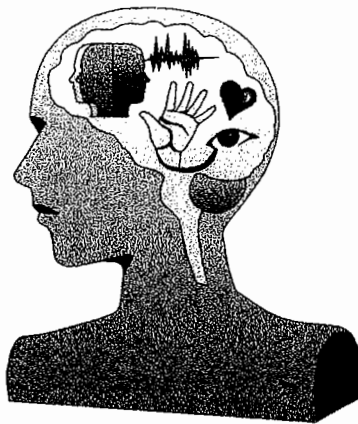


DEFINING AND ACCOMMODATING COGNITIVE DISABILITIES in criminal justice clients



Prevalence of Disabilities in Offender Populations

Mental Retardation

Specific Learning Disability

Attention Deficit Disorders

Nancy Cowardin, Ph.D.

PREVALENCE OF DISABILITIES IN OFFENDER POPULATIONS

	GENERAL POPULATION	OFFENDER POPULATION	% ARRESTED 5 Yrs. POST HIGH SCHOOL
EMOTIONALLY DISTURBED	2%	16.2%	57.6%
LEARNING DISABLED	3-6%	36%* 30-40%** 17.5%***	31.0%
MENTALLY RETARDED	2-3%	9.5%	18.1%
VISUALLY HANDICAPPED	.1%	1.6%	3.7%
HEARING IMPAIRED	.5%	1.4%	12.9%
OTHER DISABILITIES	4.1%	2.8%	12.7%

Cognitive Disabilities are significantly overrepresented in the criminal justice system, where studies consistently reveal 3 to 8 times the number found in the general population. Causes include poor reasoning and adaptability on the part of these disabled individuals that can lead to bad initial decision-making, as well as easy manipulation and scapegoating by peers. Finally, the fact that their arrest rate is also elevated suggests system-wide ignorance that breeds suspicion and intolerance regarding disability-based behaviors.

* National Center for State Courts (1982)

** Statistics compiled from 55% of reviewed studies (N. Brier, Journal of Learning Disabilities, 1989)

*** Pervasive LD found in L.A. County juvenile camp populations (3 year study, Cowardin, 1997)

MR: Mental Retardation

IS: a decreased state of functioning that begins in childhood and is characterized by limitations in both intelligence and two or more major life activities that affect: communication, self-care, home living, social skills, community use, health and safety, self-direction, functional academics, leisure, and work.

CAN: be characterized by the level of external support needed to promote and enhance independent functioning:
INTERMITTENT - assistance is provided on an as-needed basis and withdrawn as appropriate;
LIMITED - support is given on a regular basis for time-limited skills and activities;
EXTENSIVE - supports are characterized by regular and ongoing involvement in at least some skills, activities, and environments; and
PERVASIVE - constant high intensity supports that are life-sustaining in nature.

MAY: have specific known causation (30-50%); multiple causes (50%); or cooccur with mental illness (25%) and/or other cognitive disorders.

READ: “CRIMES OF INNOCENCE: Examining Transgressions of the Mentally Young Offender”

<u>DISABILITY</u>	<u>DEFINITION</u>	<u>HOW IT LOOKS</u>	<u>FILE HINTS</u>	<u>HOW DIAGNOSED</u>	<u>PROBLEMS & ISSUES</u>
MENTAL RETARDATION	- ONSET PRIOR TO AGE 22 YEARS - DELAYED EARLY MILESTONES - LIKELY TO CONTINUE INDEFINITELY - SUBSTANTIAL LIMITATIONS IN 3 (2 per AAMR) OR MORE MAJOR LIFE ACTIVITIES - SIGNIFICANTLY REDUCED IQ	- ADAPTIVE SKILLS DEFICITS (See chart) - ILLITERACY: Prose, Document, Quantitative - REDUCED LANGUAGE DEVELOPMENT: Concrete, Literal, Outdirected, Semantic Restrictions, Parroting, - SOCIAL/MORAL IMMATURITY: Reduced Empathy, Insight, Role-Taking - LITTLE ABSTRACT UNDERSTANDING - PHYSICAL CUES: Genetic Syndrome, FAS, CP, Epilepsy, Speech Defects, Motor Skills Deficits	- SPECIAL ED CLASS OR LABEL: EMR, ER, TMR, DD, MMR... - HAS AN IEP OR IPP - GETS SSI - FAMILY HISTORY - OTHERS AFFECTED - IQ BELOW 75 - CLIENT OF THE DEPARTMENT OF DEVELOPMENTAL DISABILITIES (WA), A DEVELOPMENTAL, OR "REGIONAL" CENTER (CA)	- IQ TEST: Verbal, Nonverbal, Composite scores - ADAPTIVE SKILLS BATTERY: 10 Areas - ACADEMIC SKILLS BATTERY: Reading, Math, Spelling - FUNCTIONAL LITERACY: Document & Quantitative Measures - LANGUAGE ASSESSMENT: Expressive & Receptive Vocabulary (Other Areas as Needed) - SOCIAL MATURITY & BASIC INFORMATION	- EASILY LED AND MANIPULATED BY OTHERS - EASILY VICTIMIZED AND RE-VICTIMIZED - MISBEHAVIOR PARTICULAR TO THE DEVELOPMENTAL LEVEL: Playing with matches; Inappropriate touching; "Taking" behavior - YOUNG MIND IN A "BIG" BODY - DEVELOPMENTAL "IMBALANCES" - PARENTING INADEQUACY AND POOR MODELING - "DURABILITY" OF LEARNING

CRIMES OF INNOCENCE:

Examining Transgressions of the Mentally Young Offender

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Kevin, 15 years old and suspected of arson, faced the most important interview of his young life without legal representation. Like many defendants with mental retardation, this youngster had no concept of what RIGHTS are, thus freely waived them upon arrest. He also made several common mistakes that we see in this disability group which include 1) feigning understanding of abstract concepts, 2) watching his interrogator's face and body language for clues of desired answers, 3) agreeing with statements and questions in order to please authority figures, and 4) providing a confabulated and/or inconsistent account which he cannot duplicate under cross examination. These behaviors* helped to mask his considerable deficits from the untrained officers.

In fact, the youngster's brief and disastrous adventure playing with matches was entirely explainable from a developmental perspective. Here, it is common for children between the ages of 4 and 7 to experiment with fire unless educated preventively and well supervised. Young teens with cognitive disabilities often have mental ages that fall into this developmental band, even though they appear to most observers to be more mature both socially and chronologically. Thus, we see an elevated incidence of arson among youngsters with mental retardation, often with the sort of unintended outcome that occurred in Kevin's case: a warehouse and all of its contents was burned to the ground.

In the following discussion, the term "mentally young offenders" includes those defendants whose reduced cognitive maturity renders them childlike regardless of their ages and physical size. Disabilities manifested in this group include mental retardation (all levels, mild to severe), specific learning disabilities, and, to a lesser extent, attention deficit disorders. These cognitive conditions have the potential to reduce culpability in criminal defendants, thus deserve and require careful assessment and advocacy with courts, juries, and other professionals in the justice system. The title, "Crimes of Innocence", is not intended to excuse antisocial actions by disabled offenders, but rather to explain the genesis of certain behaviors and actions from a developmental perspective. Discussion will therefore focus on several categories of crimes involving developmental immaturity, experiential deviance, and personal incompetence in disabled as well as young normal individuals. Both client groups manifest cognitive deficits that can limit the ability to plan and control multiple and typically unintended outcomes of their impulsive actions. They may therefore be as surprised and horrified as innocent bystanders when unexpected outcomes involving property damage and/or personal injury unfold before their eyes. In addition, their developmental ceilings often limit abstract understanding of the far-reaching implications of these actions, thus they neither self-advocate at arrest nor demonstrate appropriate insight or remorse in hindsight. Finally, it cannot be overlooked that the very obviousness of some cognitive disorders leads to exploitation by more capable individuals who sense their vulnerability and need for friendship. For example, youth gangs often assign mascot status to one or more disabled "wannabe's" simply to use them as lackeys. Here again, we must question the culpability of the disabled accomplice in group activities that result in criminal outcomes.

* A listing of language issues that can interfere with self-advocacy and suggested remedies follows this article.

Crimes of Immaturity

To understand the actions of disabled defendants in some situations, we must look to research in the stages of normal human development. Here, the developing child becomes less egocentric with increasing maturation, and this enables him to envision the possible outcomes of his own behavior from the perspective of others, as well as its impact on the larger society. However, this level of “externality” typically requires adolescent development at a minimum mental age of 11 to 12 years. Prior to this developmental stage (Formal Operations), children view the world from a selfish perspective, believing that their own impulsive desires and expectations are widely shared by others. This is the foundation for actions that lead to petty thefts, arson, and exploratory sexual behavior with younger children.

Arson. Thirteen year old Eduardo set fire to a wooden shed on a neighbor’s property in an impulsive, experimental manner just to see if it would burn. This disabled teen’s behavior was similar to 7 year old James’ decision to light a “small” fire in the coat closet of his classroom in order to attract the teacher’s attention. Both boys functioned in a mental age range where such experimental behavior is predictable under the right conditions. Neither boy could envision the ultimate destructive outcome of his exploratory action, nor understand the lengthy legal entanglement that followed. Children at this “Concrete Operational” stage are indeed limited in their ability to foresee negative consequences and are thus unprepared to make adaptive adjustments when situations like these get out of hand.

Petty Theft. Likewise, several of my young adult clients with mental retardation impulsively “took things” they fancied without considering the risks and consequences of these actions. Reggie appropriated two flags from his school auditorium because he admired them; while Moses snatched a carton of cookies from a parked factory delivery truck. When Tyrone, a 19 year old “Crip” gang mascot, roughly handled a gold chain on a young lady’s neck, it broke and fell free as she pulled away. His decision to pick it up ultimately constituted robbery charges. Finally, Charles snatched a purse from a woman on the street and ran off with it. All of these impulsive crimes of opportunity went awry when the disabled perpetrators botched the “getaway” by dropping the items on the ground behind themselves. None were *planned* in the conventional sense, nor did they show the sophistication of seasoned criminals. Yet, probation reports routinely describe random actions by disabled offenders in this very manner, then recommend stiff prison terms as punishment.

Sexual Curiosity. While troubling to many parents, child-to-child sexual exploration has been well documented in the early developmental stages. For example, “playing doctor” between the ages of 4 and 7 years is not considered deviant by most observers, as long as the participants are chronological peers. Yet, the criminal justice system steps in when *mental ages* of differing *chronological ages* engage in similar experiences. Although these immature crimes of exploration vary in motivation depending on the individual case, three common themes are evident where the perpetrator is disabled: pure curiosity, re-enactment of one’s own abuse, and exploitation by the younger partner in the scenario.

Casey and Aaron are both 13 year olds whose separate crimes involved the inappropriate touching of 4 and 5 year old children. Both boys have cognitive disabilities that reduce their mental ages to levels similar to their child victims. Yet, both matters were relegated to juvenile courts where prosecutors sought high-term periods of incarceration among teenaged felons. This discussion must first point out that sexual curiosity is a natural byproduct of physical maturation, even where mental development has been stalled in early or middle childhood. For many adolescents with mental retardation, this physical-mental imbalance leads to confused feelings and desires which remain outside the realm of understanding due to their cognitive limitations. Without proper preventive sexual-social education, these youngsters may behave inappropriately with both adults and children in their acquaintance, due to natural curiosity that is oblivious to sanctions without such instruction. "Proper" preventive education should be timed so as to head off emerging problems, and must provide concrete instruction related to *appropriate versus inappropriate, public versus private* behaviors. The most effective curricula in this area include direct commands that serve as guideposts in times of uncertainty. For example, the "Circles Stop Abuse" program (James Stanfield Publishers, Santa Barbara, CA) utilizes colorful relationship circles to depict varying degrees of closeness among acquaintances. Most or all children are placed in the orange "Wave" circle, with the instruction, "We never touch children; we only wave to them." Without preventive education of this sort, youngsters like Casey and Aaron may remain unaware of boundaries, especially when interacting with children who are their mental peers.

