

Detained Juvenile Offenders with Substance Abuse Treatment Needs: An Examination of Associated Legal Issues

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I. Introduction

Juvenile delinquency and substance abuse are issues that separately receive a great deal of attention and debate.¹ Law enforcement officials, politicians and communities view these issues as major concerns because of their potential impact on crime rates and the welfare and safety of society.² Because both juvenile delinquency and substance abuse raise such concerns independently, it is not surprising juvenile offenders who engage in substance abuse cause particular apprehension and debate.

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¹ Drug use is prevalent among juveniles. A national survey conducted in 2001 found that 4.9 million youth between the ages of twelve and seventeen used illicit substances during the past year and more than a million youth were determined to have a substance dependence disorder. Gary M. McClelland et al., *Detection and Prevalence of Substance Use Among Juvenile Detainees*, OFF. JUV. JUST. & DELINQ. PREV. 2 (June 2004). In addition, as described below, more than 2 million juveniles are arrested each year. Howard N. Snyder, *Juvenile Arrests 2001*, OFF. JUV. JUST. & DELINQ. PREV. 12 (Dec. 2003).

² ROBERT D. HOGE, THE JUVENILE OFFENDER: THEORY, RESEARCH AND APPLICATIONS 1-4 (2001); PANEL ON JUVENILE CRIME: PREVENTION, TREATMENT, AND CONTROL, NATIONAL RESEARCH COUNCIL AND INSTITUTE OF MEDICINE, JUVENILE CRIME, JUVENILE JUSTICE 13 (2001); Scott W. Henggeler et al., *Four-Year Follow-Up of Multisystemic Therapy With Substance-Abusing and Substance-Dependent Juvenile*

“Juvenile offender” is not a phrase with a universally accepted definition.³ A juvenile offender is someone below a specified age who has committed a delinquent act or a status offense, but what constitutes a prohibited behavior and the age cut-off vary from jurisdiction to jurisdiction.⁴ For example, “status offenses” involve prohibitions that apply only to juveniles and not to adults, but jurisdictions differ on the behavior encompassed and the sanctions invoked.⁵ Thus, the actions of a juvenile might trigger a judicial response in some jurisdictions but not in others. Similarly, while “juvenile” typically encompasses persons seventeen-years-old or less, in a number of states an individual must be sixteen or under to be considered a juvenile, and in a few states the individual must be fifteen or under.⁶ In addition, considerable discretion exists within most juvenile justice systems regarding whether to intervene with a given juvenile.⁷

Despite these variations, information exists on the number of juvenile offenders in the United States. It is estimated that out of over 70 million juveniles in this country, 2.3 million were arrested in 2001.⁸ Many of these juveniles were alleged to have committed status offenses or relatively minor crimes, and those who were arrested for more serious crimes were generally involved in property crimes rather than crimes against persons.⁹ Further, of the 1.9 million juveniles arrested in 1998, those who were actually found guilty and adjudicated as juvenile

Offenders, 41(7) J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 868, 868-69 (2002); Annaclare van Dalen, *Juvenile Violence and Addiction: Tangled Roots in Childhood Trauma*, 1(1) J. SOC. WORK PRAC. IN THE ADDICTIONS 25, 25 (2001).

³ HOGE, *supra* note 2, at 14.

⁴ *Id.*

⁵ *Id.* at 15. Examples of status offenses include truancy, curfew violations, and running away. *Id.*

⁶ Snyder, *supra* note 1, at 12 (in 2001, there were ten states where all seventeen-year-old individuals were defined as adults and three states where all sixteen- and seventeen-year-old individuals were defined as adults).

⁷ HOGE, *supra* note 2, at 14, 89.

⁸ Snyder, *supra* note 1, at 1. A drug abuse violation was the most serious offense charged in 202,500 of these arrests (an increase of 121% since 1992, which compares to an increase of 33% in adult arrests for this offense over the same time period), a liquor law violation in 138,100 arrests, drunkenness in 20,400 arrests, and driving under the influence in 20,300 arrests. *Id.* at 3, 10.

⁹ RICHARD J. LUNDMAN, PREVENTION AND CONTROL OF JUVENILE DELINQUENCY 5 (2001). Although juveniles accounted for 15% of all violent crime arrests in 2001 (and 17% of all arrests), the rate of juvenile arrests for violent crimes declined for the seventh consecutive year to its lowest level since 1983, was 44% lower than in 1994, and was five times less than the rate of juvenile arrests for property crimes. Snyder, *supra* note 1, at 5.

offenders numbered approximately 446,000.¹⁰ Of these juvenile offenders, those who were placed in a residential facility numbered about 109,000 in 1999.¹¹ Although many considerations go into a judicial decision to place a juvenile in a residential facility, these juveniles often tend to be involved in more serious infractions of the law.¹²

Just as there is no clearly established definition of juvenile offender, “substance abuse” is also somewhat amorphous.¹³ While the legal definition of substance abuse encompasses the use of a prohibited drug or using a prescription drug without a prescription or for nonmedical reasons,¹⁴ the medical definition denotes a more specific state of dependence “defined by criteria such as escalation of dosage and frequency, narrowing of the behavioral repertoire, loss of control over use, and continued use despite adverse consequences.”¹⁵ Generally referred

¹⁰ LUNDMAN, *supra* note 9, at 24.

¹¹ Melissa Sickmund, *Juveniles in Corrections*, OFF. JUV. JUST. & DELINQ. PREV. 3 (June 2004). In addition, on June 30, 2000, 7,600 youth younger than age eighteen were held in adult jails nationwide, where they constituted 1.2% of the total jail population, and in 1999 an estimated 5,600 youth younger than age eighteen were admitted to a state prison, which constituted 2% of all new prison admissions. *Id.* at 18, 19.

¹² *Id.* at 3, 8 (juveniles charged with a status offense comprised only 4% of the residents of juvenile residential placement facilities nationwide; among juveniles charged with a delinquent act, they were more likely to be placed in custody for an offense against a person (35% of the residents) than for a property offense (29%).

¹³ Alan E. Kazdin, *Adolescent Development, Mental Disorders, and Decision Making of Delinquent Youths*, in YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE 45 (Thomas Grisso & Robert G. Schwartz eds., 2000) (“Estimates of substance abuse [in adolescents] vary because of the age ranges sampled, the range of substances included (such as inhalants), the assessment methods (self report versus medical emergency visits), and the impact of many moderators (social class, ethnicity, and neighborhood).”).

¹⁴ There tends to be considerable variation within this legal definition as well, particularly with regard to substance abuse offenses by juveniles. For example, alcohol and tobacco are generally prohibited drugs for juveniles. However, enforcement of these prohibitions tends to be very uneven across jurisdictions and different from that for drugs that are also prohibited for adults. Thomas L. Hafemeister & Shelly L. Jackson, *The Effectiveness of Sanctions and Law Enforcement Practices Targeted at Underage Drinking That Do Not Involve the Operation of a Motor Vehicle*, in REDUCING UNDERAGE DRINKING: A COLLECTIVE RESPONSIBILITY 490 (Committee on Developing a Strategy to Prevent and Reduce Underage Drinking, Richard J. Bonnie & Mary Ellen O’Connell eds., National Research Council & Institute of Medicine of the National Academies, 2004).

¹⁵ David A. Boyum & Mark A. R. Kleiman, *Substance Abuse Policy from a Crime-Control Perspective*, in CRIME: PUBLIC POLICIES FOR CRIME CONTROL 331, 378 (James Q. Wilson & Joan Petersilia eds., 2002).

to as a disorder rather than use or abuse, this dependence can be psychological, physical, or both, and arises in the person after administration of the drug on either a periodic or continual basis.¹⁶ Although the characteristics of dependence can be a function of the drug involved, addiction is often characterized by tolerance (a need to increase dosage) and habituation (psychological dependence), as well as physical dependence.¹⁷

Whether a substance abuse problem must necessarily involve a clearly demonstrated addiction is an important question when it comes to an analysis of the treatment of detained juvenile offenders and states' obligation to provide such treatment. For instance, if a substance abuse problem is viewed as a mental disorder, as some mental health professionals approach it, rather than a purely voluntary act, there might be a correspondingly greater obligation on the state to provide treatment. As will be discussed, a great deal of the debate on how to categorize a substance abuse problem centers not on the symptoms of a particular individual but on how the phrase "substance abuse" is framed.¹⁸

This article will examine legal issues associated with the treatment of detained juvenile offenders who have substance abuse problems. The issues surrounding the treatment of these juveniles are difficult and unique because the juveniles often have a significant and immediate need for services, especially in the case of offenders with a history of drug abuse.¹⁹ At the same time, because of concerns that these

¹⁶ Charles Winick, *The Drug Offender*, in *PSYCHOLOGY OF CRIME AND CRIMINAL JUSTICE* 373 (Hans Toch ed., 1979).

¹⁷ *Id.*

¹⁸ Compare Kazdin, *supra* note 13, at 37 ("Substance Abuse Disorder: A set of disorders (depending on the substance) characterized by a maladaptive use of the substance as evident in recurrent and significant adverse consequences (such as failure to fulfill role obligations at school, work, or home, and social and interpersonal problems). A period of twelve months is required of use and its associated consequences and continued use after untoward consequences (such as in role performance, legal problems, school expulsion) have occurred.") with Sergei Tsytsarev et al., *The Use of Reinforcement and Punishment on Incarcerated and Probated Substance-Abusing Juvenile Offenders*, 44(1) *INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY* 22, 25 (2000) ("Substance abuse can be defined as a maladaptive coping response to life stressors that develops and is maintained through prior learning, situational antecedents, reinforcement contingencies, cognitive expectations, and biological influences that coexist and interact. Briefly, substance abuse is considered as a habitual replacement response for more adaptive coping.").

¹⁹ Henggeler et al., *supra* note 2, at 868-69.

juvenile offenders may show a life-long proclivity to criminal behavior and because substance abuse can be an enduring problem, the availability and effectiveness of this treatment can have long-term implications.²⁰ Furthermore, because these juveniles are often placed in the custody of a state juvenile justice department and become the legal responsibility of the state, many unique questions arise as to the authority of courts to order substance abuse treatment for them, the role of the courts in supervising or directing this treatment, the rights of juveniles and their parents with respect to the delivery of this treatment, and, most fundamentally, whether a right to substance abuse treatment exists in this setting and, if so, what are the parameters of this right.

