illness and violence, there is limited evidence that mental illness alone is sufficient to warrant a determination that a defendant is likely to be dangerous to himself/herself or others in the future. Several reviews have concluded that the connection between mental illness and violence among adults is modest, but substantiated (see Monahan, 1992; Mulvey, 1994; Otto, 1992). At the same time, researchers have generally concluded that this increased risk is not clearly attributable to serious mental illness per se. In one study, for instance, there was no higher rate of violence among mentally ill patients than matched community members, except when there was a co-existing substance abuse problem (Steadman, Mulvey, Monahan, Robbins, & Appelbaum, 1998). In another analysis of these data, researchers found that neighborhood effects exerted a strong and independent effect on the likelihood of violence in discharged mental patients (Silver, Mulvey, & Monahan, 1999).

Without rigorous research, it is impossible to make any firm conclusions about the link between mental illness and future violence in adolescence. However, a number of mental disorders have been identified as empirically related to future aggression in youths, including mood disorders, posttraumatic stress disorder, and attention-deficit/hyperactivity disorder (ADHD) (Borum, 2000). In addition, research on juvenile psychopathy has been flourishing over the past decade, stimulated by the development of instruments to measure psychopathy in youth. Several measures have been developed, of which the Psychopathy Checklist: Youth Version (PCL: YV; Forth, Kosson, & Hare) is the most well known. Currently, none of these instruments is used in forensic evaluation, but many see their use in the justice system as inevitable (e.g., Seagrave & Grisso, 2002). Seagrave and Grisso (2002) caution against the premature use of juvenile psychopathy instruments in forensic settings in part because of methodological problems. They argue that many of the behavioral characteristics that define psychopathy (e.g., impulsiveness and self-centeredness) are considered to be part of normal adolescent development. Note also that Odgers, Moretti, and Reppucci

(in press) raise issues regarding their use with adolescent females as little or no empirical foundation exists for this group. In addition, more research is needed to examine the relation of psychopathy to mental disorders common among children and adolescents, such as ADHD and conduct disorder.

TREATMENT AND MONITORING OF PLACEMENT

Once the court has determined a disposition for a juvenile, the remaining issue concerns the court's role after the order has been entered. Most state statutes are vague, and case law is generally sparse and unclear about the extent of the court's monitoring and enforcement power. Recognizing the importance of the family in treatment for delinquency, the juvenile court judge generally has the power to order services for the youth and his or her parents. If either the juvenile or his or her parents fail to comply with the court order, they can be held in contempt of court. Most states require continued review of juvenile court placements every six to nine months (Steinberg & Schwartz, 2000). Whether such review can be done effectively, given the large caseloads in most courts, is an open question. The level of review actually conducted by the courts and the value of this procedure requires further investigation.

Some have argued that the length of treatment, rehabilitation, or incarceration possible in a juvenile system that only has jurisdiction over a juvenile until his or her 18th birthday is too short (Torbet et al., 1996). States have responded by extending commitment for treatment until age 21 or even 25 (e.g., California, Oregon and Wisconsin). In four states (Colorado, Connecticut, Hawaii, and New Mexico) the juvenile court's jurisdiction is indefinite (Torbet et al., 1996). The effects of extended jurisdiction for the treatment of mentally ill juveniles are unclear. It may enable the juvenile court to provide services that would be unavailable in the adult system. Continued placement is usually based, however, on perceived threat to the community rather than the youth's best interest. Youth with mental illnesses may thus be at increased risk of extended placements in secure facilities for the perceived link between their disorder and likely future violence.

The coordination of aftercare services for juvenile offenders who have been released back to the community has received increased attention in recent years. On the national level, the Office of Juvenile Justice and Delinquency Prevention has initiated a multi-year, three-site intensive community based after-care program, but outcome data are not yet available (Wiebush, McNulty, & Le, 2000). Although the results from several published studies of aftercare programs have not conclusively demonstrated that post-release services are effective at reducing recidivism or improving work or educational outcomes (see Altschuler, 1998), youth with mental disorders would likely have a greater need for post-release services. They may have difficulty obtaining community-based treatment for their disorders (Brummer, 2001), especially if they are returning to families that are not well acquainted with mental health services. Despite the growing recognition of the importance of reintegration services, the provision of aftercare services has been virtually ignored by lawmakers and there is no formal requirement that states provide aftercare (Brummer, 2001). In 1999, *Wakefield v. Thompson* became the first federal case to recognize the state's obligation to provide post-release medical services. The only case law relevant to juveniles is *Williams v. McKeithen* (2000), in which the court found that upon release, providers must do after-care planning relevant to the services that the juvenile was receiving while in placement. Legislation and case law that establish a right to transitional mental health care are likely to be crucial to the treatment of juveniles leaving secure facilities.