Casey's situation provides a good look into the dynamics involved where immature curiosity motivates such behavior. This youngster was born with a rare genetic syndrome that limits overall intelligence (measured IQ of about 50); but he also possesses the unreserved friendliness, loquaciousness, and curiosity documented in other individuals with this disorder. Casey additionally demonstrates mental preoccupation with several perseverative topics, one of which is, and has always been, the location and function of body parts. Because of his small stature, young age, and cognitive limitations, appropriate sex education had not been initiated by his school or family; although in hindsight, all concerned admit that the precursor behaviors were in place. Casey's inappropriate touching of a 5 year old girl must therefore be evaluated as a somewhat foreseeable exploratory action that happened when his customary strict supervision lapsed during a visit with relatives. Advocacy on Casey's behalf included a complete psychoeducational assessment of his skills and weaknesses so as to describe his composite mental age and developmental stage to the Court. In his particular state of residence, both *competence* and *capacity* are issues that must be addressed in order to dismiss punitive sanctions against a given youngster. Due to the severe cognitive deficits outlined in his assessment report, Casey was declared both incompetent to stand trial and incapable of committing a purposeful crime. Thus, preventive alternatives in the form of counseling and proper sexual-social education were put into effect in lieu of incarceration.

The second theme underlying crimes of sexual exploitation occurs when an abuse reactive teen reenacts his or her experiences with a peer or younger child. This was precisely the case for Thomas, a 15 year old California youth with a dual diagnosis of mental illness and severe learning

disabilities. Here, the boy's repeated sexual acting out was rather obviously correlated to his developmental, emotional, and social levels. Compounded by his serious interrelated disabilities, Thomas's early victimization by a deviant adult caused much sexual confusion as he entered puberty. Here, the prolonged exploitation could not be maturely processed by the youngster due to both his young age and various cognitive deficits. In addition, his relationship to the temporary father-figure who perpetrated the abuse led to a host of contradictory feelings and reactions. The result was a serious, persisting interest in related sexual activities, expressed in jokes, provocative language, and copycat behaviors that were inappropriate for Thomas's age and peer group. Immediate re-education was crucial to head off the victimization of others by this child who was himself the confused victim of such abuse. It seems pertinent to add here that, in today's social and political climate, sex offenders of all ages are immediately divested of their victim status.

For individuals whose cognitive development has "ceilinged" below 11 or 12 years of age, there may *never* be complete understanding of the social and personal ramifications of sexual maturation or experience. This remains true despite the plethora of sexually explicit messages promoted on a daily basis in the current entertainment media. It goes without saying that individuals with cognitive impairments cannot provide knowing consent where sexuality is concerned; but neither can they be held to the same standards as their agemates for sexual "acting out". The solution in Thomas's case had to balance public safety with the youngster's own needs regarding reeducation and counseling. All concerned agreed that he was unlikely to receive appropriate intervention in a correctional system designed merely to punish offenders. Instead, a group treatment facility appeared to be the best alternative, and one that held the most promise for the sort of specialized remedial interventions that will shape his future social behavior.

Finally, we have encountered cases where a teen or young adult with cognitive disabilities was actually sexually exploited by a younger normal peer. This was the scenario when Andrea, a 22 year old woman with mild mental retardation, was befriended by several 14 year old youngsters in her neighborhood. The young woman had recently been placed in an independent living situation by her California Regional Center, and was struggling with the isolation that sometimes accompanies such autonomy. She was therefore happy to occasionally welcome one of the youths into her apartment, oblivious of his developing sexual curiosity. When he suggested they "try out" a condom he brought along, she consented, and was subsequently charged with child molestation. Advocacy in Andrea's case again included a complete cognitive and adaptive skills evaluation so as to accurately portray her intellectual and social limitations. When it was made clear that the young enticer's mental age exceeded her own, the court was willing to forego penalties that would have required Andrea's mandatory registration as a sex offender. This status would have precluded her inclusion in the more appropriate Regional Center residential option that was put in place following the incident. This group home setting offered the best hope of eliminating the "opportunity" factor that contributes to recidivism in such cases. In this and all of the situations discussed in this section, the cognitive immaturity of the disabled defendants *both led to and mitigated* their involvement in the criminal justice system.

Crimes of Deviant Experience

Stephen is a 55 year old male whose case illustrates the effects of deviant past sexual experience. He grew up in an institution for the mentally retarded in New York State from the age of about 4 to 26 years. He never knew his natural parents and did not establish close relationships with any adults in foster or institutional settings. Diagnosis as "mildly" mentally retarded remains fairly consistent throughout his file; with accompanying epilepsy, "environmental" and "psychosocial deprivation", and psychosis indicated by various examiners. All of his education took place within institutional classrooms, which were numbered 1 through 12. Presumably, this numbering system corresponded to public school grade levels, where the client completed Classroom 6 just before his adult release from the facility.

Stephen's history of institutionalization had a profound impact on his present functioning in all life domains, and his sexual development is no exception. It should be noted that institutions in the 1950s and 1960s commonly omitted sex education from training options offered to clients. It was believed that such information would only lead to sexual experimentation between clients, difficult behavior management, and possible embarrassing outcomes for all concerned. Also, to lessen the chance of pregnancy among institutionalized clients in instances where adequate supervision failed, both male and female clients were customarily sterilized during this time period. Thus, institutionalized clients rarely had appropriate sex education, nor experienced normal sexual development and/or healthy and consensual heterosexual encounters with peers. Homosexual encounters were (and still are) available to most institutionalized clients, but are usually discouraged when detected by staff members.

Unfortunately, the vast majority of mentally disabled clients (upwards from 75%) have experienced deviant, often abusive, sexual encounters with staff and others in school and institutional settings. Often, these deviant experiences are the only source of sexual information for retarded clients, and their side effects are difficult to extinguish. As educators, we have found the need to use graphic teaching scripts and pictures along with detailed explanations, discussion of appropriate sexual behavior, ample time for questions to clear up misconceptions, and overlearning of content in order for even minimal learning to occur. However, even with this instruction, it is not uncommon for retarded clients to miss a great deal of content, to misunderstand and internalize grossly inaccurate information, or to forget curricular content and instead rely on deviant sexual experience as their only first-hand information. In the present case, Stephen reported several homosexual contacts with same-age institutional peers. He also indicated that he submitted to sexual relations with a male employee at the institution on four occasions in order to "get special privileges". As an independent adult, Stephen had continued to reenact some of these experiences. In this regard, he was accused in connection with several instances of inappropriate sexual conduct, including child sexual abuse (charges dropped 16 years ago) and, more recently, indecent exposure in the presence of two older females. He had never married or maintained a successful long-term relationship with a female in his age group.

Stephen's current charge involved the sexual assault of an elderly woman who he assisted on a public bus. He was in turn invited to her home for dinner, and allowed to spend the night on the sofa. The victim awoke in the middle of the night as Stephen attempted a failed rape. During the assault, he spoke apologetically as he reenacted what appears to have been a familiar deviant experience of his own. The incident brought to light the fact that the client needed direct teaching of appropriate sexual behavior, with specific information about normal heterosexual relationships from both physiological and social perspectives. Like others who tend to act reflexively, he needed to distinguish between behaviors which are publicly acceptable, those which are appropriate only in private, and those which are never acceptable at any time (e.g., sexual assault). There was also some concern here that Stephen himself would continue to be sexually victimized as he was in his earlier years. Advocacy efforts on behalf of this defendant succeeded in characterizing him as the hapless victim of an institutional system that, through its defective educational and custodial programs, had doomed the client to repeated failure in several life domains.

With these concerns in mind, it became apparent that the prison system was the *least likely* source of appropriate treatment for this disabled offender. This is because, until quite recently, the California Department of Corrections (CDC) had no programs or classes in place to assist its disabled inmate population. They were instead channeled into living units, classrooms, and vocational programs with violent offenders who exploited their vulnerability in every imaginable way. Recent class action lawsuits* on behalf of disabled inmates in California prisons have resulted in some improvements. For example, CDC Reception Centers now attempt to identify and classify developmental disabilities in incoming offenders, then take steps to remove these inmates from the general population. Still, there remain serious unresolved issues that will only be ameliorated over time with close monitoring by disability advocates, attorneys, and other public agencies. Until then, advocates recommend appropriate alternatives to prison for those disabled offenders determined to be good candidates for a variety of placement arrangements. California diversion statutes authorize a hierarchy of secure group facilities which frequently monitor appropriate and prosocial behavior. These residential programs pair correctional and retraining efforts under court supervision, with reevaluation on a regular basis. The diversion statute recognizes that individuals like Stephen will most certainly not learn anything but aberrant behavior from incarceration with violent offenders.

* For the full text of the federal court's Findings of Fact and Conclusions of Law in *Armstrong v. Davis* (C94-02307), visit the Northern District of California web site at: www.cand.uscourts.gov

Crimes of Incompetence

The final category of crimes associated with disabled defendants involves actions which they *fail to take* due to self-perceived or actual incompetence. Facing several charges of child endangerment, 36 year old Tina presents just such an example. This mentally handicapped mother of two daughters failed to prevent their molestation by her husband and two brothers. To complicate

matters further, all of the individuals involved in this New York case had been diagnosed with mild to moderate mental retardation, with Tina and her husband the highest functioning of the group. The client was identified as developmentally delayed in her early school years, and enrolled in a full-time special education setting until her "graduation" with a nonstandard diploma at the age of 18. Reports document that she was the victim of long term sexual and physical abuse by her father and, at approximately 14 years of age, gave birth to his child. It does not appear that her father was punished for his transgressions, nor was her mother supportive or protective of Tina. Following high school, the young woman established a common law marriage with a classmate who was also her first cousin. Their two preteen daughters have been tracked into special education classes since their early school years. Tina and her younger daughter both received SSI payments, while her husband collected unemployment for a physical disability. Having been homeless in past years, the family was assisted in finding housing by a social service agency. The four of them lived with Tina's mother-in-law in a three-bedroom apartment along with several pet dogs, cats, and hamsters. They also allowed friends and relatives into their home for extended stays, including Tina's young "Godson", who was also named as a victim in the case.

The family's living environment was extremely cluttered with possessions and debris, and rarely cleaned thoroughly. As a result, the apartment became infested with insects, and the children were removed from the home temporarily. Determined to regain custody of the children, Tina doused the place with several gallon containers of professional strength insecticide. Her daughters were returned to the home, along with a government-assigned homemaker who assisted the family weekdays, 8 AM to 4 PM. Her duties were not restricted to cleaning the apartment, but included assisting with bill paying, arranging medical appointments, helping the children with homework, shopping, and providing assisted care to the grandmother. Thus, Tina's substandard domestic skills were acknowledged and supported through government intervention.

The family enjoyed numerous birthday and holiday celebrations, many of which were attended by Tina's two mentally retarded brothers. These celebrations were typically barbecues held in the common outdoor area of their apartment complex. Unfortunately, however, the family held several more private functions where lewd conduct was the norm. At these events, as well as during typical visits, both of Tina's brothers and their friend and former classmate sexually assaulted the three children in her care. Review of videotaped and transcribed arrest interviews indicates that Tina made numerous attempts to intervene on behalf of the children to prevent abuses such as those she, herself, suffered as a youngster. Most, if not all, of these interventions (yelling, slapping and hitting, telling "very nicely", shadowing, warning and threatening, punishing, and the like) were unsuccessful in effecting permanent behavior changes in family members and friends. As a result, Tina found herself included among the defendants in this complex case, characterized as an enabler and lesser perpetrator of child abuse.

The point of presenting this somewhat detailed case study is to illustrate the enormity of the day-to-day problems faced by this defendant in her efforts to both support her family and protect her children. Here, her own deviant parents provide poor models of effective intervention. At her mental age, Tina had never thoroughly processed and integrated the specific transgressions of her parents nor their betrayal of her innocence. Another issue here was the fact that Tina's own husband was intermittently involved in the abuses that took place in her home, and this posed an insurmountable moral dilemma for one with such intellectual limitations. Here, on the one hand, her daughters and their well being were of paramount concern; but she also felt an obligation to protect her husband from criminal prosecution. Finally, Tina's own actions at family gatherings were marginally inappropriate, especially on a few occasions when alcohol was involved. Her reported behavior in these instances illustrates a sort of blurring of sexual and familial boundaries based on her experiential and intellectual deprivation. However, even though there remained much confusion in her consciousness, to her credit, she did take the specific steps listed above to break the cycle of family sexual abuse.