After briefly addressing the prevalence of juvenile offenders with substance abuse problems, relevant treatment options, and the role of the juvenile justice system in general, this article will explore the broad range of legal issues that arise in conjunction with these offenders. Particular attention will be paid to the system of juvenile justice in the Commonwealth of Virginia, with specific focus given to the operation of the Virginia Juvenile and Domestic Relations Courts and the Virginia Department of Juvenile Justice (DJJ). Finally, this article will conclude with an assessment of how best to employ the juvenile justice system so as to provide more effective treatment options to this particularly visible and yet vulnerable population.

II. Prevalence of Substance Abuse Among Juvenile Offenders

Although the strength of the correlation is debated, substance abuse is found with great frequency among delinquent youths and without a doubt is one of the major risk factors associated with delinquency.²¹ Between July of 1997

²⁰ *Id.* at 873.

²¹ FRANCES LEXCEN & RICHARD E. REDDING, JUVENILE JUSTICE FACT SHEET: MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS 4 (2000); Khanh Van T. Bui, *Cross-lagged Relationships among Adolescent Problem Drug Use, Delinquent Behavior, and Emotional Distress*, 30(2) J. DRUG ISSUES 283, 283; David Huizinga et al., *Delinquency and Crime: Some Highlights from the Denver Youth Survey*, in TAKING STOCK OF DELINQUENCY: AN OVERVIEW OF FINDINGS FROM CONTEMPORARY LONGITUDINAL STUDIES 57 (Terence P. Thornberry & Marvin D. Krohn eds., 2003) (“One of the most robust empirical findings over the last several decades is the relationship between drug use and other delinquent behaviors.”); Kazdin, *supra* note 13, at 49; van Dalen, *supra* note 2, at 28.

Further, substance abuse was the predicate of the most serious offense faced by 16.8% (381,300) of the 2,273,500 juveniles arrested in 2001. See Snyder, *supra* note 1, at 3 (202,500 were

and June of 1998, over half of the youth admitted to detention facilities in the Commonwealth of Virginia had histories of substance abuse, including 62% of boys and 53% of girls.²² Further, it is estimated that over 40% of these boys and 35% of these girls can be categorized as having a high probability of drug and/or alcohol dependence.²³ A study of youth arrested and detained in Cook County, Illinois, found that 50.7% of the males and 46.8% of the females met the criteria for a substance abuse disorder, the most common psychiatric disorder found in the sample.²⁴ The prevalence of substance abuse and dependence among delinquents is at least five times that found among juveniles in general,²⁵ and roughly a quarter

arrested for drug abuse violations, 138,100 for liquor law violations, 20,400 for drunkenness, and 20,300 for driving under the influence). Because these statistics only focus on the most serious charge, it is likely that a substantial number of additional arrests involved substance abuse by the juvenile. Steven Belenko & TK Logan, *Delivering More Effective Treatment to Adolescents: Improving the Juvenile Drug Court Model*, 25 J. SUBSTANCE ABUSE TREATMENT 189, 190 (2003); Snyder, *supra* note 1, at 2.

²² EFFECTIVE TREATMENTS FOR THE MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS: A REFERENCE AND TRAINING MANUAL FOR JUVENILE JUSTICE PROFESSIONALS 86 (2001) [hereinafter EFFECTIVE TREATMENTS].

²³ Studying Treatment Options for Offenders Who Have Mental Illness or Substance Abuse Disorders: To the Governor and General Assembly of Virginia 47 (Committee of the Joint Commission on Behavioral Health Care, Virginia State Crime Commission and the Virginia Commission on Youth 2002) [hereinafter Studying Treatment Options].

²⁴ Linda A. Teplin et al., *Psychiatric Disorders in Youth in Juvenile Detention*, 59 ARCHIVES GEN. PSYCHIATRY 1133, 1135-36 (2002). See also Richard Dembo & James Schmeidler, *A Classification of High-Risk Youths*, 49(2) CRIME & DELINQ. 201, 212 (2003) (45% of arrested youth entering the juvenile justice system in Florida tested positive for cocaine, opiates, PCP, methamphetamines, or marijuana, with 14% testing positive on two or more drugs); Michael M. Faenza & Christine Siegfried, *Responding to the Mental Health Treatment Needs of Juveniles*, in FORENSIC MENTAL HEALTH: WORKING WITH OFFENDERS WITH MENTAL ILLNESS 32-2, 32-3 (Gerald Landsberg & Amy Smiley eds., 2001) (more than 60% of detained youth may have substance abuse disorders); McClelland, *supra* note 1, at 6 (85.4% of detained youth had used some kind of illicit substance in the past six months and 94% had used an illicit substance at some point in their lifetime).

It has also been asserted that the formal diagnostic criteria for substance abuse or dependence fail to encompass many youth with such a disorder, Deborah Deas & Himanshu Upadhyaya, *Crossing the Line: When Does Teen Substance Use Become Abuse or Dependence?* 2(7) CURRENT PSYCHIATRY (July 2003), at http://www.currentpsychiatry.com/2003_07/0703_substance.asp, and that there is a general underdetection of substance abuse among juvenile detainees, Sheryl Kataoka et al., *Mental Health Problems and Service Use Among Female Juvenile Offenders: Their Relationship to Criminal History*, 40(5) J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 549, 553 (2001).

²⁵ Kazdin, *supra* note 13, at 39 (analyzing existing studies, substance abuse and dependence was found to occur in 2-5% of adolescent community samples and 25-50% of adolescent delinquent samples).

of all institutionalized adolescent offenders had used alcohol or an illicit substance immediately before committing their offense or offenses.²⁶

Researchers have specifically examined the links between substance abuse and juvenile offenses.²⁷ One study found that juveniles who abused multiple drugs had the highest offending rates, while nonusers had the lowest rates.²⁸ For most offenses, multiple drug users were the most likely to commit a given offense, followed in descending order by marijuana users, alcohol users, and nonusers.²⁹ The study also found a clear relationship between offense type and the level of substance abuse, with juveniles who committed the most serious offenses having the highest rates of consumption of alcohol, marijuana, and multiple drugs.³⁰ In general, studies have found that delinquent youth initiate substance use at an earlier age and use drugs more frequently than nondelinquent youth, and that early onset and frequent use of drugs are positively associated with serious delinquency and violent behavior.³¹

Research indicates there is a wide variability in the patterns of substance abuse among juvenile offenders. This variability may reflect the range of psychosocial factors and underlying mental disorders associated with this abuse.³² What have been described as “less serious” substance abusers may follow a

²⁶ *Id.* at 49.

²⁷ See e.g., Thomas E. Keller et al., *Parent Figure Transitions and Delinquency and Drug Use Among Early Adolescent Children of Substance Abusers*, 28(3) AM. J. DRUG ALCOHOL ABUSE 399 (2002).

²⁸ DELBERT ELLIOTT, DAVID HUIZINGA, & SCOTT MENARD, *MULTIPLE PROBLEM YOUTH: DELINQUENCY, SUBSTANCE USE AND MENTAL HEALTH PROBLEMS* 56 (1989).

²⁹ *Id.* at 56-57. It was also reported that multiple drug users consistently have the highest prevalence and severity of mental health problems, with a relatively weak link found between mental health problems and alcohol and marijuana use. *Id.* at 63-86.

³⁰ *Id.* at 62-63. See also Huizinga et al., *supra* note 21, at 58 (“[S]erious offenders are substantially more likely to be drug users and to use drugs more often than are less serious offenders, and nondelinquents are less likely to use drugs than offenders of any kind.”).

³¹ David Huizinga & Cynthia Jakob-Chien, *The Contemporaneous Co-Occurrence of Serious and Violent Juvenile Offending and Other Problem Behaviors*, in *SERIOUS & VIOLENT JUVENILE OFFENDERS: RISK FACTORS AND SUCCESSFUL INTERVENTIONS* 48 (Rolf Loeber & David P. Farrington eds., 1998) (“There is a consistent finding across many empirical studies that as the seriousness of offending increases, so does the seriousness of drug use, both in terms of types of drugs used and in frequency of use.”); McClelland, *supra* note 1, at 2; Cathryn C. Potter & Jeffrey M. Jensen, *Cluster Profiles of Multiple Problem Youth: Mental Health Problem Symptoms, Substance Use, and Delinquent Conduct*, 30(2) CRIM. JUST. & BEHAV. 230, 231 (2003).

³² FRANCES LEXCEN & RICHARD E. REDDING, *JUVENILE JUSTICE FACT SHEET: SUBSTANCE ABUSE AND DEPENDENCE IN JUVENILE OFFENDERS* 1 (2000).

progressive pattern that begins with alcohol consumption, expands to marijuana use, and is then followed by the use of a variety of other illicit drugs. Among “more serious” drug users, it is not uncommon to see marijuana used before alcohol or to see other drugs used before marijuana.³³

Substance abuse in juvenile offenders often occurs in conjunction with mental disorders beyond a substance abuse disorder.³⁴ Also, serious delinquent offenders have been found to be significantly more likely than nonserious offenders and nondelinquents to have overlapping substance abuse and mental health problems.³⁵ Among boys, substance abuse is often accompanied by conduct disorder, with the substance abuse frequently a manifestation of the disorder.³⁶ Among girls, substance abuse more commonly co-occurs with depression and the substance abused is often used in an attempt to self-medicate.³⁷ There is also evidence of a link between substance abuse and attention-deficit/hyperactivity disorder (ADHD).³⁸ The severity of the substance abuse problem tends to be increased if accompanied by a mental disorder.³⁹ At the same time, substance abuse may exacerbate a juvenile’s

³³ *Id.* at 5-6. The category of “other” illicit drugs includes cocaine, opiates, stimulants, hallucinogens, PCP, tranquilizers, and sedative-hypnotics. *Id.*

³⁴ LEXCEN & REDDING, *supra* note 21, at 4; Belenko & Logan, *supra* note 21, at 198; Dembo & Schmeidler, *supra* note 24, at 201; Robert Milin et al., *Psychopathology Among Substance Abusing Juvenile Offenders*, 30 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 569 (1991). Cf. Faenza & Siegfried, *supra* note 24, at 32-3 (“The percentage of [detained] youth receiving mental health services who also have substance abuse disorders may be as high as 50 percent.”); Kazdin, *supra* note 13, at 42 (among adolescents with a diagnosis of substance abuse, more than 70% meet criteria for other disorders); Naimah Z. Weinberg et al., *Adolescent Substance Abuse: A Review of the Past 10 Years*, 37(3) J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 252, 256 (1998) (“[Adolescent substance use disorders] have a significant co-occurrence with other psychiatric disorders and behavioral problems.”).

³⁵ Potter & Jensen, *supra* note 31, at 232.