RIGHT TO TREATMENT

An important final issue that courts have had to face is whether or not juveniles in the juvenile justice system have a fundamental right to treatment. Although a number of courts have acknowledged a basic right to treatment in the juvenile justice system, the cases only enforce the right to the extent necessary to ensure that abusive practices do not occur and that the most fundamental of services are provided (e.g., *Alexander v. Boyd*, 1995; *Morgan v. Sproat*, 1977). Some courts have argued that because there is no right to juvenile court disposition, no

specific treatment need be provided (e.g., *State v. Martin*, 1995). Nowhere in the case law does the right to treatment extend to providing comprehensive mental health services. However, some commentators have argued that the Supreme Court's decision in *Youngberg v. Romeo* (1982) provides legal precedent for requiring the provision of mental health services in the juvenile justice setting (Slobogin, 1999). In *Youngberg*, which was concerned with the provision of services to patients in mental institutions, the Court held that the state has the duty to provide treatment if it is necessary to protect the safety of the patient or if it will "lead to freedom" (p. 318). However, this argument is weakened in a court system that emphasizes incapacitation and punishment rather than treatment and rehabilitation.

Courts have also considered fourteenth amendment arguments that juveniles have a right to mental health treatment because due process demands that the nature of treatment be reasonably related to the purpose for which the individual is confined (*Jackson v. Indiana*, 1972; *Miletic v. Natalucci-Persichetti*, 1992). The court in *Miletic* found that juveniles committed to correctional institutions have a right to treatment under the fourteenth amendment. In order for this argument to be effective, states must consider treatment and rehabilitation to be goals of their juvenile justice systems. However, by explicitly adding punishment to the expressed goals, the right to treatment may be undermined (Chernoff, 2001). For example, in *Santana v. Collazo* (1983), the court found that because rehabilitation is not the sole purpose of the juvenile court, there is no mandated right to treatment.

In the absence of clear case law recognizing a right to treatment in the juvenile justice arena, some commentators believe that state laws provide the most promise for ensuring that delinquent youth receive rehabilitative services (Holland & Mlyniec, 1995). In fact, some states have mandated the provision of services to youth with mental disorders in the system. The state code of Connecticut requires the provision of "programs and services designed to meet the needs of juveniles charged with the commission of a delinquent act...including, but not limited to, mental health services" (2001 Ct. ALS 181). In addition, several recent cases in Washington, South Carolina, and Ohio, have held that juvenile offenders have rights to treatment under the state's

juvenile justice laws. More specific statutory provisions are likely to ensure more comprehensive mental health treatment. For example, a youthful offender in Florida is entitled to treatment consistent with his or her specific rehabilitative needs, including substance abuse services, counseling, and psychological and psychiatric services. In the upcoming years it will be necessary to evaluate the implementation of the new laws to see if they are an effective means of addressing the mental health needs of juveniles with mental disorders.

CONCLUSIONS AND RECOMMENDATIONS

Since the original version of this article was published a decade ago, substantial strides have been made to identify and treat youth with mental health disorders in the juvenile justice system. Notably, several states have made efforts to clarify their definitions of “mental illness” and others have created legislation that helps to ensure that juveniles are evaluated and assessed for mental health disorders. However, most legislation remains inadequate in providing guidelines and resources for dealing with these youth. In addition, other changes in the juvenile justice arena that have resulted from the “tough on crime” mentality, such as legislation increasing the use of waiver to adult criminal court, have likely left these youth in no better position than they were 10 years ago.

After examining the policies, legislation, and case law affecting juveniles with mental disorders, one is left with a picture of a system with little theoretical clarity or institutional infrastructure for systematically identifying and treating these youth. Several factors contribute to this lack of clarity. First, the varied, and often, conflicting missions of the court make the design and implementation of a coherent policy for dealing with the treatment needs of juveniles with mental health disorders difficult. Second, the criminal justice system has been forced to integrate two legal statuses – mental illness and adolescence - in a way that it has never had to before. Being mentally ill (severely and persistently) has always meant that you were entitled to special treatment under the law. Likewise, being an adolescent has always meant that you deserved special treatment. Concerns about community

protection and retribution, however, have curtailed the claims for special treatment for both groups. Although there are some statutes in place that account for these special considerations, (like the law in Wisconsin that does not allow a juvenile to waive his or her rights to an attorney during questioning), most of the new legislation limits the processing options available to these youth without any accompanying methods for recognizing and responding to the status of being an adolescent with a mental illness.