Clearly, a task of this magnitude was simply beyond the capability of this mentally disabled client. Psychoeducational assessment revealed that she could not articulate sexual-social boundaries if, indeed, she intellectually discerned them at all. This finding left justice professionals to determine what, apart from parental incompetence and poor social judgment, constituted her offenses. Local newspaper accounts of the sordid case both shocked and educated the public, many of whom never realized that persons with mental retardation can and do become parents. These accounts also highlighted the crucial need for more effective parenting education in programs for mentally handicapped teenagers. In the end, Tina spent only a few months in prison, in that time served in jail and under observation at a state hospital sufficed as her punishment. However, this incompetent mother has paid the ultimate price in losing her daughters to State custody until they reach adulthood.

Conclusion

This discussion was not intended to minimize antisocial actions on the part of disabled clients, nor to excuse them from punishment where justified. Instead, it is offered to help explain cognitive conditions involving immaturity, deviant experience, and incompetence, all of which contribute to the behaviors at hand. Many or most crimes of mentally handicapped offenders epitomize the sort of innocence we see in children who have made unwise choices. The bungling, random nature of these actions calls into question issues of capacity and intent that must be considered by our justice system if fundamental fairness is to prevail.

LANGUAGE ISSUES IN CLIENTS WITH COGNITIVE DISABILITIES: SUGGESTED REMEDIES

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- ▶ ***Lack of self-trust resulting in “outerdirectedness”***
Avoid leading the client by smiling, nodding, using facial expressions or body language that communicate an expected or desired answer. Support the client’s attempts to supply his own answers. Extend the “wait time” for the client to formulate answers.
- ▶ ***Literal, concrete translations***
Use low level language; avoid abstractions and double-meaning words; be concrete.
- ▶ ***“Parroting” the phrases of others without understanding***
Ask the client to paraphrase statements he takes from other sources by asking, “What does that mean to you?” or “How do you understand that?” Ask the client to restate using his own words.
- ▶ ***Naivety: Inability to discern sarcasm, “in-jokes”, and subtle messages***
Don’t confuse the client with sarcastic comments or esoteric phrases. Be direct in your questions, comments, and/or instructions.
- ▶ ***Immaturity in terms of content and presentation style***
Be prepared to accept and parrot back immature terms and phrases rather than inserting your own. Use lowest language level terms and explanations in your communications.
- ▶ ***Inappropriate or unrelated comments in specific situations***
You may wish to ignore such comments and redirect the client back to the topic that is underway OR use these utterances as communicative springboards. (NOTE: Several studies have shown that off-track utterances and verbal perseverations may have communicative intent that should be utilized to make a conversational connection rather than be extinguished.)
- ▶ ***Semantic restriction of multiple meaning words***
Try to avoid using words that have more than one meaning. If you must do so, explain the meaning of the word in *your particular context* (*Example*: A RIGHT is SOMETHING YOU ARE ALLOWED TO DO. It is different from BEING RIGHT or ON THE RIGHT).

- ▶ ***No/little incidental learning of common terms and phrases***
Do not expect the client to understand slang, street terms, or other vernacular even though it may be popular in his/her age group. Avoid using such language as it can be quite confusing to the client.
- ▶ ***No/little notice of peripheral details -OR- Focus scattered to peripheral details***
Be specific in pointing out details that you want considered; redirect attention to the main focus of your presentation.
- ▶ ***Misinformation from unmonitored TV watching (or other experiences)***
Parents/caregivers should provide adult guidance to accompany televised programs. Where lacking, correct misperceptions with clear explanations. Use real life experience and manipulative materials where possible.
- ▶ ***Failure to grasp abstract concepts and terms***
Use concrete terms and explanations instead.
- ▶ ***Associating unrelated terms and information***
Avoid terms which are vague. Simplify content and language.
- ▶ ***Conceptual and/or perceptual confusion***
Ask client to rephrase what was said, listen for confusion, and correct it.
- ▶ ***Confabulating or agreeing in order to please the questioner***
Question his/her answers and assertions. Ask, "Is that what *really* happened?" or "Are you sure about that?" Discuss the difference between truth and lies. Admonish the client not to tell any lies whenever he talks to you.
- ▶ ***Inappropriate disclosure of information can jeopardize personal safety***
Caution the client not to talk about his personal business where others can overhear him.
- ▶ ***Limited vocabulary makes self-expression labored or confusing***
Take the time to sort out all the details in confused stories. Check to be sure you have received the intended meaning of utterances (Example: "Are you saying ...?" or "Let me be sure I understand you..."). Help the client stay focused and follow a logical sequence in telling and retelling the details of his experiences.

LANGUAGE AND PRAGMATICS THAT SIGNAL DIFFICULTY IN COGNITIVELY DISABLED CLIENTS

“Outerdirectedness”	Reading social cues, body language, facial expressions, Head nodding, etc., to formulate acceptable answers.
INTERRUPTIONS AND HESITATIONS	“They live on... okay, my hu... they live on Van Ness... okay, 139 th , okay, I’m goin’...”
REPETITIONS / FILLERS	“They say dial 9-1-1, so I just dialed 9-1-1... That’s the only thing I think of, 9-1-1. They say emergency, dial 9-1-1, so I dialed 9-1-1 and that’s just all I did.
REQUESTS FOR CLARIFICATION	“Why didn’t I do it?” “Huh?” “Where did I go?”
WORD FINDING / EXPRESSIVE DIFFICULTIES	Q: “Wait a second. The man ran down the stairs from her front door...” A: “He was <i>in the front door</i> , right...” Q: “John, he ran down the stairs, is that correct?” A: “Yes, he <i>ran down the stairs</i> ...” Q: “And you followed him down the stairs.” A: “ <i>Followed him down the stairs</i> ...” Q: “Then where did he go?” A: “He was heading toward... Like I told you, got this big old thing...” Q: “The <i>planter</i> in the back?” A: “Yeah, there you go.”
RECEPTIVE CONFUSION	Q: “Both your sister and Mike said...” A: “Both my sisters? One of my sisters was at work.” Q: “Huh? No. Both your sister and Mike said...” A: “There you go saying both my sisters again. One of my sisters was at work.” Q: “John. Listen to me. Both your sister and Mike - See there’s two of them - They both said it.” A: “Oh.”
SARCASM DUE TO MISCOMMUNICATION	Q: “Makes me think you got something more to do with it.” A: “Me, to do with it?” Q: “No, <i>Tommy</i> ! Why else am I talking to you here?”

CONCEPTUAL LANGUAGE DEFICITS IN COGNITIVELY DISABLED CLIENTS

<u>CONCEPT / TERM TO DEFINE</u>	<u>ACTUAL CLIENT QUOTES</u>	<u>DEMONSTRATES</u>
COURTROOM PERSONNEL / JOBS:		
LAWYER	“Uh huh. <i>Lawyer</i> .”	IMITATIVE REPETITION
DISTRICT ATTORNEY	“Testing the blood” “DNA Testing”	MISPERCEPTION / Misinformation from Judge Judy / Simpson trial
JUDGE	“He says no to drugs - no cigarettes.”	CONCEPTUAL CONFUSION: Police / DARE Campaign / Courts
JURY	“You wear on your neck.”	AUDITORY MISPERCEPTION: “Jewelry”
PLEAS ENTERED IN COURT	“Thank you very much and I miss you.”	SEMANTIC SCAFFOLDING: “Please”
PLEA BARGAIN	“Beg the judge - I’ll go to church!”	SEMANTIC RESTRICTION: “Plead”
A RIGHT	“ <i>Right</i> Hand” / “You be <i>right</i> on things.”	SINGLE MEANING APPLICATION: “Right”
WAIVE YOUR RIGHT	“You just pick up your hand and <i>wave it</i> and promise to tell the truth.”	EXPERIENTIAL CONFUSION: Sworn in
CONSTITUTIONAL RIGHTS:		
RIGHT TO COUNSEL	“I have to go to <i>counseling</i> .”	ASSOCIATIVE RESPONSE
SELF-INCRIMINATION	“On Monday, we go bowling.”	IRRELEVANT RESPONSE
CONFRONT ACCUSERS	“We hid in the car.”	CONFABULATION
SUBPOENA POWER OF THE COURT	(No response)	FAILED COMMUNICATION

TRANSLATING *ENGLISH* TO *ENGLISH* FOR COGNITIVELY DISABLED CLIENTS

DO YOU WAIVE AND GIVE UP
YOUR RIGHT TO A JURY TRIAL?

DO YOU WANT A JURY TRIAL?

YOU WOULD BE ABLE TO USE
THE SUBPOENA POWER OF THE
COURT AND TO PRESENT A
DEFENSE.

***YOU COULD HAVE PEOPLE COME
IN AND TELL YOUR SIDE OF THE
STORY.***

NOW, THERE ARE CERTAIN
CONSEQUENCES OF YOUR PLEA.

***THERE ARE THINGS THAT WILL
HAPPEN.***

IF YOU DO THINGS CONTRARY
OR IN OPPOSITION TO WHAT YOU
ARE SUPPOSED TO DO, YOU
COULD GO TO PRISON.

***IF YOU DON'T FOLLOW THE RULES
YOU COULD GO BACK TO JAIL.***

THIS CASE MIGHT BE USED TO
ENHANCE A SUBSEQUENT
PENALTY YOU MIGHT GET IN
A NEW CASE.

***THEY'RE GOING TO KNOW YOU'VE
BEEN HERE BEFORE AND THEY CAN
USE IT AGAINST YOU IF YOU DO
WRONG AGAIN.***

WE ARE GOING TO ASK THE
JUDGE TO WAIVE THAT FINE.
COURT: SO WAIVED.

***THE JUDGE SAYS HE'S NOT GOING TO
MAKE YOU PAY BECAUSE HE KNOWS
YOU DON'T HAVE ANY MONEY.***

[Following initial instructions that she may not leave the "Guest Home" alone, but must be accompanied by a staff member, this statement is posed to Marian 20 minutes later:]

YOU CAN CONTINUE TO GO TO
A.A. MEETINGS IF YOU WANT
TO. WE ENCOURAGE YOU TO DO
THAT.

WILL YOU GO THERE BY YOURSELF?

[NO.]

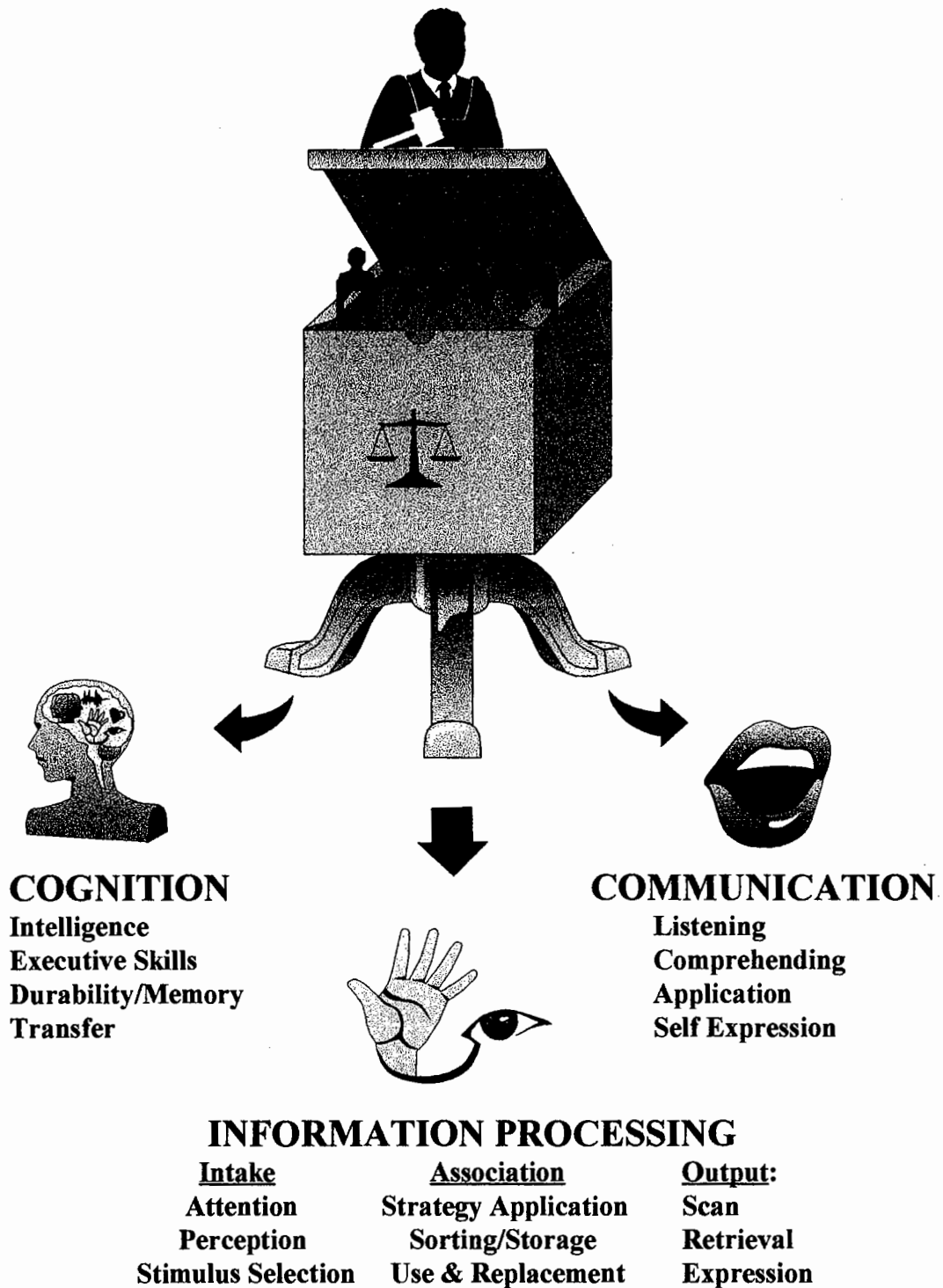
WHO WILL GO WITH YOU?