³⁶ LEXCEN & REDDING, *supra* note 21, at 4. See also Weinberg et al., *supra* note 36, at 256 (“[T]hree population-based studies suggest high rates of [psychiatric] comorbidity with [adolescent substance use disorder], particularly for [conduct disorder]. . . . Clinical studies are congruent with population studies in finding an association of [conduct disorder] with [adolescent substance use disorder].”).

³⁷ LEXCEN & REDDING, *supra* note 21, at 4. See also Kataoka et al., *supra* note 24, at 552 (79% of female juvenile detainees had a substance use problem and 41% of them had symptoms of an emotional disorder).

³⁸ Belenko & Logan, *supra* note 21, at 198.

³⁹ LEXCEN & REDDING, *supra* note 21, at 4.

mental disorder.⁴⁰ In addition, patterns of substance abuse in adolescents with a mental disorder have been found to increase the risk of delinquency, violence and recidivism.⁴¹ Further, conduct disorder accompanied by substance abuse has been linked to an increased risk of antisocial personality disorder developing later in life.⁴²

In addition to co-occurring mental disorders, researchers have identified a number of risk factors that are associated with an enhanced likelihood that a juvenile will engage in substance abuse.⁴³ Leukefeld et al. divided these risk factors into a number of etiological variables.⁴⁴ These included individual factors, such as lack of self-esteem and sensation-seeking,⁴⁵ and family factors, such as family drug use patterns and family atmosphere.⁴⁶ Family atmosphere included both family

⁴⁰ Suzanne M. Dupée, *Psychosis in Juvenile Offenders*, in CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY HANDBOOK OF JUVENILE FORENSIC PSYCHOLOGY 170 (Neil G. Ribner ed., 2002); McClelland, *supra* note 1, at 2.

⁴¹ LEXCEN & REDDING, *supra* note 21, at 4.

⁴² *Id.*

⁴³ See generally Belenko & Logan, *supra* note 21, at 197-200; Diana H. Fishbein & Deanna M. Pérez, *A Regional Study of Risk Factors for Drug Abuse and Delinquency: Sex and Racial Differences*, 9(4) J. CHILD & FAM. STUD. 461, 470 (2000) (“Drug use was best predicted by all three personal attitude variables, attitudes toward police, prosocial values, and attitudes toward fighting, as well as by negative peer influences.”); Alfred S. Friedman & Kimberly Glassman, *Family Risk Factors Versus Peer Risk Factors for Drug Abuse: A Longitudinal Study of an African American Urban Community*, 18 J. SUBSTANCE ABUSE TREATMENT 267, 267 (2000) (comparison of relative impact of family problems/influences versus peer relationship/social activity risk factors before age sixteen on likelihood of drug abuse); Jie Guo et al., *A Developmental Analysis of Sociodemographic, Family, and Peer Effects on Adolescent Illicit Drug Initiation*, 41(7) J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 838, 838 (2002) (high family conflict, low family bonding, and high antisocial activities in peers predicted a higher risk of initiating illicit drug use in juveniles from ages twelve to twenty-one).

⁴⁴ C.G. Leukefeld et al., *Adolescent Drug Use, Delinquency, and Other Behaviors*, in DELINQUENT, VIOLENT YOUTH 98 (Thomas P. Gullotta et al. eds., 1998).

⁴⁵ *Id.* at 100-01. See also Belenko & Logan, *supra* note 21, at 197-98 (“A number of individual factors have been linked to substance abuse and delinquency.”).

⁴⁶ Leukefeld et al., *supra* note 48, at 100-01. See also Belenko & Logan, *supra* note 21, at 198-99 (“The intergenerational transmission of substance abuse has been hypothesized to be due to genetic factors as well as other factors such as access and social learning.”); Keller et al., *supra* note 27, at 417 (in a study of children of drug addicted parents, “approximately half the youths reported involvement in drug use, and an even higher percentage participated in delinquent activities.”).

composition and interaction.⁴⁷ For instance, children of single-parent families with a mother as the parent had a much higher likelihood of being substance abusers.⁴⁸ There is also a link between drug use and negative communication patterns, inconsistent or unclear behavioral limits and unrealistic parental expectations.⁴⁹ Additional etiological risk factors included peer and peer resistance factors, with a correlation found between drug use and both peer rejection and peer drug use.⁵⁰ Also relevant were school factors, neighborhood and social factors, and biological factors.⁵¹

⁴⁷ Leukefeld et al., *supra* note 48, at 100-01. See also Kenneth W. Griffin et al., *Parenting Practices as Predictors of Substance Use, Delinquency, and Aggression Among Urban Minority Youth: Moderating Effects of Family Structure and Gender*, 14(2) PSYCHOL. ADDICTIVE BEHAV 174, 181 (2000) (“[P]arental monitoring had the strongest protective effect of any parenting variable . . . The finding that parental monitoring plays a central protective role in adolescent problem behavior has been observed in previous studies.”).

⁴⁸ Leukefeld et al., *supra* note 48, at 102. See also Griffin et al., *supra* note 51, at 180 (“Findings indicated that . . . [youth] from single-parent families engaged in higher rates of several problem behaviors.”). But see Keller, *supra* note 27, at 417-18 (study found that, while parent figure transitions were associated with an increased likelihood of later delinquent activity for both boys and girls, drug use was only associated with parent figure transitions for girls; for boys, age was the predominant factor, suggesting a greater influence by deviant peers, greater access to illicit substances, and adolescent rebellion and experimentation); *Id.* at 419 (study found no difference in the likelihood of delinquency for children with a stable single parent compared to children with a stable two-parent family).

⁴⁹ Leukefeld et al., *supra* note 48, at 103. See also Dembo & Schmeidler, *supra* note 24, at 207 (“The youths [who entered a Florida Juvenile Assessment Center] tended to come from families who had experienced a number of difficulties in psychosocial functioning.”). Parental psychopathology has also been reported to be associated with adolescent substance abuse disorders. Weinberg et al., *supra* note 36, at 255.

⁵⁰ Leukefeld et al., *supra* note 48, at 103-04. See also Belenko & Logan, *supra* note 21, at 198 (“Peer behavior is a very important risk factor for adolescent substance use and delinquency.”); Dembo & Schmeidler, *supra* note 24, at 208 (“The youths reported high rates of friends’ involvement with alcohol and other drugs. . . . Furthermore, large proportions of the youths’ close friends had some type of contact with the legal system.”); Steve Sussman et al., *Group Self-Identification as a Prospective Predictor of Drug Use and Violence in High-Risk Youth*, 14(2) PSYCHOL. ADDICTIVE BEHAV. 192, 192 (2000) (group self-identification is a significant prospective predictor of drug use and other problem behaviors, with a high-risk group reporting greater levels of drug use and violence-related exposure than other groups). But cf. Weinberg et al., *supra* note 36, at 255-56 (research indicates that peer influence is less significant than previously thought in predicting drug use or drug abuse and that the previously reported correlation between individual and peer drug use “may primarily be due to adolescent drug users selecting drug-using friends”).

⁵¹ Leukefeld et al., *supra* note 48, at 104-08. See also Belenko & Logan, *supra* note 21, at 199-200.

In assessing the causes of substance abuse disorders, a variety of theories have been employed to account for tendencies towards addiction and dependence, many of which go beyond the inter-personal factors described by Leukefeld et al.⁵² One theory addresses sociological factors, finding a positive correlation between drug use on the one hand and economic depression on the other.⁵³ Another theory invokes a social bio-psychological approach and asserts drug dependence comes from either personal involvement in a drug subculture or a strong biological craving for the drug, or both.⁵⁴ A life-cycle theory postulates that a variety of factors including availability of the drug, disengagement from normative proscriptions and “role strain” tend to lead to substance abuse in juveniles.⁵⁵

While some researchers tend to view delinquency and substance abuse as independent problems each caused by a core of similar underlying risk factors,⁵⁶ others view substance abuse as a risk factor of juvenile delinquency, the latter noting that the risk factors associated with substance abuse and delinquency often coincide but are not identical.⁵⁷ For example, one study found that factors such as deviant

⁵² Winick, *supra* note 16, at 373.

⁵³ *Id.* at 381.

⁵⁴ *Id.* at 382-83.

⁵⁵ *Id.* at 383. See also Keller, *supra* note 27, at 420 (chronic accumulation of stress arising from a series of parent transitions—including constant role confusion and ambiguity, boundary redefinition, and conflicting loyalties—may contribute to delinquent behavior and drug use).

⁵⁶ See generally Fishbein & Pérez, *supra* note 47, at 462 (“[P]ropensity for delinquency and drug abuse can be understood as the result of dynamic interactions between many varied and diverse risk factors, . . . [such as] [s]ocial conditions which . . . include family functioning, parenting techniques, peer influences, and school environments . . . [and] certain individual-level characteristics.”); Potter & Jensen, *supra* note 31, at 231 (listing a series of studies that found that many of the same factors that predict the onset of delinquent behavior are related to the initiation of substance use among adolescents).

⁵⁷ Judith S. Brook & Patricia Cohen, *A Developmental Perspective on Drug Use and Delinquency*, in *FACTS, FRAMEWORKS, AND FORECASTS: ADVANCES IN CRIMINOLOGICAL THEORY* 231 (Freda Adler & William Laufer eds., 1992). See generally Kazdin, *supra* note 13, at 49 (although refraining from the conclusion that substance abuse plays a causal role in delinquent acts, notes that substance abuse “clearly fosters, promotes, and increases the likelihood of such acts by reducing inhibition or elevating bravado” and “[i]f the individual is already predisposed to impulsive acts, . . . then substance use may greatly increase the likelihood of delinquent behavior.”). It might conversely be argued that delinquent behavior causes drug use, but changes in drug use patterns have been shown to lead to changes in delinquent behavior, while changes in delinquency have a relatively small impact on patterns of drug abuse. See Bui et al., *supra* note 21, at 297 (using structural equation modeling to examine the causal relationship between problems drug use and delinquent behavior in a sample

family, peer and school environments were consistent risk factors for both substance abuse and delinquency, but environmental variables such as urban setting, low socio-economic status and the absence of a father figure had links to delinquency but no cognizable connection to drug use.⁵⁸

Further supporting the view that substance abuse is a cause of delinquency is the finding that substance abuse is the single strongest risk factor for juvenile violence and criminal behavior.⁵⁹ In general, the more extensive a juvenile's involvement in drugs, the greater the likelihood that the juvenile will exhibit delinquent behavior.⁶⁰ Similarly, beginning substance abuse in early adolescence has been found to be associated with more risk behaviors and more serious delinquency.⁶¹ Although there is a strong linkage and a possible causal relationship, it can not be assumed that all delinquents or all serious delinquents are substance abusers (nor that all drug users are serious delinquents).⁶² Nevertheless, the detection of substance abuse in juveniles within the juvenile justice system can help identify youth at greatest risk for serious problems.⁶³

III. Treatment of Juvenile Offenders with Substance Abuse Problems

It was not until the 1960s that drug dependence was re-conceptualized as not only a law enforcement problem but as also having health and mental health implications.⁶⁴ Since that time, the optimal starting point of any substance abuse treatment program for juvenile offenders is an initial evaluation of their treatment needs following placement in the juvenile justice system. Any effective treatment

of more than 3000 West Coast adolescents who were assessed at the equivalent grades of ten and twelve, modest support was found for the principle that delinquency tends to precede problem drug use).