Based on our examination of the legal issues affecting youth with mental health disorders, we have generated several recommendations. Some of our recommendations were mentioned in the prior review, while others are related to issues that have emerged within the past ten years. We begin with the right to treatment, which we consider to be the most essential recommendation, and then move to rights to competence in legal proceedings and to the insanity defense. We conclude with a discussion of future directions in the prediction of dangerousness, assessments of amenability to treatment and implications of disproportionate minority confinement for youth with mental health disorders.

First, and most importantly, the right to treatment for youth with serious and persistent mental disorders needs to be made explicit in statutory law. While some might consider a blanket right to mental health treatment for all youth in the juvenile justice system to be desirable, it is probably unfeasible considering that up to 80% of adolescents may be diagnosed with a mental disorder (Kazdin, 2000). However, without a duty to provide treatment to youth with serious mental illnesses, there is an over reliance on the good will and knowledge of judges and other court and justice facility personnel. This, coupled with the vagaries of funding streams, does not form a coherent policy approach to addressing the mental health needs of young offenders. Because the due process rights of juveniles are not total and certain actions can be taken in the juvenile justice system in the name of the child’s best interest, it is necessary to provide a right to treatment as a trade off for these limitations on individual liberty and family privacy, at least for those individuals who are most vulnerable to the bluntness of process and in need of individualized intervention.

State statutes and regulations seem to be the most likely way to recognize that juveniles have a right to treatment. Youth with mental health disorders have a stronger right to treatment claim when the purpose clause of the juvenile justice code maintains a rehabilitative focus. In order to be effective, statutes must specify clear guidelines for screening procedures and for the administration of treatment plans. Although there is no current requirement that states offer post-release services, a comprehensive legislative package should include provisions for aftercare services (Brummer, 2001). In an *amicus* brief to the court in *Brad H. v. City of New York* (2000), several organizations advocated for discharge planning for adult prisoners that would include the provision of a written discharge plan and a temporary supply of medication, along with referrals and linkages to community mental health services. States might consider using the provisions recommended in the *amicus* brief to the *Brad H.* case in drafting post-release legislation for juveniles. If state codes require assessments and treatment plans for juveniles, consideration needs to be given to providing resources for training and service implementation to make these plans become a reality in the lives of the adolescents and their families.

Second, we recommend that parties should have the right to raise the issue of competency in juvenile court proceedings and that juveniles have rights to the insanity defense that are co-existent with those of adults. The adjudication of youth in juvenile court carries greater jeopardy than it did ten years ago. Therefore, greater due process protections are warranted. With regard to competence evaluations, legislation should address guidelines for restoration of juveniles found to be incompetent, including timeframes for review. In addition, standards of adult competence may be insufficient in assessing the capacities of juveniles, especially in light of errors in the identification of mental disorders among adolescents. At a minimum, evaluators should be trained to recognize limitations in capacities associated with adjudicative competence in youth that may be the result of mental health related deficits. Although the insanity defense is unlikely to be used in juvenile court for several reasons (e.g., possibility of increased length of confinement, low likelihood of being used successfully), the changes

that have made the juvenile court more “adult-like” justify the right to an insanity defense for youth.

Third, several issues related to youth with mental disorders require additional research to inform the juvenile justice system about the effectiveness of its processing of these cases. One major focus of this research agenda should be the prediction of future dangerousness among adolescents. It is currently unclear how mental illness and violence are related in adolescent populations. Recent studies conducted with adult mental patients and new developments in juvenile risk assessment have provided some insight that will help to guide the research agenda. Issues that may be of particular importance in the prediction of violence in adolescence include abuse of drugs and alcohol, peer influences, and family environment.

Another portion of the research should examine how mental illness affects determinations of amenability to treatment in the juvenile justice system. This is especially critical when determinations that a youth is not amenable to treatment will result in transfer to adult criminal court. Given that identification of mental disorder is less precise in adolescence, the matching of juveniles with appropriate treatment may also be less precise. Future research should focus on determining the goodness of fit between juveniles and treatment options.

Research on the causes and effects of disproportionate minority confinement on adolescents with mental disorders is needed. Disproportionate minority representation at each stage of the juvenile justice process means that minority youth are at risk above and beyond the risk experienced by Caucasian adolescents with mental health disorders. The impact of mental illness may be compounded even further for non-native English speakers, in part because parents who do not speak English may be less able to advocate for their children. In addition, identification of mental health disorders may be even less precise among non-native English speakers, which highlights the need for validation of screening and assessment instruments in languages other than English.

In conclusion, increased attention to addressing mental health concerns in the juvenile justice system has resulted in some legislation that may help to set the stage for more effective service delivery.

However, an examination of the existing legal policies toward juveniles with mental health disorders shows that there is considerable room for improvement.

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