[MISS F. - Guest Home administrator]

Readability Index: Grade 8

Readability Index: Grade 4

Nancy Cowardin, Ph.D.
Educational Diagnostics



True "TRIAL COMPETENCE" requires intact underlying skills related to Cognition, Communication, and Information Processing. Without this foundation, the "box" of trial competency facts taught in institutional classes remains unsupported and meaningless.

LD: Learning Disabilities

IS: a lifelong disorder in one or more of the basic psychological processes involved in acquiring, understanding, and using spoken or written language and symbols. Related disorders can interfere with one's ability to listen, think, speak, read, write, spell, or do numerical calculations.

CAN: distort, block, or scramble information at any point in the processing chain including:
INTAKE - material can be omitted, misperceived, or only partially received;
ORGANIZATION - mistakes during sorting and storage of material can lead to confusion and inconsistency; and/or
EXPRESSION - errors involving scan, retrieval, and/or output can interfere with smooth and automatic oral and written communication.

MAY: cooccur with perceptual-motor disabilities, attention deficit disorders, severe behavior disorders, expressive and receptive language problems, "dyslexia", and/or other processing lags.

READ: "Disorganized Crime: Learning Disability and the Criminal Justice System"

<u>DISABILITY</u>	<u>DEFINITION</u>	<u>HOW IT LOOKS</u>	<u>FILE HINTS</u>	<u>HOW DIAGNOSED</u>	<u>PROBLEMS & ISSUES</u>
SPECIFIC LEARNING DISABILITY	- A LIFELONG DISORDER	- FUNCTIONAL ILLITERACY	- SPECIAL ED CLASS OR LABEL: LD, SLD, LDG, EH, BD, LAS	- IQ TEST: Verbal, Nonverbal, Composite	- EASILY COACHED, LED, AND SCAPEGOATED BY OTHERS
	- "NORMAL" IQ	- REDUCED LANGUAGE DEVELOPMENT: Concrete, Literal, Disconnected, Peripheral, Perseverative	- HAS AN IEP OR "504 PLAN"	- ACADEMIC SKILLS BATTERY: Reading Decoding/Comprehension, Spelling/Written Language, Math Computation/Application	- POOR PLANNING AND DECISION-MAKING SKILLS = IMPULSIVITY
	- SIGNIFICANT IQ-ACHIEVEMENT DISCREPANCY: One or More Academic Subjects	- BEHAVIOR PROBLEMS: Immaturity, Mood swings, Impulsivity, Inattention, Defiance, Low Self Esteem	- FAMILY HISTORY - OTHERS AFFECTED	- FUNCTIONAL LITERACY: Document & Quantitative Measures	- IMMATURE COGNITIVE STRATEGIES = RANDOM BEHAVIOR
	- AFFECTS ONE OR MORE BASIC PSYCHOLOGICAL PROCESSES:	- POOR SCHOOL ACHIEVEMENT / PUNCTUALITY / TRUANCY	- IQ ABOVE 70	- INFORMATION PROCESSING BATTERY: Auditory and Visual Modalities	- SOCIAL NEED TO MASK DEFICITS AND BE ACCEPTED
	A) Learning & Using Written or Spoken Language	- POOR MOTOR SKILLS: Clumsy Large &/or Fine Motor Skills, Poor Eye-Hand Coordination	- REPEATED ONE OR MORE GRADE LEVELS	- LANGUAGE ASSESSMENT: Expressive & Receptive	- LITTLE OR NO "INCIDENTAL" LEARNING
	B) Automatic Symbolization	- MOSTLY BOYS	- "CONFIDENTIAL" GUIDANCE FILE	- SOCIAL/MORAL MATURITY	- MORE "PERIPHERAL", LESS "CENTRAL" ATTENTION
	C) Perceptual-Motor Skills			- LEVEL OF BASIC INFORMATION	
	D) Attention				

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DISORGANIZED CRIME: LEARNING DISABILITY AND THE CRIMINAL JUSTICE SYSTEM

Nancy Cowardin, Ph.D.

OVERVIEW

Between three and six percent of school-aged children are diagnosed with Learning Disability (LD), a specific cognitive disorder which affects the learning of academic and social information despite otherwise normal intellect. Yet, it is widely estimated that 20 to 55% of criminal justice clients qualify as having specific to pervasive Learning Disabilities (Keilitz & Miller, 1980; Larson, 1988; Brier, 1989; Cowardin, 1998). This finding is of great significance to defense attorneys at the trial and sentencing phases of the criminal justice process. It also raises theoretical and practical questions which cannot be ignored by educators or the criminal justice system.

DEFINING LEARNING DISABILITY

Learning Disability affects cognitive systems related to perception, attention, language and the symbolization abilities required to learn to read and/or carry out mathematical calculations in an automatic manner. Importantly, LD is not simply another term for Mental Retardation or Attention Deficit Disorder, although all three are considered to be *learning handicaps*. Neither should LD be confused with emotional disturbance. Persons with LD may function in one or more areas at levels consistent with mental retardation, may have concurrent behavior, conduct or emotional problems, and/or may display hyperactivity or limited attention capabilities. Still, the disorder remains unique in specifying a significant IQ-Achievement discrepancy in academic learning. In other words, the individual with a specific Learning Disability must display intelligence within the "normal range", and certainly above the commonly accepted cutoff for classification as mentally retarded, and one or more academic lags which are "significantly" (at least 1 ½ standard deviations) below this measured ability level. Formal diagnosis should also delineate a possible basis for the condition, e.g., a specific perceptual deficit which interferes with the intake, organization, retrieval and/or expression of academic or social information.

Learning Disability has been considered a school-related problem in that it is first noticed when a child fails to learn academic material and requires school-based remediation to improve functioning. However, it is pertinent to this discussion to point out that LD also affects the learning of social information which is needed for decision-making in nonacademic situations. Thus, it is not surprising that Learning Disabled youth and adults in incarcerated populations represent 3 ½ to 10 times the percent found among school children.

CHARACTERISTICS OF THE LD OFFENDER

The Learning Disability literature posits three hypotheses for the disproportionate number of these clients who fall into the criminal justice system: the School Failure, Differential Treatment and Susceptibility Theories. This paper will focus on the latter, which outlines several interrelated cognitive, language, social and personal characteristics common to LD offenders. It is believed that these differences may be responsible for 1) poor decision-making skills and easy manipulation by peers which lead to involvement in criminal behavior; 2) weak or missing avoidance and detection strategies which result in easy apprehension by authorities; 3) behavior problems which lead to harsher treatment within the justice system; and 4) inability to learn experientially in order to prevent recidivism.

Cognitive and Developmental Lags. The first characteristic which has been linked to criminal involvement and increased recidivism in the LD population is *lower intelligence*. Here, offender populations average a 7 to 9 point IQ deficit despite controls for race, age, gender, and socioeconomic status. This IQ discrepancy mirrors that of the LD population, which, although technically normal, falls at the lower end of this test band. Repeat offenders average a lower IQ than nonrecidivists, which helps to explain the overrepresentation of LD among "third-strike" offenders.

Studies have shown that most Learning Disabled teenagers have not developed cognitively to the same levels as their nondisabled peers. This is most observable during *information processing* tasks requiring an organized sequence of cognitive action which includes intake, organization, retrieval and expression of specific information. Here, normal teens employ mature, language-based strategies on an automatic basis. LD teens tend to function at a two to four year deficit in this regard, displaying inconsistent strategy use if, indeed, they use them at all. This inconsistent pattern of mental organization and performance can persist into adult life for these clients, greatly jeopardizing the possibility that they can keep up with normal peers. Instead, they tend to become overwhelmed with task variables during complex activities. Here, we often see the LD client simply "shutting down" all processing, preferring instead to take direction from others.

Roy and two younger teens dabbled in satanic worship as a means of increasing the popularity of their rock band. Under the influence of drugs, Roy chanced upon these youngsters on the evening they planned their second attempt to murder a female classmate. Skeptical, he accompanied them to a remote area and stood "frozen" as the two implemented their plan. He could neither prevent nor assist with the crime due to stimulus overload. Eventually, on direct instruction from his friends, Roy provided half-hearted and minimal assistance. After several months of extended "processing time", Roy turned himself in to authorities.

Language Immaturity. Much has been written about *language processing* differences in LD clients. Here, they have been characterized as deficient in the use of internal language, the "private speech" needed to mediate one's own actions. This deficiency can affect social awareness, personal organization and self control, all linked to delinquent behavior and criminal apprehension. We have

found it typical for our LD clients to employ ineffective nonverbal imagery to make choices and adaptive decisions once an action is underway. Processing information in this less mature, random manner greatly increases the likelihood of errors of *omission*, where not all information is received, and *commission*, where inaccurate information can result in behavioral confusion.

Language immaturity also affects ability to organize and monitor input on a continuing basis. Thus, LD clients often appear disorganized, relying instead on impulse, guesswork and luck. They often enter a crime situation with a "half-plan", that is, a poorly thought out image of a desired outcome, but have not conceptualized the small steps for actually reaching this goal. Then, when the situation escalates, the individual does not have sufficient internal language to correct his original plan through self-coaching.

John is a severely Learning Disabled man who faced the death penalty in a Special Circumstance murder case. Using keys taken from his brother's repair truck, he rode his bicycle to a private home during the work day with the intention of burglary. He soon became lost in placing odd objects, many of which were not the least valuable, in plastic bags which he piled by the kitchen door. This activity took several hours, during which he misplaced his pager somewhere in the house. While he frantically looked for it, the female tenant arrived home from work and found her home in disarray. Her murder apparently took place when John could not exit her home without a physical confrontation. Several personal items, including the victim's watch and harmonica, were found in John's backpack when he was apprehended a few days later.

Finally, *internal language* is a necessary ingredient for inducing and maintaining self-control in escalating social situations. Here, LD clients need to be taught to employ self-talk to curb aggressive impulses and effect more positive outcomes. People who do not routinely think through possible consequences of actions using private speech are more likely to act first, then encounter and deal with the fallout later. One lecturer (featured in PBS Video, 1989) has described this typical LD behavior as "**Ready...Fire...Aim!**" Thus, decision-making and self-monitoring do not appear to be language-based functions in LD offenders. Instead, they seem to make decisions and adaptations in a random manner, and are typically quite surprised when things go wrong.

Distorted Social Perception. Social perception is greatly influenced by the information processing abilities discussed above. Here, we have seen LD individuals who miscue from people and the environment due to impaired role-taking ability, poor conversation and interrogation skills, and misinterpreting social expressions and gestures. Deficits in *social awareness* can result in reduced ability to grasp the precariousness of one's actions or the magnitude of the predicament once apprehended. These individuals may also be less able to avoid apprehension because social "tip-off" cues are not being received. They are often left literally "holding the bag" by peers who, sensing danger, have fled the scene.

Gilbert was invited by his nondisabled friends to "cruise" the Coast Highway on a Friday night. The boys were dismayed to find metered parking along the highway, and this launched a lively discussion about just how much money is collected in the average parking meter. Gilbert actively assisted in a group effort to remove the meter from the pole, oblivious to passersby who were witnessing and discussing the boys' mischievous behavior. He was the only youth remaining at the scene, parking meter in hand, when the police car pulled up.