⁵⁸ Brook & Cohen, *supra* note 61, at 245.

⁵⁹ RICHARD E. REDDING, BARRIERS TO MEETING THE MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS: DEVELOPMENTS IN MENTAL HEALTH LAW 19 (1999).

⁶⁰ Leukefeld et al., *supra* note 48, at 111; Potter & Jensen, *supra* note 31, at 231.

⁶¹ McClelland, *supra* note 1, at 2; Potter & Jensen, *supra* note 31, at 231.

⁶² It has also been argued that all three hypotheses (drugs cause crime, crime leads to drug use, or both behaviors are dependent on other underlying social and personal factors) may be true when applied to certain populations or groups of youth, as may a fourth hypothesis that delinquency and drug use are mutually reinforcing. Huizinga & Jakob-Chien, *supra* note 31, at 51-52.

⁶³ Huizinga et al., *supra* note 21, at 58; McClelland, *supra* note 1, at 2.

⁶⁴ Winick, *supra* note 16, at 389-90.

plan requires knowledge of the patterns of a juvenile offender's substance abuse, the presence of any other mental illness and relevant psychosocial factors.⁶⁵ In Virginia, the initial evaluation of detained juvenile offenders is conducted by staff at the Reception and Diagnostic Center (RDC). If a Virginia juvenile court judge determines that a youthful offender should be assigned to the custody of the Department of Juvenile Justice for possible placement in a juvenile correctional center, the juvenile will first be sent to the RDC.⁶⁶ During this period, the juvenile receives a psychological, social, educational and medical evaluation, with a central goal being to uncover any substance abuse problem. At the RDC, the treatment services to be subsequently received by the juvenile are classified as mandatory, recommended or ancillary.⁶⁷

The specific type of substance abuse treatment plan that a correctional facility chooses to implement varies considerably, as may the effectiveness of the program. Some intervention programs are ineffective because they fail to address the juvenile's particular risk factors or address only one of several risk factors pertinent to the juvenile.⁶⁸ Other problems may arise when the treatment programs used have not been proven effective or when poorly trained staff, low staffing levels or insufficient program duration results in the treatment program not being implemented or applied effectively.⁶⁹ The programs that work most effectively for treating juveniles with substance abuse problems tend to be those treatments empirically demonstrated to be effective, which address multiple risk factors germane to a given juvenile and maintain high standards of staffing levels, training for staff and accountability.⁷⁰

There are a variety of treatment programs and settings that are used for juveniles with substance abuse problems including inpatient programs, outpatient programs, multisystemic therapy (MST), adventure-based residential programs, and

⁶⁵ LEXCEN & REDDING, *supra* note 34, at 3.

⁶⁶ Studying Treatment Options, *supra* note 23, at 39-40.

⁶⁷ *Id.* at 39.

⁶⁸ EFFECTIVE TREATMENTS, *supra* note 22, at 52.

⁶⁹ *Id.*

⁷⁰ *Id.* at 53.

behavioral family therapy.⁷¹ The advantage of inpatient services is that they provide a great deal of supervision of the juvenile and can enhance compliance with a given treatment program, which can be especially helpful in the case of juvenile offenders who lack motivation to participate in a treatment program. Inpatient treatment also isolates the juvenile from problems in the home, which often contributed to the substance abuse in the first place.⁷² However, outpatient treatment has generally been proven to be more effective overall than inpatient services, partly because the changes in behavior and thinking that juveniles learn during inpatient treatment may be lost upon their being returned to the environment where they engaged in substance abuse.⁷³ It is possible, however, that outpatient programs are not available, may not sufficiently target offenders' needs or may be insufficient to provide assurances of community safety.

Adventure based programs give juveniles an opportunity to engage in physically challenging activities to enhance their self-esteem and sense of self-accomplishment as they reach goals that are seemingly difficult to attain. The programs emphasize teamwork and peer support and encouragement. The few evaluations conducted of these programs generally report positive outcomes but limits in their methodologies have led to reservations about their findings and to suggestions that program effects may be short-term and may not be sustained when the juveniles return to their communities.⁷⁴

Behavioral family therapy (also known as behavioral parent training) focuses on counseling the family of the juvenile to change the juvenile's reward and punishment patterns. This approach is based on the theory that the negative attention juveniles receive from their parents as a result of their substance abuse reinforces

⁷¹ LEXCEN & REDDING, *supra* note 13, at 3-4. For a description of other treatment modalities—including therapeutic communities, psychoeducational approaches, and pharmacotherapy—that are used to address the needs of juvenile offenders but which are widely used with adults as well, see C. Aaron McNeece, David W. Springer, & Elizabeth M. Arnold, *Treating Substance Abuse Disorders*, in *TREATING ADULT AND JUVENILE OFFENDERS WITH SPECIAL NEEDS* (Jose B. Ashford et al. eds., 2001).

⁷² LEXCEN & REDDING, *supra* note 10, at 4.

⁷³ Boyum & Kleiman, *supra* note 15. ⁷⁴ Tamara L. Brown, Charles M. Borduin, & Scott W. Henggeler, *Treating Juvenile Offenders in Community Settings*, in *TREATING ADULT AND JUVENILE OFFENDERS WITH SPECIAL NEEDS* 445, 446-47 (Jose B. Ashford et al. eds., 2001).

⁷⁴ Tamara L. Brown, Charles M. Borduin, & Scott W. Henggeler, *Treating Juvenile Offenders in Community Settings*, in *TREATING ADULT AND JUVENILE OFFENDERS WITH SPECIAL NEEDS* 445, 446-47 (Jose B. Ashford et al. eds., 2001).

the juveniles' behavior and that familial response patterns need to be adjusted.⁷⁵ Although widely used in the United States to treat child antisocial behavior, its demonstrated success has been generally limited to the treatment of problem behavior of young children and its effectiveness in modifying adolescent behavior has been questioned.⁷⁶

Multisystemic therapy ("MST") has received a great deal of support in recent years as "the only treatment program to demonstrate short- and long-term efficacy with chronic, serious, and violent juvenile offenders."⁷⁷ Designed to address not only substance abuse problems but a variety of problematic juvenile behaviors, the therapy is multi-modal, focusing on substance abuse and other problems in the contexts of home, school, neighborhood and community.⁷⁸ Its primary goals are to reduce criminal activity and other types of antisocial behavior, including drug abuse, and it is tailored to chronic, violent or substance abusing male and female juvenile offenders.⁷⁹ MST aims to improve parental discipline practices, enhance family relations, decrease juvenile association with substance abusing peers, improve school performance and foster engagement in positive recreational outlets.⁸⁰

Studies done on drug abusing juvenile offenders, as well as juvenile sex offenders, chronic juvenile offenders and violent juvenile offenders, have all shown substantial reductions in the rate of recidivism following the juvenile's completion of an MST treatment program.⁸¹ One study determined that rates of recidivism among those juveniles receiving MST was twenty-two percent, compared with a seventy-one percent recidivism rate when psychotherapy was used as the treatment program.⁸² In another study, two-year and four-year follow-ups found that, in

⁷⁵ LEXCEN & REDDING, *supra* note 13, at 4.

⁷⁶ *Id.* at 447-48.

⁷⁷ D.C. Tate, N.D. Reppucci, & E.P. Mulvey, *Violent Juvenile Delinquents: Treatment, Effectiveness and Implications for Future Action*, 50 AM. PSYCHOLOGIST 777, 779 (1995).

⁷⁸ LEXCEN & REDDING, *supra* note 10, at 3-4.

⁷⁹ EFFECTIVE TREATMENTS, *supra* note 22, at 92-93.

⁸⁰ RICHARD E. REDDING, JUVENILE JUSTICE FACT SHEET: CHARACTERISTICS OF EFFECTIVE TREATMENTS AND INTERVENTIONS FOR JUVENILE OFFENDERS 7-8.

⁸¹ *Id.* at 7. *See also* Brown et al., *supra* note 51, at 458 (studies have shown that "MST was effective in reducing substance use and arrests for substance-related crimes").

⁸² C.M. Bourduin, B.J. Mann, L.T. Cone, S.W. Henggeler, B.R. Fucci, D.M. Blaske, & R.A. Williams, *Multisystemic Treatment of Serious Juvenile Offenders: Long-term Prevention of Criminality and Violence*, 63 J. CONSULTING & CLINICAL PSYCHOLOGY 569 (1995).

addition to less criminal activity, youths receiving MST exhibited less aggression with peers and more family cohesion.⁸³ Given these positive results, there is much reason to speculate on the effective use of MST in the future.

Another treatment model for juvenile offenders with substance abuse problems is the Arizona Amity Model. Designed specifically for detained juveniles with serious substance abuse problems, the program was developed by the Arizona Department of Corrections and takes a holistic approach to the problem of drug abuse.⁸⁴ The model uses individual and group counseling techniques and emphasizes the development of academic and vocational abilities and participation in leisure activities.⁸⁵ The treatment program seeks to accommodate various cultural backgrounds and the somewhat distinct needs of female and male juvenile offenders.⁸⁶ It also endeavors to involve family members in the treatment therapies and to develop a treatment plan that extends beyond the end of the period of detention. Little evaluation of the effectiveness of this program has thus far been provided.