Impaired social perception and problem-solving also affects the *personal organization* of LD individuals, and helps account for the high degree of what we have termed, "disorganized crime" in this population. This sort of mental disorganization is magnified greatly once action is underway and the LD individual cannot generate adaptive solutions to encountered problems. This type of client is often seen forging blindly ahead with the original plan (or half-plan) despite growing evidence which would lead a normal person to abort the endeavor completely. Social misperception in our client group has led to almost comical blunders in the Entry, Escalation and Exit phases of criminal activity. Here, as examples, one of our clients donned a ski mask after interacting with his victims for over ten minutes undisguised; another allowed a youthful McDonald's clerk to call his manager at home to get permission to hand over the money in the cash register; and several of our clients have left personal items such as wallets, notebooks and pagers at crime scenes. Thus, we see social perception as a key variable which, along with impaired internal language, almost dooms LD would-be criminals to failure without external direction.

Attention Disorders. The Learning Disability literature (Krupski, 1981) points to attention difficulties which increase significantly when LD children are presented with cognitive (nonautomatic) tasks. Here, we see children who cannot select the proper cue from a stimulus laden background and/or come to attention upon demand. We also find those who are highly distractible and/or cannot sustain attention over the long term at school, though well able to attend to video games for hours at a time at home. Thus, issues of *inattention and distractibility* are related to volition, or choice, as well as to the precise type of task being required. Accordingly, the federal definition of Attention Deficit Disorder which specifies chronic "limited alertness" may not be entirely descriptive of the issue in LD populations. On the contrary, we often notice that attention is not lacking, but aimed equally at all stimuli in the environment, interfering with task "vigilance". This client does not display an attention deficit, but a condition of cognitive overload which greatly interferes with attention in academic and social settings.

Attention lapses have been identified as one reason why our client group is so amenable to outside influence and manipulation by peers. Here, we tend to see clients with poorly developed internal vigilance, who are more than eager to release control to others. It is not coincidence that many youth gangs admit one or more members who they perceive will follow all directions without question. These members, often tagged "Loco" or "Clown", are useful as "go-fors" during delinquent activity. They are also typically the ones used as scapegoats or characterized as "ring leaders" by other gang members during plea bargaining.

Finally, *response commissions* (failure to inhibit oneself consistently) during stimulus overload are at the heart of crimes of *impulsivity*. Here, we often see "trigger-happy" reactions which seem out of character to both the client's personality and the situation at hand. This was clearly demonstrated by one of our clients who fired shots in the air as his would-be attackers were in the process of retreating. This action only served to reactivate a conflict which would have otherwise subsided without harm to either party. We shudder to think how many preventable crimes have occurred where handguns were paired with impulsivity.

Chris and a friend collaborated on an ATM robbery. Here, the friend offered to wait in and drive the get-away vehicle if Chris would carry out the actual robbery at gunpoint. When a patron approached the ATM machine, Chris stood nearby with a hidden gun, waiting for the right moment to demand money. But instead of a withdrawal, the man made a deposit, forcing Chris to come up with an adaptive solution. Although he had no cigarettes, Chris asked the man for a match and followed him to his car to locate one. At this point, Chris impulsively displayed the gun even though there was no cash available. The man lunged forward to grab it away and the gun fired, killing him. Chris's friend was now nowhere in sight, so he was forced to take the man's car in order to flee the scene.

Social and Emotional Deficits. Teachers of Learning Disabled children attest to the fact that emotions often run high in their classrooms. This characteristic volatility is further compounded by a degree of emotional lability, or mood swings in the disability group. Thus, we see inconsistent and dramatic emotional reactions which appear inappropriate to the situation at hand. Some of this behavioral display is merely compensatory in nature, that is, an attempt to mask social strategy failure. It is understandable that these students have developed a fair amount of frustration due to poor academic skills and social failure, thus become angered quickly. We are reminded of the LD youngster whose teacher announced a "pop" spelling quiz in ten minutes. His reaction was to kick a fellow student, thereby breaking a cardinal classroom rule. In this way, he manipulated a trip to the office in lieu of taking the quiz and risking social failure

While normal teens may be able to talk or charm their way out of a disciplinary situation, it is not uncommon to see the LD youth become sullen, defiant or belligerent when confronted by an authority figure. It is not unusual to find that the LD youngster is the only one of his peer group to be arrested for a minor offense. This may occur in part due to poor detection avoidance strategies (i.e., he's the only one caught), but is also the result of the *abrasive interpersonal skills* discussed above. It is not surprising that 31% of the Learning Disabled and 57% of the Emotionally Disturbed have experienced arrest by the time they are five years out of school. Similar inappropriate behavior and attitudes may also be displayed while in the courtroom or in meetings with the Probation Officer, further insuring that the LD youth will receive harsher treatment in the system.

Let's return to Gilbert left alone holding the parking meter as the police drove up. Instead of quickly concocting a believable story ("Gee, Officer, this came off the pole. Good thing you're here!"), the 17 year old became sullen and defiant. He refused to answer questions or offer any plausible excuse. He also refused to incriminate his friends, thus was taken to the police station. Gilbert's parents were called to come and pick up their son. By this time, it was 2:00 in the morning.

DIFFERENTIAL TREATMENT

Disability advocates have documented numerous instances where Learning Disabled clients received more punitive treatment and/or extended periods of incarceration or probation. For example, Alberto, a client with pervasive disabilities, was told by the judge that he would not be released from probation until he obtained a high school diploma. Our assessment determined that this adult client functioned at first and second grade levels in spelling and reading, and demonstrated specific processing deficits which scored as low as the 5 year age level. Habitually trying to hide his severe disabilities, he had not sought previous academic remediation. Through our efforts, the Court received education regarding Alberto's disabilities. We also intervened with his adult school in order to best meet the client's unique educational needs.

We have encountered judicial ignorance, especially critical in juvenile cases, concerning Learning Disability. Here, judges routinely take school reports of failing grades and/or behavior referrals at face value in making major decisions related to client disposition. Yet, they rarely require school officials to identify underlying causation for poor performance. Here, that one additional step could result in disability identification and eventual remediation for a Learning Disabled youngster. Thus, while the Differential Treatment Theory may not adequately explain why so many LD youth become offenders, it does help to explain their entrapment in a system which does not understand or respond to their unique learning needs.

INCARCERATION ISSUES

When a Learning Disabled defendant faces incarceration, the defense attorney is in an excellent position to assume an advocacy role in alerting prison officials of the client's condition. It is suggested that all diagnostic reports be forwarded to the Reception Center as a means of alerting staff to the presence of a disability. Making sure there is disability documentation in an inmate's file will eliminate the burden of his having to prove this status to receive fair accommodation as mandated by the Americans with Disabilities Act (ADA). ADA accommodation impacts a variety of prison programs and activities, including vocational training, hearings, and other aspects of daily prison life. Additionally, under the federal IDEA law (Individuals with Disabilities education Act, formerly PL 94-142), prisons have a legal obligation to provide continued special education services to inmates under 22 years of age who enter the system with active remedial education contracts (Individualized Educational Plans, or IEPs).

Failure to Provide Educational Accommodation

Prisons typically provide basic remedial education courses (ABE classes) for inmates who have not attained high school diplomas and test below the 7th grade level. In the California prison system, ABE classes cannot be defined as special education in that 98% of them are not staffed by trained special educators, they do not conduct standardized individual pre/post assessments, they do not adhere to a formal team-generated Individualized Educational Plan and they do not provide the low pupil:teacher ratio needed to produce maximum academic gains in Learning Disabled students. Thus, at best, ABE offerings duplicate the same remediation efforts which were unsuccessful when the LD inmate was in school. Yet, other than these basic remedial offerings, there are *no* special education provisions in most prison programs.

Failure to Provide Vocational Accommodation

We found in the California prison system that only inmates who score above a sixth grade reading level are enrolled in vocational training programs. In this way, LD inmates, as well as others with low academic skills, are denied all but the most menial jobs, and are rarely able to obtain any sort of paid employment within the prison system. We have concluded that vocational offerings in most prisons exclude LD inmates based on entrance criteria (literacy attainment) which are beyond their capabilities. The problem is compounded by the fact that LD inmates cannot improve their academic skills without special education, and therefore remain unable to meet entrance requirements for the vocational training program. The outcome is that LD inmates who may be capable of doing the manual work for which a program trains and/or who have worked in such a field prior to incarceration are effectively barred from vocational participation.

Failure to Provide Accommodation in Daily Prison Life

Inmates with LD are often unable to fully participate in the daily activities which are part of prison life. For example, several LD inmates have complained that existing library materials are not appropriate for their low reading levels. Library personnel are neither consistently available nor trained to assist illiterate inmates in accessing essential library materials such as taped novels and self-instruction workbooks.

Inability to read posted notices has resulted in punitive and even life threatening circumstances for several LD inmates whom we encountered. Yet, the posting of important information in printed form remains the primary, and sometimes only method of communication between inmates and prison officials. Asking other inmates for help may be viewed as a sign of weakness, thereby making an individual more vulnerable to predators. Neither is asking prison officials for reading assistance a workable alternative. In this scenario, the LD inmate is rendered more dependent on staff than are his nondisabled peers. Such requests may be viewed as "pestering" a staff member, which can result in retaliation, ridicule or even disciplinary action.

Filling out prison forms is a process which also requires assistance for most LD inmates. Requests for certain supplies and medical appointments in the prison setting typically require the completion of a written form. Here, the LD inmate's only alternative, enlisting an inmate helper, can result in inaccurate or erroneous information.

Finally, reading personal and legal mail is yet another obstacle which faces LD inmates in daily prison life. This main form of communication with the free world, including legal counsel, is often denied to LD and other prisoners who are illiterate. These inmates have two options: 1) to ask for staff assistance in reading or responding to private or otherwise sensitive material, or 2) to procure help from peers who may have poor skills themselves or may take advantage of their dependence. Neither option is an appropriate accommodation under the Americans with Disabilities Act.

Failure to Provide Accommodation at Hearings

Most procedures associated with hearings, including such tasks as filling out hearing requests, appeal forms, and reading/ responding to disciplinary reports, depend on an inmate's ability to read and write. All inmates must participate in a number of hearings during their incarceration. Classification hearings concern the inmate's housing and other programming within the institution. Disciplinary hearings adjudicate rules violations which can result in loss of privileges/credits or even placement in security. Finally, parole hearings determine whether an inmate has attained parole and/or provide recommendations to help him increase his chances of earning parole in the future. These hearings have important implications for prison life, thus it is imperative that all inmates, including the Learning Disabled, fully comprehend and participate in the proceedings. Apart from the problems LD prisoners may have with written text, those with language and processing disorders may require assistance in comprehending the verbal content of these hearings. Accommodations may also be needed in reading and translating written notice of charges against them, conducting investigation or file review in preparation for a hearing, rewording abstract language at hearings, formulating written responses to charges, and filing appeals.

Parole hearings often provide LD inmates with a final hurdle by requiring *educational improvement* as a condition for earning parole. For the LD inmate, it is unrealistic to require educational progress without offering special education as a means of obtaining this outcome. Far too often, parole commissioners neither understand LD nor have been provided any sort of training toward this end. As a result, they are not able to make realistic or appropriate recommendations for LD inmates.

CONCLUSION

This paper has attempted to define and explain the link between Learning Disability and involvement in the criminal justice system. An overwhelming number of these youth and adults are currently in custody where they receive little or no remediation or accommodation for their various disabilities. With the exception of some juvenile clients with current disability status, it has been our finding that the justice system neither detects, understands, nor provides for cognitive differences at arrest, adjudication or disposition unless assisted or ordered to do so.

Finally, incarceration is likely to have a more devastating impact on criminal offenders with Learning Disability than on nondisabled inmates. This is so because accommodations needed by LD inmates for responding to the daily challenges of prison life have not been implemented by most correctional systems. Until necessary ADA accommodations are implemented for LD offenders, the justice system would do well to look for more appropriate sentencing alternatives whenever possible.

DETERMINING THE NEED FOR LD ASSESSMENT

Learning Disability assessment can yield information which is especially valuable to attorneys in the presentencing and sentencing stages of representation. Following is a symptom checklist which may be helpful in determining whether to refer a client for LD assessment. Attorneys are urged to select a qualified diagnostician to conduct a complete, multidimensional assessment and prepare a detailed report of findings. The report should describe the disorder in functional terms and yield cognitive levels in several developmental areas including intelligence, academic skills, information processing, language, and social development. An educational psychologist/diagnostician or special education learning specialist with doctoral training is recommended for this task.

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LEARNING DISABILITY SYMPTOM CHECKLIST

Nancy Cowardin, Ph.D.

ACADEMIC DEFICITS:

1. ___ Poor grades despite adequate school attendance
2. ___ Reads or writes at childish levels
3. ___ History of special education class enrollment
4. ___ Low yearly achievement test scores in school cum file
5. ___ Spiky profile (both high and low skills)
6. ___ Lacks general age-appropriate information

ATTENTION DEFICITS:

7. ___ Exhibits physical "overflow" movements while working
(noise-making, rocking, tapping, etc.)
8. ___ Recall shows "hit and miss" attending to content
9. ___ Can be easily distracted from task
10. ___ Needs redirection or prompting to complete tasks

SPEECH-LANGUAGE DEFICITS:

11. ___ Needs restatement, simplification or repetition of questions and directions
12. ___ Talks a lot but makes little sense
13. ___ Missing or incorrect labels for nouns/verbs
14. ___ Speech/articulation problems
15. ___ Generally hard to communicate with

PHYSICAL DISABILITY CLUES:

16. ___ History of maternal drugs, birth injury or head trauma
17. ___ Family member has similar disabilities

ADAPTIVE SKILL DEFICITS:

18. ___ Problems communicating information to others
19. ___ Behaves immaturely and/or has younger friends
20. ___ Acts randomly without considering possible consequences
21. ___ Cannot apply academic skills to daily living

SOCIAL-BEHAVIORAL DEFICITS:

22. ___ Impulsivity (makes fast, bad decisions)
23. ___ No plan, half-plan, or abandons plan once action is underway
24. ___ Emotional mood swings
25. ___ Needs outside direction in a crisis
26. ___ Odd, immature, disorganized or poorly accepted by others
27. ___ Used by peers as scapegoat or "go-for"
28. ___ Easily led, bribed or cajoled to self-incriminate
29. ___ Lacks confidence in own decision-making
30. ___ Misinterprets social gestures, facial expressions or environmental cues

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- Cowardin, Nancy (1998). Disorganized Crime: Learning Disability and the criminal justice system, Criminal Justice, 13 (2), pp. 11-16.

ADD: Attention Deficit Disorder

IS: “chronic limited alertness” that can interfere with one’s ability to listen, think, and learn, as well as to organize, plan, and execute goal-oriented behaviors.

CAN: affect one or more basic attentional dimensions:
OMISSIONS - “inattention” that can cause lapses in vigilance and related “holes” in learned content and observations;
COMMISSIONS - “impulsivity” that prompts a series of fast, random, and maladaptive decisions and reduced ability to inhibit one’s actions;
REACTION TIME - slower “speed of response” that results in missed opportunities for success; and
VARIABILITY - “inconsistency” in terms of pacing one’s reactions.

MAY: cooccur with perceptual-motor disabilities, learning disabilities, severe behavior disorders, and other information processing lags.

READ: “ADD on Trial: ‘Winning’ is Still Losing”

<u>DISABILITY</u>	<u>DEFINITION</u>	<u>HOW IT LOOKS</u>	<u>FILE HINTS</u>	<u>HOW DIAGNOSED</u>	<u>PROBLEMS & ISSUES</u>
A TTENTION	- "CHRONIC LIMITED ALERTNESS" - AFFECTS IMPULSE CONTROL &/OR VIGILANCE	- POOR FOCUS ON SPECIFIC TASKS - DISTRACTIBILITY	- SPECIAL ED CLASS OR LABEL: ADD, ADHD, SBD, OHI, SED - HAS AN IEP OR "504 PLAN"	- HISTORICAL INTERVIEW/FILE SEARCH: Evidence of ADD/ADHD in Childhood - INFORMATION PROCESSING BATTERY: Attending Behavior across Auditory and Visual Modalities	- READY, FIRE, AIM! - POOR PLANNING AND DECISION- MAKING SKILLS = IMPULSIVE ACTIONS/REACTIONS
D EFICIT	- MAY INVOLVE DISTRACTIBILITY - MAY INVOLVE IMPULSIVITY	- RANDOM OR UNPLANNED MOTOR RESPONSES: Overflow movements, wiggling, jerking, tics, off-task glances	- FAMILY HISTORY - OTHERS AFFECTED - WITH OR WITHOUT ACCOMPANYING LEARNING DISABILITIES	- VARIABLES OF ATTENTION IN HIGH AND LOW-STIMULUS CONDITIONS:	- IMMATURE COGNITIVE STRATEGIES = RANDOM BEHAVIOR
D ISORDERS	- WITH OR WITHOUT HYPERACTIVITY: High Activity Level + Random or Purposeless Behavior	- BEHAVIOR PROBLEMS: Immaturity, Lability, Impulsivity, Inattention, Disruptiveness	- "CONFIDENTIAL" GUIDANCE OR PSYCHIATRIC FILE - MEDICAL PRESCRIPTION FOR ATTENTION BOOSTING MEDICATION: Ritalin, Cylert, Dexedrine	- WITH OR WITHOUT ACCOMPANYING LEARNING DISABILITIES	- MEDICAL MANAGEMENT AND OFF-DRUG TRANSITION - OFF-TASK BEHAVIOR IN CLASSROOM VERSUS INFORMAL SETTINGS - DUAL DIAGNOSIS WITH OTHER DISABILITIES

ADD On Trial: “Winning” is Still Losing

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Over the past ten years, cases of diagnosed Attention Deficit Hyperactivity Disorder (ADHD) and related information processing deficits appear to have increased in frequency, not only in the general population, but among criminal defendants. Accordingly, criminal justice professionals now require additional information to recognize and accommodate these cognitive differences and to better understand how disorders of attention impact human behavior. The following case studies represent three young men with similar attentional disorders, but different advocacy needs with courts, juries, and/or corrections. Each was provided extensive services, including psychoeducational assessment, case analysis, and/or expert testimony, in hopes of promoting fairness for all clients through a more enlightened criminal justice system.

Personalizing ADD/ADHD: Case Studies

Chris is a 20 year old defendant with documented behavioral issues since toddlerhood, and subsequent diagnosis of ADHD in early elementary school. No long-term medical solution was ever put into effect due to the family's instability. Here, after being abandoned by his parents as a preschooler and again by his grandparents at the age of 14, Chris was placed in a succession of 21 foster care and institutional settings. While in placement, the youth's maladaptive behavior escalated to the point that he accumulated six arrest petitions and was remanded to the California Youth Authority by the age of 17. Now a young adult, Chris had violated a court restraining order and found himself in the County Jail, where he quickly established a negative reputation. On the day of his recent assessment, he had just been released from a month of solitary confinement for a minor disciplinary infraction. Jailers characterized Chris as a troublemaker who would periodically enter and exit the correctional system “like a revolving door”.

Testing for this client revealed a classic and ongoing ADHD condition characterized by impulsivity, response inconsistency, and distractibility. Although a young adult, he still lacked self-control strategies despite numerous and varied social interventions. This was probably because parents and schools had “dropped the ball” when it came to appropriate medical intervention; and former hospital placements, as well as his present correctional setting, had chosen to deal with him by prescribing tranquilizer medications which rendered him stuporous much of the time. As a result, Chris was never adequately tested to obtain an accurate representation of his learning profile and complex attentional issues. Records contain no indication that any educational or therapeutic placement attempted to 1) assist in medical management of his ADHD condition, 2) teach cognitive behavior modification (CBM) techniques designed to empower him to direct and monitor his own actions, or 3) structure the environment to accommodate his escalating, disability-based behavior problems. In one of its final reports related to the “Chris problem”, his school district provided only sparse and rather pathetic recommendations including “consideration” of programs in the “least

restrictive environment", nebulous "other interventions" to assist with behavior and growing emotional problems, and a suggestion to his caregivers: "...check on the location of his glasses." What followed was a total abdication of responsibility to the local Mental Health Department which responded by arranging the string of out-of-home placements mentioned above. While in these court-ordered placements, Chris was subjected to countless rounds of group and individual therapy, tranquilizer medications, medical tests for defective thyroid function (which proved inconsequential), shortened day assignments, and eventually, classroom suspension, all of which failed to effect positive change. At the time of the March, 1999 evaluation arranged by his attorney, Chris had never participated in any court, school, correctional, or social program which considered his ADHD in both the diagnostic and prescriptive phases of assessment.

*Now 17, **Andrew** was retried earlier this year for the murder of his sister which occurred when the youth was only 14½ year of age. The youngster had a long-standing diagnosis of ADHD and had been taking Ritalin prior to a recent relocation to live with his father's "new family" in Virginia. He entered his new home on shaky ground, having been banished by his natural mother due to escalating behavior problems. Although drug therapy in his former school setting was successful, Andrew's father never refilled the prescription, thus the youth began high school in his new location without this support. Within two weeks, he received a suspension notice for a rules violation, and arrived home early to nervously await his fate. At this time, the youngster accessed a loaded shotgun from his father's bedroom closet and took it to his room. Three gunshots were fired that afternoon, the first of which surprised Andrew as it went through his mattress and into the floor below. The additional shots also appear to be the result of a succession of random and clumsy movements which are typical of children with ADHD: one of these went through his bedroom ceiling while the other resulted in his sister's death. This youngster was tried as an adult, found guilty of purposeful murder, and sentenced to 17 years in a state prison for adults. Were it not for his grandparents' work to reveal several instances of juror bias, this verdict would not have been overturned. His attention deficit condition was raised as a mitigating factor for the first time during the 1999 appeal of his murder conviction.*

Advocacy for this client included a thorough review of school and medical records, as well as the inservice education of Andrew's appeal attorneys to insure that they were familiar with all aspects of this disability condition. As such, his report focused on defining attentional deficits like ADD/ADHD as "chronic limited alertness" and associating them with other medical disorders which may fall under the broader heading, Physical Handicaps (e.g., Other Health Impairments). Childhood indicators of the condition were reviewed as far back as his preschool years, where the boy was described as able to "destroy a room faster than you could believe!" It was suggested that medical attention for this condition should have been sought well prior to junior high, when failure

behaviors and attitudes had become well established in this youngster. Next, proper assessment of information processing, as well as variables of attention was outlined. Here, discussion focused on specific analysis of “breakdowns” which may occur at information intake, organization and storage, retrieval, and/or expression. It was further observed that ADD tends to interfere with initial intake, and that this may manifest throughout the processing chain. In other words, not paying attention at intake is likely to impact organization, storage, retrieval, and expression via “cascade-effect”. Specific variables of attention, as measured by the Test of Variables of Attention* (TOVA), were also defined as follows:

- **Omissions** of attention are distractions and/or lapses in vigilance over the length of a task. Omissions tend to produce a pattern of cycling attention which, in turn, results in spotty knowledge, incomplete intake of directions and/or information, and partial learning of academic content. *Omissions* are the most recognized attentional deficits, tending to occur in younger and/or lower IQ test subjects.
- **Commissions** are false positives associated with impulsive and/or random behavior. This dimension describes an individual’s ability to inhibit himself and his physical actions. High *Commissions* usually involve random, purposeless, and/or clumsy reactions which seem outside of the physical control of the test subject.
- **Reaction Time** is simply the amount of time it takes for a person to formulate and produce responses to desired stimuli. *Reaction Time* is measured over task conditions which change from low-stimulus (infrequent) to high-stimulus (very frequent) conditions.
- **Variability** refers to the consistency of reaction time and intensity across test conditions. As such, this measure helps explain changes in frequency of Omissions and Commissions in test subjects, as well as functional variations in performance over time.

Since no TOVA results were obtainable for this client, this analysis relied on statements of his parents, teachers, and medical professionals which documented and described his ADHD condition. For example, his grandfather described Andrew as inattentive (Inattention = high *Omission* rate), stating that he was “fine for a few minutes... then it was like talking to a wall.” Reports from school personnel also described *Omission* errors related to distractibility which interfered with task vigilance and concentration over time. The youngster’s *Commission* errors were documented as random or clumsy “overflow” movements associated with spatial and timing misjudgments, as well as failure to consistently envision probable consequences of his actions.