The Teaching-Family Model is another substance abuse treatment program designed for detained juvenile offenders.⁸⁷ Juveniles are placed in homes that typically include about seven chronic juvenile offenders and a trained couple (called “teaching parents”), with the goal of replacing the juvenile’s pathological behaviors with prosocial behaviors that will facilitate better functioning at home and in the community.⁸⁸ There is an emphasis on creating a system of family self-government that involves positive relationships and constructive feedback for the juvenile. Although it is one the most broadly disseminated community-based group-home treatment approaches for juvenile offenders, with extensions having been made into treatment foster homes and home-based treatment, support for the effectiveness of these programs has been characterized as “limited” with studies indicating that, although the programs induce short-term reductions in delinquent behavior, substance use and antisocial behavior, these reductions have not been maintained after juveniles leave the program.⁸⁹

⁸³ EFFECTIVE TREATMENTS, *supra* note 22, at 95.

⁸⁴ HOGE, *supra* note 2, at 278.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.* at 280-83.

⁸⁸ *Id.* at 281-82; Brown, *supra* note 51, at 448.

⁸⁹ Brown, *supra* note 51, at 449.

In Virginia juvenile correction centers, the basic treatment program combines individual, group and family therapies, as well as substance abuse education and prescriptive services.⁹⁰ About eight weeks in length, the basic program focuses on increasing the juvenile's awareness of the consequences of drug and alcohol abuse and on motivating juveniles to alter their behavior. Prescriptive services, which last about twelve weeks, target relapse and seek to prevent recidivism. Seventeen of the twenty-two juvenile detention centers in Virginia also provide some form of substance abuse treatment.⁹¹

While some programs have proven effective with regard to detained juvenile offenders, particularly MST, there are several barriers that juvenile detention facilities face in providing ideal treatment services. First and foremost is a lack of resources, including limits on the availability of evaluation and treatment services in these facilities.⁹² For example, it is estimated that more than 1600 detained juveniles in need of substance abuse treatment in Virginia are not receiving any services.⁹³ An absence of substance abuse treatment services for detained offenders may lead to withdrawal symptoms and an increased chance of future relapse.⁹⁴

An additional problem with treatment services in juvenile detention facilities is the demonstrated lack of efficacy of inpatient treatment when compared with various outpatient programs. Although institutional treatment allows for closer monitoring of program integrity and the behavior of the juvenile, "criminologic risk and need factors exhibited by delinquent youth are manifested in their home, school, peer group and neighborhood environments" and treatment out of this context has less long-term success.⁹⁵ Limits on the efficacy of inpatient treatment are often compounded by the difficulty of coordinating information and services among multiple agencies in this setting. Many juveniles detained in detention facilities

⁹⁰ Studying Treatment Options, *supra* note 23, at 47.

⁹¹ *Id.* at 48.

⁹² LEXCEN & REDDING, *supra* note 13, at 10.

⁹³ KELLOGG & RICHARD, VIRGINIA MODEL JAIL AND JUVENILE DETENTION CENTER MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS AND JAIL AND JUVENILE DETENTION CENTER SURVEY RESULTS: PRESENTATION TO THE JOINT COMMITTEE STUDYING TREATMENT OPTIONS FOR OFFENDERS WITH MENTAL ILLNESS OR SUBSTANCE ABUSE DISORDERS (2001). During FY 1999, there were 20,569 admissions to Virginia secure detention facilities with an average length of stay of 20 days. Virginia Department of Juvenile Justice, *Fiscal Year 1999 Statistics* (last visited May 7, 2003) <http://www.djj.state.va.us/statistics/htm>.

⁹⁴ LEXCEN & REDDING, *supra* note 13, at 3.

⁹⁵ HOGE, *supra* note 2, at 261.

have previously been involved in delinquent acts and may have had previous screenings for substance abuse or mental health problems. However, this related and important information may not be available to staff conducting subsequent inpatient treatment programs. The involvement of various agencies over a long span of time often means there is little coordination in the delivery of services, resulting in fragmented, ineffective and repetitious services for juveniles placed in a detention facility.⁹⁶

It is important to keep in mind these potential difficulties in treating detained juvenile offenders who have substance abuse problems. Evidence thus far indicates that comprehensive treatment programs with a range of ongoing services are the most effective, especially when they focus on identifying and addressing the special needs of individual juveniles.⁹⁷ However, within detention facilities, these services may be fragmented and uncoordinated, limiting their effectiveness.

IV. Evolution of the Juvenile Justice System

A. Establishment of the Juvenile Justice System in the United States

Although the impetus for a distinct court system to handle juvenile cases originated in England, concern about the special needs of children led to the idea gaining widespread popularity in the United States beginning around the year 1900.⁹⁸ Up to that point, children over the age of seven were tried in adult courts, although the mitigating circumstance of youth could be considered in adjudication and sentencing.⁹⁹ Currently, every state in the nation has a separate juvenile justice system for the adjudication of juveniles not transferred to the adult system.¹⁰⁰

⁹⁶ *Id.* at 263-65.

⁹⁷ LEXCEN & REDDING, *supra* note 13, at 10.

⁹⁸ Candace Zierdt, *The Little Engine that Arrived at the Wrong Station: How to Get Juvenile Justice Back on the Right Track*, 33 U.S.F. L. REV. 401, 405-06 (1999). Illinois was the first state to create a juvenile court on July 1, 1899. *Id.* at 406.

⁹⁹ Cynthia Conward, *The Juvenile Justice System: Not Necessarily in the Best Interests of Children*, 33 NEW ENG. L. REV. 39, 41 (1998); Zierdt, *supra* note 75, at 403. "In other words, it was recognized that a child over the age of seven sometimes lacked capacity or maturity of an adult to understand the consequences of his or her actions. Thus, a child might not be held liable even for a crime as reprehensible as murder. More commonly, however, the law held children fully responsible for all of the actions after a certain age." *Id.*

¹⁰⁰ DOUGLAS E. ABRAMS & SARAH H. RAMSEY, *CHILDREN AND THE LAW: DOCTRINE, POLICY AND PRACTICE* 1038 (2000).

The philosophical underpinning of the juvenile justice system was that juveniles should be rehabilitated¹⁰¹ and that this could be best accomplished by placing them in a system clinically tailored to meet their specific rehabilitative needs.¹⁰² Adopting a *parens patriae* role, the state would intervene at an early stage to reduce the likelihood that the juvenile would appear before an adult criminal court in the future.¹⁰³ This approach was justified on the grounds that (1) juveniles are more malleable than adults and would benefit from treatment-oriented confinement and (2) juveniles are less culpable for their acts than adults because they are less cognitively and volitionally developed.¹⁰⁴ Working from these assumptions, many of the procedural and evidentiary requirements of adult courts were relaxed in juvenile courts, and the focus on determining guilt or innocence was replaced with providing juveniles with resources targeting their rehabilitative needs.¹⁰⁵ To support rehabilitation, housing in large institutions was largely condemned and juveniles removed from their parents were instead placed in small living groups or foster families.¹⁰⁶

By the 1960s and 1970s, however, many of the purported rehabilitative services of the juvenile justice system had been shown to be a myth or to be relatively ineffective. When coupled with the reduced procedural protections of the system, juvenile offenders were viewed as being exposed to considerable risk of harm.¹⁰⁷ As noted by the Supreme Court, “[t]here is evidence . . . that the child receives the worst of both worlds: that he gets neither the protection accorded to adults nor the solicitous care and regenerative treatment postulated for children.”¹⁰⁸ As a result,

¹⁰¹ Paul Holland & Wallace J. Mlyniec, *Whatever Happened to the Right to Treatment?: The Modern Quest for a Historical Promise*, 68 TEMP. L. REV. 1791, 1792 (1995).

¹⁰² Conward, *supra* note 76, at 42; Holland & Mlyniec, *supra* note 77, at 1795; Barry C. Feld, *The Juvenile Court Meets the Principle of Offense: Punishment, Treatment, and the Difference It Makes*, 68 B.U. L. REV. 821 (1988).

¹⁰³ Feld, *supra* note 78, at 824; Holland & Mlyniec, *supra* note 77, at 1792; Julian W. Mack, *The Juvenile Court*, 23 HARV. L. REV. 104, 107 (1909).

¹⁰⁴ Christopher Slobogin, Mark R. Fondacaro, & Jennifer Woolard, *A Prevention Model of Juvenile Justice: The Promise of Kansas v. Hendricks for Children*, 1999 WIS. L. REV. 185, 190-91 (1999).

¹⁰⁵ Feld, *supra* note 78, at 825; Holland & Mlyniec, *supra* note 77, at 1795; Zierdt, *supra* note 75, at 408.

¹⁰⁶ Zierdt, *supra* note 75, at 406.

¹⁰⁷ *Id.* at 409.

¹⁰⁸ *Kent v. United States*, 383 U.S. 541, 556 (1966).

the Court extended many procedural safeguards to the juvenile justice system,¹⁰⁹ placing greater emphasis on accurately assessing the existence of responsibility for the offense before rehabilitation came into play.¹¹⁰ However, the rehabilitation of juvenile offenders remained the focus of the system and reliance on community programs over institutional confinement remained a central tenet.¹¹¹

Beginning in the 1990s and up to the present day, the focus of the juvenile justice system shifted again as it was perceived that the increasing crime rate was partly due to juvenile offenses.¹¹² Efforts have been made to increase the use of the juvenile justice system to punish offenders, hold them accountable for their crimes and deter future criminal activities.¹¹³ For example, placing juveniles in correctional centers, rather than foster homes or other community-based centers, has become favored as evidenced by the increasing number of states imposing mandatory sentences for certain offenses.¹¹⁴ Another change has been the increased removal of juveniles from the juvenile system to be tried in adult courts.¹¹⁵

¹⁰⁹ See *Kent*, 383 U.S. 541 (holding juvenile may not be transferred to adult court without a waiver hearing and juvenile has a right to an attorney at that hearing); *In re Gault*, 387 U.S. 1 (1967) (holding juvenile has right to advanced written notice of the charges, assistance of counsel, protections of privilege against self-incrimination, fair and impartial hearing, and cross-examination of witnesses); *In re Winship*, 397 U.S. 358 (1970) (holding standard of proof in delinquency hearing is proof beyond a reasonable doubt); *Breed v. Jones*, 421 U.S. 519 (1975) (holding protections of double jeopardy clause apply to juveniles). *But see* *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971) (holding juveniles do not have a constitutional right to a jury trial); *Fare v. Michael*, 442 U.S. 707 (1979) (holding Miranda warnings are not required when a juvenile requests to see his probation officer).

¹¹⁰ Feld, *supra* note 78, at 821, 826.

¹¹¹ Holland & Mlyniec, *supra* note 77, at 1795; Feld, *supra* note 78, at 826; Zierdt, *supra* note 75, at 411; Conward, *supra* note 76, at 44.