* For additional TOVA information, contact Universal Attention Disorders at 1-800- PAY-ATTN.

Individuals with these impairments often require extended time to think through their impulsive actions, make sense of them, then plan and initiate remedial actions. Finally, evidence was reviewed which indicated that Andrew's responses were marked by lapses in both *Response Time* and *Variability*. Review of TOVA variables contributed information that became important in making sense of the boy's seemingly odd and undirected post-crime behaviors. These included taking his sister's body into the bathroom (to access first aid?); his preoccupation with cleaning the carpet as well as completing several assigned household chores (thought to promote internal organization); and his eventual, though almost completely forgotten, flight to a nearby wooded area where he remained cold, wet, and without food until reappearing back at home the next afternoon.

Along with the information processing analysis, TOVA discussion helped to depict the possibility that 14 year old Andrew could not mentally accommodate the horrible results of random and impulsive actions that remained outside of his physical control. Much of the shocking scene that followed may not have been fully encoded, leaving informational gaps at intake. It is also likely that the youngster's attention may have cycled as he tried to organize and store information about the shooting, thus rendering the final information processing phase, retrieval/expression, clearly dysfunctional during the ensuing videotaped police interview. In fact, the interviewing officer did a superb job using probe questioning to "jog" the youth's memory of facts and details related to the previous afternoon's events. However, due to the processing and *Omission* errors noted above, it remains possible that some details and information derived from their reciprocal conversation were mere conjecture on Andrew's part, i.e., "fillers" of informational gaps which would bring some modicum of internal closure for the boy while at the same time, pleasing the officer. Here, regardless of the interviewer's dedication to duty, we must question his decision to interview a distraught 14 year old with a known history of attentional deficits, without an advocate present to facilitate and monitor accurate two-way communication. The interview also took place without the presence of legal counsel.

A final area which required discussion in advocating for Andrew concerned normal vs. atypical adolescent development. Here, attorneys were familiarized with the development of cognitive strategies which typical teens utilize to assist information processing. These "memory tricks" include strategies such as "verbal rehearsal" where an individual repeats information sequences to himself until verbal expression is required, "chunking" parts of the whole for easier initial encoding, and "clustering" like pieces of information together for easier storage and retrieval. None of these techniques are actually taught to us, but appear to develop naturally in typical 12 to 14 year old children. Importantly, research with adolescents who have cognitive deficits such as ADHD indicates that they may require an additional two or more years to begin developing such strategies, take longer to stabilize them, then tend to discard them even though they may prove effective for accessing certain desirable outcomes.

Thus, it is probable that at only 14 years of age, Andrew had not achieved the level of cognitive development we might expect simply looking at his outward presentation. Certainly, cognitive immaturity affected his actions related to and following the shooting incident, as well as during the subsequent police interrogation. In this particular interview, the officer knew of Andrew's ADHD condition, but took no action to call an appropriate advocate for the youth. What he did instead was to offer friendship and understanding ("You're the only boy, huh?... That's got to be kind of tough"), apply many prompts to recall the previous day's events ("Well, what's the next thing you remember after you hung up the phone with her... Then what did you do?"), and provide discrete pieces of information to fill in memory gaps ("Well, when she was in your room yesterday... *were the two of you talking in there?*"; "What did you have to clean up - *did you drop something?*") These techniques were highly effective in getting the boy to talk for hours; however, knowing the nature of *Omission* and *Commission* errors inherent in ADHD as a syndrome, the accuracy of his recall and statements remains questionable even today.

Carl faced the death penalty having been found guilty of the robbery-murder of a convenience store cashier. As the lone assailant, all of his actions were video-and/or audiotaped via store surveillance equipment. Here, the 21 year old ADHD client can be seen entering the stimulus-laden environment and approaching the counter where he attempts to purchase cigarettes. He alternately stares at the counter and at another uncluttered surface, presumably in order to gather his wits and proceed with the robbery. He then orders the cashier onto the floor, face down, while he empties money from the register. As Carl steps behind the counter for this purpose, he is out of camera range, but can be clearly heard demanding time and time again that the clerk remain still and lie face down on the floor. After several minutes of repeated pleas of this sort, two shots are heard, followed by Carl's final comment before fleeing: "Stupid m— f—."

On the surface, Carl's case looked like a lost cause, even from the most optimistic defense attorney's perspective. This attractive, biracial young man had been a basketball star throughout his school career and was never enrolled in special education. Additionally, although parents, teachers, and coaches recalled many behaviors consistent with ADHD, the family had refused medical intervention in the form of drug therapy for the condition. His court-ordered cognitive assessment revealed an IQ in roughly the normal range, and only borderline Learning Disability qualification in a few academic splinter skills. However, his ADHD condition was clearly observable in the various jail settings accessed for assessment purposes. For example, only minimal impulsivity was observed when Carl was tested in a private cubicle facing a blank wall on Day 1; but he fell apart completely when tested at an interview "counter" in the main attorney room on Day 2. Here, he was observed to scatter his focus to any and all external stimuli, with particular difficulties whenever any form of visual distraction occurred. Since he was facing the entry door where there was much inmate and guard activity, he remained virtually untestable in this highly charged setting. Accordingly, Day 3 was arranged in a private office inside the medical unit of the jail where only

minimal outside distractors could impact his concentration. Still, he was observed to monitor the most minimal visual stimuli outside the room's small window, requiring redirection to task following any such occurrence. Carl also required external "transitioning" across tasks, following breaks, and even where significant body position changes occurred. Finally, when a gnat entered the test area, he could not focus on tasks until it was eliminated. With distractibility of this magnitude, TOVA assessment became imperative for this client.

The TOVA print-out not only verified an ADHD diagnosis, but analysis further suggested that neurological assessment was in order due to his high *Omissions* rate (Standard Score <25). *Reaction Time* was deviant due to its slowness (SS of 28), while *Response Variability* was high (SS <25). In addition, information processing testing verified extreme variability and performance cycling in the face of not only visual, but also auditory distractors. Here, distractibility occurred whenever any extraneous noise occurred, such as a door closing or distant conversation. In some cases, Carl could not recall *any* information just presented to him following such an occurrence, so the entire test item was repeated. Thus, the information processing age scores obtained in this assessment (12 and 13 years), were assisted by repetitions which would not be likely to occur in everyday life. Carl's cognitive deficit profile helped to explain his initial confusion upon entering the high stimulus store environment and his need to "recover" cognitively by limiting visual distractors. It also regarded his pleading demands of the noncompliant victim, and his final impulsive decision to shoot him. Carl's final recorded statement appeared to rebuke the clerk for his "stupid" decision to defy orders: he was found lying face up, more than ten feet away from the initial counter location.

Carl's family, friends, and particularly his basketball coach recalled consistent observations of attentional issues which interfered with performance consistency. For example, his coach recalled numerous instances where he would set up a play during time-out and send the team back on the court, only to find Carl out of position or otherwise unprepared to do his part. In these instances, teammates covered for him until the information "kicked in". Both the coach and teammates came to expect that Carl "would have to go through and screw it up once" before he could transition to the new play. Other episodes of distractibility during game time were handled simply by calling Carl's name or "grabbing his arm" to prompt and direct attention. The coach's recollection that "something" interfered with continuity and decision-making in this player was interesting in light of the findings of the current assessment. Data derived from these psychoeducational tests helped to quantify and qualify that nebulous "something" precisely and to explain it to the penalty phase jury. Due to this and other advocacy on behalf of the client and his family, Carl was granted life without parole when the jury "hung" 8 to 4 in opposing the death penalty.

Trial Advocacy: What Courts Need to Know

The three cases presented above represent differential advocacy needs in the courtroom, yet all required explaining ADD/ADHD to those in decision-making positions. In Chris' case, variability and impulsivity related to his ADD condition was finally explained, with information offered that would affect future placement and treatment options. The Court in this matter needed to understand what can result when severe ADHD goes medically untreated in childhood and continues to be ignored through adolescence and into adulthood. Like many untreated children, Chris never developed self-monitoring strategies with which to ameliorate escalating problems during task vigilance. For example, during the low stimulus TOVA condition, he attempted conversation with the Examiner which interfered only minimally with consistency during task vigilance. However, once the high stimulus condition began, his attempts at conversation became more problematic. Unable to look away from the computer screen for fear of missing a target, he continued to ask questions and make off-hand comments, but these were far out-numbered by self-regulating remarks ("Caught myself again!"; "I don't know why I pushed the button -- I didn't even want to!") Many times, his poorly timed comments were followed almost immediately by a near miss ("Oh shoot -- I almost missed it!") but this lesson appeared to be lost on Chris. Thus, failure to teach self-regulating strategies and behavior to this client *as a child* have resulted in an immature and ineffective adult style which requires and can now benefit from medical intervention. If Chris' brush with the criminal justice system accomplishes this outcome, then perhaps the "revolving door" prediction can be averted.

Andrew's case presented an opportunity to educate the Court and jury about ADD/ADHD and other developmental issues related to very young offenders. This client had much to gain through such advocacy, and could have walked away a free teenager if his sister's death were ruled accidental. In that the 14 year old Andrew was no longer available for assessment or questioning, a written analysis presented to the Court the possibility that the shooting could have resulted from clumsy, random, and/or unplanned actions which were disability-based. It was further proposed that unraveling Andrew's *intent* presented a virtual impossibility, even for professionals with much expertise in ADD/ADHD and related cognitive disorders, and remained well outside the expertise of the layperson. Unfortunately, the judge in this matter refused to allow funding or the time extension needed to present such testimony.

"Winning" LWOPP

Carl's case was successful from a trial attorney's perspective, in that he got Life **With**Out the **P**ossibility of **P**arole in lieu of the death penalty. Although his grateful family cried tears of joy at this decision, it should be evaluated critically considering probable outcomes for this and other disabled clients. First among our concerns is the fact that treatment for ADD/ADHD is virtually nonexistent in California correctional settings. Here, Ritalin, Cylert, and other such medications are restricted prescriptions which are not administered to inmates. We know of several cases where adult prisoners with attentional disorders were drugged with antipsychotic medications to "calm" them, with potentially disastrous effects. Gene is one such prisoner who was prescribed Lithium

to ameliorate behaviors associated with his long term ADHD diagnosis. Unfortunately, corrections staff knew little about the potential side effects of this and other heat-sensitive medications until Gene suffered a seizure in the hot exercise yard. Since then, he has experienced intermittent seizures for which he understandably desires medical information and reassurance. However, since Gene also suffers from a Learning Disability which renders him illiterate, he requires staff assistance to fill out prison forms requesting medical appointments, and this has apparently become an administrative annoyance. Thus, Gene has been branded a “pest” and admonished that he may only ask one medical question per month related to his prison-imposed seizure condition.

Inmates like Carl can look forward to little or no actual treatment related to their disability conditions. Indeed, Reception Centers assess certain skills in incoming prisoners such as academic (as per a multiple-choice format test) or vocational ability, but final placement decisions are far more concerned with an inmate’s security rating due to past convictions, his commitment offense, and social affiliations (e.g., gang membership). Thus, a client like Carl is likely to end up in a maximum security housing unit such as the notorious “SHU” at Corcoran and Pelican Bay. These placements require in-cell isolation for up to 23 hours per day, with one hour allotted for solitary recreation. Under these conditions, no educational, vocational, or other programming is accessible, regardless of disability verification in the Central file.

Even if an inmate is housed with the general population, as a “lifer” he may be barred from certain beneficial and/or therapeutic activities. For example, Tony is serving a life sentence at Corcoran Prison, with classification that does not allow him to obtain vocational training which will lead to gainful employment. A model prisoner, Tony has now qualified to take the GED examination in order to obtain his high school diploma. However, several months following this qualification, his instructor had neither requested nor arranged test administration.

These and other inmates with special education qualification are out of luck in the California prison system, in that no formal offerings exist. Despite losing several recent class action lawsuits related to disability accommodation in prison populations, the California Department of Corrections (CDC) has not taken appropriate steps to assure that special needs are met, even for those prisoners below the age of 22 years and who have current school classification at the time of incarceration. In that more commonly understood disorders such as Deafness or Mental Retardation are not being appropriately accommodated in educational and vocational programs, at hearings, or in daily prison life, it remains unlikely that ADD/ADHD will fare any better without major changes in the correctional system. As mentioned above, one avenue to change appears to be through litigation based on the Americans with Disabilities Act of 1990*; but even where successful, administrative remedies have been slow in coming. There has also been interest on the part of certain California Legislature subcommittees in overseeing and monitoring the CDC more closely where disability-related issues are concerned. All agree that much training in identifying and accommodating cognitive disabilities is needed in corrections and parole, thus it is hoped that the Courts and/or Legislature can and will be instrumental in making positive change a reality. Until then, “winning” for ADD/ADHD and other disabled defendants is still “losing” as they enter a closed system which neither understands nor accommodates their individual differences.

* For full text of Judge Wilkin’s Findings of Fact and Conclusions of Law in the *ARMSTRONG V. DAVIS* disability rights lawsuit, visit the Northern District of California Web Site at: www.cand.uscourts.gov

The ABCs of Disabilities, Special Education, and Advocacy

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ACLD	Association for Children and adults with Learning Disabilities
ADA	Americans with Disabilities Act of 1990
ADD	Attention Deficit Disorder
ADHD	Attention Deficit (with) Hyperactivity Disorder
ADD/WO	Attention deficit without hyperactivity, or “Undifferentiated ADD”
APA	American Psychiatric Association
APE	Adapted Physical Education
ARC	Association for Retarded Citizens
ASHA	American Speech-Language-Hearing Association
AT	Assistive Technology
ATD	Assistive Technology Device
ATS	Assistive Technology Service
BD	Behavior Disordered
CASE	Council of Administrators of Special Education
CBM	Curriculum-Based Measurements <u>OR</u> Cognitive Behavior Modification
CEC	Council for Exceptional Children
CFR	Code of Federal Regulations
CH	Communicative Handicaps (Include: deaf, deaf-blind, and hard of hearing; severe language impairments such as aphasia; articulation defects)
CLD	Council for Learning Disabilities
CNS	Central Nervous System
CP	Cerebral Palsy
DD	Developmental Disability (A severe, chronic mental and/or physical disability beginning before age 18, likely to continue indefinitely, and affecting one or more major life function or activity)
DE	U.S. Department of Education
DHHS	Department of Health & Human Services
DLD/CEC	Division for Learning Disabilities/Council for Exceptional Children
DSM	Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association publication and guide)
ED	Emotionally Disturbed
EH	Educationally Handicapped
EHA	Education of the Handicapped Act of 1975
ER	Educationally Retarded (formerly Educable Mentally Retarded-EMR)
FAPE	Free, appropriate, public education
FERPA	Family Educational Rights and Privacy Act

IDEA	Individuals with Disabilities Education Act, amended 1997
IEP	Individualized Educational Plan
IEPT	Individualized Educational Plan Team
IFSP	Individualized Family Service Plan
ILP	Individualized Learning Plan
IRA	International Reading Association
IWEN	Individual With Exceptional Needs (all disabilities)
LAS	Language and Speech Impairments
LD	Learning Disability (includes dyslexia, dyscalculia, dysgraphia, and information processing deficits that interfere with academic and social learning)
LDA	Learning Disability Association (formerly the ACLD)
LEA	Local Education Agency (school district or local planning unit)
LEP	Limited English Proficient
LH	Learning Handicaps (Include: mild mental retardation and specific to pervasive Learning Disabilities)
LRA	Least restrictive alternative (least severe <i>treatment</i> option)
LRE	Least restrictive environment (least segregating <i>placement</i> option)
MBD	Minimal Brain Dysfunction
MCO	Managed Care Organization
MR	Mental Retardation
NAPAS	National Association of Protection and Advocacy Systems
NASP	National Association of School Psychologists
NCLD	National Center for Learning Disabilities
NICHHD	National Center of Child Health and Human Development
NIH	National Institute of Health
OCR	Office of Civil Rights
ODS	Orton Dyslexia Society
OH	Orthopedically Handicapped
OHI	Other Health Impairment
OSEP	Office of Special Education Programs
OSERS	Office of Special Education and Rehabilitative Services
OT	Occupational Therapy
P&A	Protection & Advocacy
PDD	Pervasive Developmental Disorder
PLD	Pervasive Learning Disability
PH	Physical Handicaps (Typically include: blind and partially sighted; cerebral palsy; all orthopedic handicaps; short-term disabling illnesses; epilepsy; other health impairments such as cancer, AIDS, diabetes, and ADHD)
PL94-142	Public Law 94-142: Education for all Handicapped Children Act of 1975
PS	Partially Sighted
PT	Physical Therapy

RC	Regional Center (for Developmentally Disabled California consumers)
RSP	Resource Specialist Program (partial-day school-based service option)
SDC	Special Day Class (full day school-based service option)
SEA	State Education Agency
Sec. 504	Section 504 (the anti-discrimination statute) of the Rehabilitation Act of 1973
SED	Severely Emotionally Disturbed
SLD	Specific Learning Disability
SH	Severe Handicaps (Typically include: lower levels of mental retardation; severe emotional disturbance; autism; multiple handicaps)
TBI	Traumatic Brain Injury
TMR	Trainable Mentally Retarded
VH	Visually Handicapped
VR	Vocational Rehabilitation

SPECIAL EDUCATION ABC'S

School cumulative record folders of identified special education students may include terms and acronyms such as the following:

Basic Category of Exceptionality:

- * PH Physically Handicapped
- * CH Communicative Handicap
- * SH Severe Handicap
- * LH Learning Handicap

Specific Diagnosis:

- * LD Learning Disability
- * EH Educationally Handicapped
- * EMR Educable Mentally Retarded
- * TMR Trainable Mentally Retarded
- * ER Educationally Retarded
- * BD Behavior Disordered
- * SED Severe Emotional Disturbance
- * OHI Other Health Impairment
- * OH Orthopedic Handicap
- * HOH Hard of Hearing
- * VH Visually Handicapped
- * S/L Speech/Language Disorders

General Diagnosis:

- * IWEN Individual With Exceptional Needs (All disabilities)

School-Based Service Contract:

- * IEP Individualized Educational Plan/Program
- * ILP Individualized Learning Plan
- * IFSP Individualized Family Service Plan

Services Provided:

- * DIS Designated Instructional Services
- * LAS Language and/or Speech Services
- * APE Adaptive Physical Education
- * PT Physical Therapy
- * OT Occupational Training/Therapy
- * VR Vocational Rehabilitation

Where Services were provided:

- * SDC Special Day Class
- * RSP Resource Specialist Program
- * HH Home/Hospital Services
- * RCP Regular Class Program

STATE AND NATIONAL RESOURCE LISTING

Abledata (Adaptive Equipment)
800/344-5405

AIDS Information
800/342-2437

Alliance for Technology Access
415/428-0747

Alzheimer's Disease and Related Disorders
800/272-3900

American Asssoc. On Mental Retardation
800/424-3688

American Cleft Palate Educational
Foundation
800/242-5338

American Counsel of the Blind
800/424-8666

American Foundation for the Blind
800/232-5463

American Diabetes Association
800/232-3472

American Kidney Fund
800/638-8299

American Liver Foundation
800/223-0179

American Paralysis Association/Spinal Cord
Injury
800/526-3456

American Parkinson's Disease
800/223-2732

American Self-Help Clearinghouse
201/625-7101

America Speech, Language, Hearing Assoc.
800/ 638-8255

Architectural and Transportation Barriers
Compliance Board
800/872-2253

Association for the Care of Children's
Health
301/654-6549

(The) Association for Persons with Severe
Handicaps (TASH)
206/361-8870

Association for Retarded Citizens of the
United States
800/433-5255

Autism Services Center
304/525-8014

Autism Society of America
301/565-0433

Better Hearing Institute-Hearing Helpline
800/327-9355

California Self-Help Center Registry
800/222-5465

Cancer Information Services National Line
800/422-6237

Captioned Films for the Deaf
800/237-6213

Center for Disease Control
404/639-3311

Center for Missing and Exploited Children
800/843-5678

Center for Special Education Technology
Information Exchange
800/426-2133

Child Abuse
800/422-4453

Clearinghouse on Disability Information
202/732-1241

Cornelia de Lange Syndrome Foundation
800/223-8355

Cystic Fibrosis Foundation
800/344-4823

ERIC- Educational Resources Information
Center
800/848-4815

Educators Publishing Service-Specific
Language Disabilities (Dyslexia)
800/225-5750

Ehlers Danlos Syndrome
313/282-0180

Epilepsy Foundation of America
800/332-1000

Estate Planning for Persons with Disabilities
800/448-1071

Family Survival Project (Cal. Only)
800/445-8106

Federal Student Aid Information Center
800/433-3243

Higher Education and the Handicapped
Resource Center
800/544-3284

Huntington's Disease
800/345-4372

International Shriner's Headquarters
800/237-5055

Juvenile Diabetes Foundation International
800/223-1138

Job Accommodation Network
800/526-7234

Learning Disability Association
412/341-1515

Library of Congress National Library Service
for Blind and Physically Handicapped
800/424-8567

Lung Line (Lung disorders, allergies)
800/222-5864

Muscular Dystrophy Association
609/529-2000

National Alliance of Blind Students
800/424-8666

National Alliance for the Mentally Ill
800/950-6264

National Amputation Foundation
718/767-0596

National Arthritis Foundation
404/872-7100

National Association for Developmental
Disability Councils
202/347-1234

National Association for Hearing and Speech
Action
800/638-8255

National Association for Sickle Cell Disease
800/421-8453

National Captioning Institute, Inc.
800/533-9673

National Center for the Blind
800/638-7518

National Center for Learning Disabilities
212/687-7211

National Center for Youth with Disabilities
800/333-6293

National Committee for Citizens in
Education
800/638-9675

National Crisis Center for the Deaf
(TDD ONLY) **800/446-9876**

National Down Syndrome Congress
800/232-6372

National Easter Seal Society
800/221-6827

National Head Injury Foundation
800/444-6443

National Health Information Center
800/336-4797

National Information Center for Children
and Youth with Handicaps
800/999-5599

National Information System for Health
Related Services
800/922-9234

National Multiple Sclerosis Society
800/624-8236

National Organization for Rare Disorders
800/999-6673

National Organization on Disability
800/248-2253

National Prosthetic Orthotics Association
718/767-8400

National Rehabilitation Information Center
800/346-2742

National Sexually Transmitted Diseases
Hotline
800/227-8922

National Special Needs Center
800/833-3232

National Spinal Cord Injury Association
800/962-9629

Orton Dyslexia Society
800/222-3123

Parent Educational Advocacy Training
Center
800/869-6782

Parents Helping Parents
408/288-5010

Prader Willi Syndrome Association
800/926-4797

Recoding for the Blind, Inc.
609/452-0606

Retinitis Pigmentosa Association
800/344-4877

Runaway Hotline
800/231-6946

Sibling Information Network
203/282-7050

Social Security Administration
800/772-1213

Special Education Software Center
800/327-8922

Special Needs Information and Referral
Center
800/426-2133

Special Olympics
202/628-3630

Spina Bifida Association of America
800/621-3141

Spinal Cord Injury Hotline
800/526-3456

Technical Assistance for Parent Programs
617/482-2915

Tourette Syndrome Association
800/237-0717

United Cerebral Palsy Association
800/872-1827

CALIFORNIA

Association for Retarded Citizens/California
120 "I" Street, 2nd Floor
Sacramento, CA 95814
916/552-6619

California State Department of Education
Special Education
515 "L" Street, Rm. 270
Sacramento, CA 95814
916/445-4613

California Department of Developmental
Services, Health & Welfare Agency
1600 9th Street NW, 2nd Floor
Sacramento, CA 95814
916/654-1897

California State Council on Developmental
Disabilities
2000 "O" Street, Rm. 100
Sacramento, CA 95814
916/322-8481

California Protection and Advocacy, Inc.
100 Howe Avenue, Suite 185N
Sacramento, CA 95825
916/488-9950

Disability Rights Education and Defense
Fund (DREDF)
2212 6th Street
Berkeley, CA 94710
510/644-2555

Learning Disability Association of California
655 Lewelling Blvd., #355
San Leandro, CA 94579
415/383-5242

Youth Law Center
114 Sansome Street, Suite 950
San Francisco, CA 94104
415/543-3379

OTHER

National Information Center for Children
and Youth with Disabilities
P.O. Box 1492
Washington, D.C. 20013-1492
202/884-8200

The Sentencing Project
918 F Street NW, Suite 501
Washington, D.C. 20004
202/628-0871

EDUCATIONAL DIAGNOSTICS

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