¹¹² Conward, *supra* note 76, at 40; Holland & Mlyniec, *supra* note 77, at 1803; Brent Patison, *Minority Youth in Juvenile Correctional Facilities: Cultural Differences and Right to Treatment*, 16 LAW & INEQ. 573, 575 (1998).

¹¹³ Conward, *supra* note 76, at 40; Feld, *supra* note 78, at 842.

¹¹⁴ Conward, *supra* note 76, at 65-66; Feld, *supra* note 78, at 862-71. The increased detention of juvenile offenders has bred problems of its own, often resulting in inadequate treatment and rehabilitation services due to overcrowding.

¹¹⁵ For instance, many states have enacted provisions that mandate that juveniles above a certain age alleged to have committed specific offenses be transferred to adult court. Zierdt, *supra* note 75, at 415-18.

For the most part, the juvenile justice system in the United States remains focused on rehabilitation. However, by adding the secondary purpose of punishment, questions arise as to what will constitute appropriate rehabilitation and treatment for detained juvenile offenders. Although punishment and treatment can co-exist in the same system,¹¹⁶ the efficacy of the treatment provided by the current juvenile justice system has been criticized.¹¹⁷

B. Establishment of the Juvenile Justice System in Virginia

The formation and development of the Virginia system of juvenile justice has reflected national trends in many ways. The first move towards a separate system of juvenile justice occurred in Virginia in 1904 when judges were granted the authority to sentence juveniles to indeterminate terms in private facilities, although the trial itself remained in adult court.¹¹⁸ In 1914, Virginia allowed certain cities to create separate juvenile courts, and Virginia's first juvenile court was established in Richmond in 1916.¹¹⁹ In 1948, the Virginia General Assembly initiated the Virginia Advisory Legislative Council (VALC) study and, based on the results of this study, a comprehensive Virginia juvenile code was enacted in 1950 under the Standard Juvenile Court Act.¹²⁰

Initially, procedural safeguards in the juvenile court were not a major concern in Virginia.¹²¹ However, the Supreme Court rulings that established the rights of juveniles in court proceedings¹²² prompted the General Assembly to reorganize the Virginia juvenile courts in 1972 and 1973, creating a statewide system of juvenile

¹¹⁶ Holland & Mlyniec, *supra* note 77, at 1814.

¹¹⁷ Feld, *supra* note 78, at 835; Pattison, *supra* note 88, at 598.

¹¹⁸ Robert E. Shepherd, Jr., *An Introduction to the Juvenile and Domestic Relations District Court*, in JUVENILE LAW AND PRACTICE IN VIRGINIA 1-1 (1994).

¹¹⁹ Robert E. Shepherd, Jr., *Overview of the Juvenile and Domestic Relations District Court Law; Role, Responsibilities and Duties of Guardians Ad Litem*, in REPRESENTATION OF CHILDREN AS A GUARDIAN AT LITEM 1 (2001).

¹²⁰ *Id.*

¹²¹ See *Cradle v. Peyton*, 208 Va. 243, 156 S.E.2d 874, *cert. denied*, 392 U.S. 945 (1968) (holding that the United States Supreme Court did not mean to require the state of Virginia to provide an attorney and a hearing for youths before they could be transferred from juvenile court to adult court).

¹²² See cases cited *supra* note 85.

and domestic relations district courts.¹²³ Before this change, juvenile courts were mostly part of the county courts.¹²⁴ In 1976 and 1977, a further revision of the juvenile justice system took place after another VALC study had been completed.¹²⁵ The recommendations made by the study and incorporated into the Virginia Code further took account of the Supreme Court's mandated due process advancements of the 1960s and 1970s.¹²⁶ In 1992, the Virginia Supreme Court adopted the Juvenile and Domestic Relations District Court Rules as part of the Rules of the Virginia Supreme Court.¹²⁷

A readjustment in the focus of the juvenile justice system to target punitive, rather than purely rehabilitative, goals was apparent beginning in 1995 with the commission of several important studies. For example, Governor George Allen created the Governor's Commission on Juvenile Justice Reform, which released its findings at the end of 1995.¹²⁸ This Commission sought to increase juvenile accountability by recommending that the records and trials of juvenile offenders be opened to the public and that the transfer of serious juvenile offenders to adult court be made easier.¹²⁹ Around the same time, the Virginia Commission on Youth created a Juvenile Justice Task Force, the findings of which emphasized the prevention of juvenile crime and encouraged more vigorous intervention.¹³⁰ In 1996, the General Assembly considered the findings and recommendations of these studies and passed bills enacted as chapters 755 and 914 of the Virginia Code that further enhanced the punitive aspects of the juvenile justice system, in part, by expanding the number of cases that could be transferred to adult court and the circumstances under which juvenile records and trials could be opened to the public.¹³¹

¹²³ Shepherd, *supra* note 95.

¹²⁴ Shepherd, *supra* note 94, at 3. Some cities had established separate juvenile courts, and other regional juvenile court were in operation.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ Robert E. Shepherd, Jr., *An Introduction to the Juvenile and Domestic Relations District Court*, in JUVENILE LAW AND PRACTICE IN VIRGINIA, 1999 SUPPLEMENT 1-1 (1999).

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

In its current form, the Virginia juvenile code provides separate adjudicatory tracks depending on whether the issue at hand is delinquency, abuse and neglect or children in need of services or supervision. It is written to provide alternative courses of action and to favor the least restrictive track when appropriate, but it also provides options for punishing juvenile offenders.

The philosophy behind the Virginia juvenile justice system is encapsulated in section 16.1-227 of the Virginia Code, which was amended in 1996 to provide:

This law shall be interpreted and construed so as to effectuate the following principles:

1. To divert from or within the juvenile justice system, to the extent possible consistent with the protection of the public safety, those children who can be cared for or treated through alternative programs;
2. To provide judicial procedures through which the provisions of this law are executed and enforced and in which the parties are assured a fair hearing and their constitutional and other rights are recognized and enforced;
3. To separate a child from such child's parents, guardian, legal custodian, or other person standing in loco parentis only when the child's welfare is endangered or it is in the interest of public safety and then only after consideration of alternatives to out-of-home placement which afford effective protection to the child, his family, and the community; and
4. To protect the community against those acts of its citizens, both juveniles and adults, which are harmful to others and to reduce the incidence of delinquent behavior and to hold offenders accountable for their behavior.¹³²

It is under these tenets that the Virginia juvenile justice system operates today.

¹³² VA. CODE ANN. § 16.1-227 (Michie 2002).

C. The Juvenile Justice System in Virginia Today

A juvenile may be placed in a correctional center in Virginia when he or she is adjudicated delinquent and is at least eleven years of age.¹³³ An offense may be reported by the police, the victim, or another citizen to one of the thirty-five Court Service Units (CSUs) in the state.¹³⁴ Staff at the CSUs handle intake for juvenile cases by receiving the complaint and determining if a petition should be filed with the Juvenile and Domestic Relations Court.¹³⁵ If the petition is filed, the CSU intake officer must decide if the juvenile should be released to the custody of his or her parents or detained pending a court hearing.¹³⁶ Should the intake officer decide to detain the juvenile, a detention hearing must be held on the next day on which the court sits where the judge will determine the need for further detention and examine the merits of the charges.¹³⁷

At the detention hearing, the judge determines if probable cause exists to hold the juvenile on the charges.¹³⁸ If so, an adjudicatory hearing will be held in the juvenile court, assuming the juvenile has not been transferred to circuit court to be tried as an adult.¹³⁹ If the juvenile is found responsible for the offense at the adjudicatory phase, the court may ask that a social history be prepared before a disposition is rendered.¹⁴⁰ This may involve an examination of contacts the juvenile has had with other state agencies, family background, physical and mental state, and a drug screening.¹⁴¹ The information can be used by the judge to determine which sanctions are the most appropriate, with possibilities ranging from a warning,

¹³³ VA. CODE ANN. § 16.1-278.7 (Michie 2002).

¹³⁴ VA. CODE ANN. § 16.1-235 (Michie 2002).

¹³⁵ *Id.* See also VA. CODE ANN. § 16.1-258 (Michie 2002). If a police officer or the original complainant disagrees with the decision of the intake officer at the court service unit, they may appeal this decision to the local magistrate who may certify the charge and return the matter to the intake officer to file a petition.

¹³⁶ VA. CODE ANN. § 16.1-248.1 (Michie 2002).

¹³⁷ VA. CODE ANN. § 16.1-250(A) (Michie 2002). This hearing must be held within seventy-two hours after the juvenile has been taken into custody unless this period expires on a Saturday, Sunday, or a legal holiday, in which case the period is extended to the next day that is not a Saturday, Sunday, or legal holiday.

¹³⁸ VA. CODE ANN. § 16.1-250(E) (Michie 2002).

¹³⁹ See VA. CODE ANN. § 16.1-269.1 to 16.1-269.6 (Michie 2002).

¹⁴⁰ VA. CODE ANN. § 16.1-273 (Michie 2002).

¹⁴¹ *Id.*

fine, probation or mandated program participation, to commitment to the Department of Juvenile Justice (DJJ).¹⁴²

Commitment to the DJJ tends to be reserved only for those juveniles whose behavior, criminal histories or treatment histories make it inappropriate to place them with foster families, in non-secure facilities or with their own families. The DJJ oversees the operation of the seven juvenile correctional centers in the state of Virginia. In addition, it provides partial funding for twenty-two private secure detention facilities in the state in which DJJ may also place a committed juvenile offender¹⁴³

If committed to the custody of DJJ, juveniles are immediately placed in the Reception and Diagnostic Center (RDC) for thirty days while they are evaluated to determine their treatment needs and placement.¹⁴⁴ Based on the findings generated during the RDC evaluation, the juvenile offender may receive treatment for substance abuse, anger management, mental health needs or sex offender services.¹⁴⁵ Certain placement facilities provide more comprehensive services in specific areas than others.¹⁴⁶

Once a juvenile offender is released from a detention facility, follow-up services may be mandated through community-based services.¹⁴⁷ For juveniles who have been receiving substance abuse services while in a detention facility, these services may include drug and breathalyzer tests, case management, education, counseling and other forms of treatment.¹⁴⁸

¹⁴² For a complete list of dispositional sanctions available to the juvenile court judge when a juvenile has been adjudicated delinquent, *see* VA. CODE ANN. § 16.1-278.8 (Michie 2002).

¹⁴³ The services provided by the DJJ go beyond providing for state wards. A significant portion of its activities are directed toward juvenile community outreach programs to address the concerns of non-state wards. DJJ provides services not only to delinquents but also to children in need of supervision (CHINSup), children in need of services (CHINS), and abused and neglected children. DJJ oversees Juvenile & Domestic Relations CSUs and provides partial funding to forty-three Offices on Youth that serve fifty-three localities. The DJJ grew out of the Department of Corrections and became its own agency in 1990, originally operating as the Department of Youth and Family Services. For more information on the history and background of the DJJ, *see* <http://www.djj.state.va.us.htm>.

¹⁴⁴ *Studying Treatment Options*, *supra* note 23, at 39-40.

¹⁴⁵ *Id.* at 43.

¹⁴⁶ *Id.* at 47-48.

¹⁴⁷ VA. CODE ANN. § 16.1-293 (Michie 2002).

¹⁴⁸ *Studying Treatment Options*, *supra* note 23, at 48.

V. Is There a Right to Substance Abuse Treatment for Detained Juvenile Offenders?

The changing conception of the juvenile justice system across the nation and specifically within the Commonwealth of Virginia has led to much debate as to how juvenile offenders should be treated, particularly when the offender has been committed to state custody. While it is widely acknowledged that juvenile offenders should be provided with some sort of treatment during their detention, the parameters of the treatment required for juveniles with substance abuse problems remains unresolved.

Detained juvenile offenders in need of substance abuse treatment often do not receive the services they need. In fact, many juvenile facilities provide no substance abuse treatment whatsoever to youth committed to their custody.¹⁴⁹ A 1997 national study that examined 2,978 juvenile detention, correctional and shelter facilities found substance abuse treatment was available in only 1,008, or 33.8%, of the facilities.¹⁵⁰ Non-treatment services such as drug testing, self-help groups, education and detoxification were only provided in a limited number of facilities as well.¹⁵¹ Within Virginia, the number of facilities housing juvenile offenders providing substance abuse treatment was below the national norm.¹⁵² Out of eighty-four responding Virginia public and private juvenile facilities, only twenty-five percent reported providing such treatment.¹⁵³

The question then arises whether facilities where juvenile offenders are detained have a duty to provide substance abuse treatment to the youth in their custody and whether, in turn, these youth have a right to receive such services. While such an inquiry often focuses on whether these facilities have a responsibility

¹⁴⁹ SUBSTANCE ABUSE TREATMENT IN ADULT AND JUVENILE CORRECTIONAL FACILITIES: FINDINGS FROM THE UNIFORM FACILITY DATA SET 1997 SURVEY OF CORRECTIONAL FACILITIES (Department of Health and Human Services, Substance Abuse and Mental Health Services Administration 1997).

¹⁵⁰ *Id.* at 11.

¹⁵¹ *Id.* at 10. Drug testing was provided in 61.6% of juvenile facilities, while self-help services such as Alcoholics Anonymous or Narcotics Anonymous were available 41.0% of the time. Education and awareness services were present in 75.4% of facilities but detoxification was available in only 4.9%.

¹⁵² *Id.* at 10.

¹⁵³ *Id.* at 39.

to provide any substance abuse treatment at all, the minimal level of care that the treatment must reach may be debated as well. When considering whether a right to treatment exists and its scope, the extent to which rehabilitation remains the paramount goal of the juvenile justice system is an important consideration. When a state juvenile justice system shifts its focus from rehabilitation to punishment, the right to substance abuse treatment may arguably be reduced. At the same time, it should be noted that adult offenders, for whom the emphasis of custody continues to be punishment rather than rehabilitation, are entitled to have their serious medical and mental health needs treated, and juvenile offenders are widely regarded as having at least the same treatment rights as adult offenders.

In general, the right of juvenile offenders to substance abuse treatment services might be made under three primary rubrics, namely, that this right is provided by the United States Constitution, relevant federal statutes or applicable state law. Each of these possibilities will be examined in turn.

A. Constitutional Right

A constitutional basis for the assertion that detained juvenile offenders have a right to treatment was first developed in the 1970s.¹⁵⁴ Although early cases did not specifically address a right to substance abuse treatment for juveniles, lawsuits challenging the conditions within juvenile correctional centers laid the groundwork for such an inquiry.¹⁵⁵ Typical early challenges focused either on institutional conditions, such as overcrowding, inadequate medical care and inappropriate punishment, or on a lack of services, such as psychiatric treatment, education and counseling.¹⁵⁶ The success of these challenges varied over time. When the juvenile justice system had a more single-minded focus on rehabilitation, juveniles were generally found to have a right to treatment because this was considered necessary for their rehabilitation. However, as the emphasis of the juvenile justice system

¹⁵⁴ See *Inmates of the Boys' Training School v. Affleck*, 346 F. Supp. 1354 (D.R.I. 1972); *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972).

¹⁵⁵ See, e.g., *Nelson v. Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972), *aff'd.*, 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974); *Pena v. New York State Div. for Youth*, 419 F. Supp. 203 (S.D.N.Y. 1976); *Morgan v. Sproat*, 432 F. Supp. 1130 (S.D. Miss. 1977); *Morales v. Turman*, 383 F. Supp. 53 (E.D. Tex. 1974), *rev'd.*, 535 F.2d 864 (5th Cir. 1976), *rev'd.*, 430 U.S. 322 (1977), *remand*, 562 F.2d 993 (5th Cir. 1977).

¹⁵⁶ *Holland & Mlyniec*, *supra* note 77, at 1797-98.

became more punitive, it became more difficult to sustain such an argument.¹⁵⁷

The two provisions of the United States Constitution that have been most commonly advanced as establishing a right of detained juvenile offenders to treatment are the Eighth and the Fourteenth Amendments. An Eighth Amendment challenge asserts that the failure to treat a juvenile offender constitutes “cruel and unusual punishment,”¹⁵⁸ while a Fourteenth Amendment challenge argues the failure to treat a detained juvenile offender results in a lack of “due process.”¹⁵⁹

When the Eighth Amendment is advanced as a basis to challenge the lack of substance abuse treatment available to a detained juvenile offender, a claimant will generally point out that in *Estelle v. Gamble* the United States Supreme Court used an Eighth Amendment analysis to rule that adult prisoners are entitled to receive care for “serious medical needs,” and detained juvenile offenders should be entitled, at a minimum, to the care afforded adults.¹⁶⁰ Because a substance abuse problem is a “serious medical need,” detained juvenile offenders should receive treatment for this problem. However, other Supreme Court rulings specifically addressing substance abuse and incarcerated individuals have tended to undercut this argument.¹⁶¹

In 1962, the Supreme Court’s landmark ruling in *Robinson v. California* led some commentators to believe that drug addiction would be given special recognition in Eighth Amendment jurisprudence.¹⁶² Citing earlier case law that held narcotic addiction was an illness,¹⁶³ the Court determined that it was cruel and unusual punishment to convict and sentence a person solely for his or her status as a drug addict.¹⁶⁴ Just as no state should “make it a criminal offense for a

¹⁵⁷ *Id.* at 1803.

¹⁵⁸ U.S. CONST. amend. VIII.

¹⁵⁹ U. S. CONST. amend. XIV, § 1.

¹⁶⁰ 429 U.S. 97 (1976).

¹⁶¹ See e.g., *Powell v. Texas*, 392 U.S. 514 (1968).

¹⁶² 370 U.S. 660 (1962).

¹⁶³ *Linder v. United States*, 268 U.S. 5 (1925).

¹⁶⁴ 370 U.S. 660. The statute in question was CAL. HEALTH & SAFETY CODE § 11721, which provided in relevant part, “[n]o person shall use, or be under the influence of, or be addicted to the use of narcotics, excepting when administered by or under the direction of a person licensed by the State to prescribe and administer narcotics . . . Any person convicted of violating any provision of this section is guilty of a misdemeanor and shall be sentenced to serve a term of not less than 90 days nor more than one year in the county jail” (*italics added*).

person to be mentally ill, or a leper, or to be afflicted with a venereal disease,” the Court held that a statute criminalizing drug addiction per se was equally impermissible.¹⁶⁵

While *Robinson* evoked speculation in the legal community that acts arising from drug or alcohol addictions could no longer be considered criminal, these conjectures were quickly put to rest just six years later in *Powell v. Texas*.¹⁶⁶ In this case, a chronic alcoholic argued that to punish him for the crime of being drunk in public would constitute an Eighth Amendment violation because his conduct was not of his own volition but was a direct result of his “disease.”¹⁶⁷ The Court held first that there was not clear evidence that chronic alcoholism was a disease¹⁶⁸ and second that the statute did not purport to punish a status but to punish the criminal conduct of a person who happened to be an alcoholic.¹⁶⁹ The Court explained that *Robinson* establishes “that criminal penalties may be inflicted only if the accused has committed some act, has engaged in some behavior, which society has an interest in preventing” but if Powell’s argument was adopted “it is difficult to see any limiting principle that would serve to prevent this Court from becoming . . . the ultimate arbiter of the standards of criminal responsibility.”¹⁷⁰

It was against this background of jurisprudence on substance abuse and the Eighth Amendment that the landmark decision of *Estelle v. Gamble* was handed down.¹⁷¹ The Court determined that inadequate treatment of medical needs only leads to an Eighth Amendment violation when there is “deliberate indifference” to the “serious medical needs” of the prisoner.¹⁷² Although the language of the opinion indicated that a prisoner would have to meet a high threshold to raise a complaint,¹⁷³

¹⁶⁵ *Id.* at 666-67.

¹⁶⁶ 392 U.S. 514 (1968).

¹⁶⁷ *Id.* at 518.

¹⁶⁸ *Id.* at 522-23.

¹⁶⁹ *Id.* at 532-34.

¹⁷⁰ *Id.* at 533. *See also* *Gorham v. United States*, 339 A.2d 410 (D.C. Cir. 1975) (holding that narcotics addiction does not constitute an acceptable affirmative defense to the charge of possession of heroin for personal use or possession of narcotics paraphernalia).

¹⁷¹ 429 U.S. 97 (1976).

¹⁷² *Id.* at 104.

¹⁷³ *See id.* at 106 “Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, a prisoner must allege acts or omissions

questions still remained as to exactly what would qualify as “deliberate indifference” and what would constitute a “serious medical need.”

Some courts applying *Estelle* have ruled that the “deliberate indifference” standard is met by a demonstration of “wantonness.”¹⁷⁴ Other courts, however, have held that even “[a] number of individual and isolated incidences of medical malpractice or negligence do not amount to deliberate indifference without some specific threat of harm from a related system wide deficiency.”¹⁷⁵

With regard to the meaning of “serious” illness and, specifically, whether a substance abuse problem entitles an offender to treatment, the answer is even less clear. Although subsequent decisions have determined that there is “no underlying distinction between the right to medical care for physical ills and [their] psychological . . . counterpart,”¹⁷⁶ other courts have indicated that it is far from certain that a substance abuse problem would qualify as a “serious” illness.¹⁷⁷

Although the Supreme Court has not directly addressed whether the Eighth Amendment provides adult inmates with a right to substance abuse treatment, several lower federal court decisions have indirectly ruled on the matter. In a closely related case, *Pace v. Fauver*, a federal District Court in New Jersey found that a failure to provide rehabilitative treatment for the alcoholism of inmates does not constitute cruel and unusual punishment.¹⁷⁸ In support of its determination, the court cited several circuit court decisions that indicated the obligation to treat drug-abusing inmates was minimal.¹⁷⁹ Adding support to this position is a subsequent Supreme Court ruling that delays in providing rehabilitative services and diminished vocational

sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend “evolving standards of decency” in violation of the Eighth Amendment.” *Id.*

¹⁷⁴ *LaMarca v. Turner*, 995 F.2d 1526, 1535 (11th Cir. 1993).

¹⁷⁵ *Dulany v. Carnahan*, 132 F.3d 1234, 1245 (8th Cir. 1997).

¹⁷⁶ *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1997).

¹⁷⁷ *Pace v. Fauver*, 479 F. Supp. 456 (D.N.J. 1979); *United States v. Krehbiel*, 493 F.2d 497 (9th Cir. 1974); *Norris v. Frame*, 585 F.2d 1183 (3d Cir. 1978); *Rhodes v. Chapman*, 452 U.S. 337 (1981).

¹⁷⁸ 479 F. Supp. 456 (D.N.J. 1979). The court in this case noted that a “serious” illness “may fairly be regarded as one that has been diagnosed by a physician as requiring treatment or one that is so obvious that a lay person would easily recognize the necessity for a doctor’s attention.” *Id.* at 458.

¹⁷⁹ *Id.* at 459. See *United States v. Krehbiel*, 493 F.2d 497 (9th Cir. 1974) (holding that it is not cruel and unusual punishment to imprison a drug addict for bank robbery rather than treat him for his addiction); *Norris v. Frame*, 585 F.2d 1183 (3d Cir. 1978) (holding that there is no

and educational opportunities within an adult prison facility do not constitute Eighth Amendment violations.¹⁸⁰

It should be recalled, however, that “serious medical needs” has been widely interpreted to include mental health needs and to the extent that a substance abuse problem is diagnosed as a substance abuse disorder¹⁸¹ or greater recognition is given to the view that substance abuse is a disease or disorder, there is likely to be a stronger argument for a right to treatment under the Cruel and Unusual Punishment Clause.¹⁸² As will be discussed, it should also be noted that detained juvenile offenders have been found by some courts to be entitled to greater Eighth Amendment protections than adult inmates.

The courts have also been relatively unresponsive to arguments made on behalf of adult inmates that they are entitled to substance abuse treatment under the Fourteenth Amendment Due Process Clause. In *Marshall v. United States*, the Court considered the constitutionality of the Narcotic Addict Rehabilitation Act of 1966, which prohibits drug addicts with two or more prior felony convictions from receiving treatment in lieu of confinement in the federal criminal justice system.¹⁸³ The Court held that “there is no ‘fundamental right’ to rehabilitation from narcotics addiction at public expense after conviction of a crime,” and this restriction did not involve a “‘suspect’ classification” requiring close scrutiny and considerable justification by the Congress.¹⁸⁴ The Court held that Congress had properly exercised its authority when it determined that persons with multiple felonies would be less likely to succeed in treatment programs and found the Act did not violate either the Due Process or Equal Protection Clause.¹⁸⁵

constitutional right in prisons to methadone maintenance facilities for the treatment of substance abuse).

¹⁸⁰ *Rhodes v. Chapman*, 452 U.S. 337, 348 (1981) (holding that minor deprivations such as limited work hours and delay before receiving educational services do not constitute cruel and unusual punishment).

¹⁸¹ Diagnostic and Statistic Manual of Mental Disorders (DSM-IV-TR).

¹⁸² See Lisa Rosenblum, *Mandating Effective Treatment for Drug Offenders*, 53 HASTINGS L.J. 1217, 1228 (2002) (“With increasing recognition by the health care industry that drug addiction is a disease, and with the American Psychiatric Association’s classification of substance-related disorders as a subset of mental illness, it is time to extend the Eighth Amendment right to treatment [for adult inmates] to include drug offenders.”).

¹⁸³ 414 U.S. 417 (1974).

¹⁸⁴ *Id.* at 421.

¹⁸⁵ *Id.* at 425.

In conjunction with the Court's Eighth Amendment jurisprudence, the *Marshall* decision has been viewed as a "major barrier . . . to any constitutional claims brought by narcotic addicts or alcoholics to rehabilitative care after conviction and confinement."¹⁸⁶ However, it is important to keep in mind that these decisions were rendered with regard to adult offenders with substance abuse problems. If juvenile offenders are equated with adult offenders, confined juvenile offenders seem unlikely to have a constitutional right to substance abuse treatment. However, it is by no means certain that juvenile offenders are to be viewed in the same way as incarcerated adults.

Despite the recent drive to enhance the punitive component of the juvenile justice system, juvenile offenders are still viewed as generally less culpable and less worthy of punishment than adult offenders, and it is widely believed that efforts should be made to rehabilitate them whenever possible.¹⁸⁷ Juvenile offenders typically are seen as more susceptible to reform than adult offenders and more likely to benefit from treatment.¹⁸⁸ Although the increasingly punitive focus of the juvenile justice system may have lessened the difference between juvenile and adult offenders, the fact that juvenile justice courts continue to exist in every state and to be employed as the primary mechanism for adjudicating responsibility and assigning dispositions to juvenile offenders suggests that the distinction between juvenile and adult offenders remains viable. Furthermore, many states, including Virginia, that have placed greater emphasis on punishment and accountability simultaneously retain a commitment to the rehabilitation of juvenile offenders.

¹⁸⁶ FRED COHEN, *THE MENTALLY DISORDERED INMATE AND THE LAW* 8-1 (1998). Despite the Court's decision in *Marshall* and the stringent test established in *Estelle*, there have been instances when drug or alcohol treatment programs were ordered for adult inmates in cases when the claim was framed as an overall failure to provide adequate medical or psychological care. *Id.* Although claims for substance abuse rehabilitation often fail, claims to treatment have a chance of success depending upon how receptive the court is to the concept of substance abuse disorders as a disease. *See e.g.*, *Palmigiano v. Garrahy*, 443 F. Supp. 956 (D.R.I. 1977) (ordering the establishment of a program for treatment of inmates physiologically addicted to drugs or alcohol at a Rhode Island adult correctional institution). Further, claims for substance abuse treatment should be distinguished from medical problems associated with drug withdrawal for which deliberate indifference can be established by a failure to treat that required only a few days of services. *Pedraza v. Meyer*, 919 F.2d 317 (5th Cir. 1990).

¹⁸⁷ Peter W. Greenwood, *Juvenile Crime and Juvenile Justice*, in *CRIME: PUBLIC POLICIES FOR CRIME CONTROL* 75, 81 (James Q. Wilson & Joan Petersilia eds., 2002).

¹⁸⁸ *Id.*

With regard to the protections of the Cruel and Unusual Punishment Clause of the Eighth Amendment, it has been argued that this clause is not applicable to juveniles at all because they have not technically been subjected to criminal punishment.¹⁸⁹ However, the possible relevance of this Clause to detained juvenile offenders has been noted by both the Supreme Court¹⁹⁰ and the Fourth Circuit.¹⁹¹ Therefore, to the extent that the Eighth Amendment provides protection to adult substance abusers under the *Estelle* decision, it potentially applies with equal force to detained juvenile offenders.

While the application of the Eighth Amendment to juveniles is unresolved, the Fourteenth Amendment Due Process Clause has been used to support the right of juveniles to rehabilitation despite the Supreme Court rulings that indicate it is not similarly available for adult offenders.¹⁹² A critical element of due process is that the nature and duration of confinement have a reasonable relation to the purpose for which the confinement was initiated.¹⁹³ Therefore, as long as rehabilitation continues to be at least one major purpose of the juvenile justice system, treatment must arguably be available to facilitate the rehabilitation.¹⁹⁴ In addition, because juveniles continue to receive fewer procedural protections than do adults, it can be asserted that they should be receiving treatment in exchange for this deprivation.¹⁹⁵

¹⁸⁹ K. Edward Greene, *Mental Health Care for Children: Before and During State Custody*, 13(1) CAMPBELL L. REV. 1, 13-14 (1990).

¹⁹⁰ See *Ingraham v. Wright*, 430 U.S. 651, 669 n.37 (1977) ("Some punishments, though not labeled 'criminal' by the State, may be sufficiently analogous to criminal punishments in the circumstances in which they are administered to justify application of the Eighth Amendment . . . We have no occasion in this case, for example, to consider whether or under what circumstances persons involuntarily confined in mental or juvenile institutions can claim the protection of the Eighth Amendment.").

¹⁹¹ See *Brown v. Harris*, 240 F.3d 383, 388 (4th Cir. 2001) (holding the Eighth Amendment applies to pretrial detainees for whom there has not been a criminal conviction). In addition, a number of courts have asserted there is an independent basis for a right of adjudicated juvenile offenders to treatment under the Eighth Amendment. See *Nelson v. Heyne*, 355 F. Supp. 451 (N.D. Ind.), *aff'd*, 491 F.2d 352 (7th Cir. 1972); *Morgan v. Sproat*, 432 F. Supp. 1130, 1136 (S.D. Miss. 1977); *Doe v. McFaul*, 599 F.Supp. 1421, 1429 (N.D. Ohio 1984).

¹⁹² AUSTIN WALLACE, *VIRGINIA'S LEGAL OBLIGATIONS TO OFFENDERS WITH MENTAL ILLNESS OR SUBSTANCE ABUSE DISORDERS* 5 (2002).

¹⁹³ See *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

¹⁹⁴ See *Alexander S. v. Boyd*, 876 F. Supp. 773, 796 (D.S.C. 1995).

¹⁹⁵ For example, juveniles in most states still do not have the right to a trial by jury or to bail. Greenwood, *supra* note 156, at 83.

In weighing a due process claim, some courts have analogized the rights of juvenile offenders to those of mentally ill adults rather than adult offenders. In *Youngberg v. Romeo*, the Supreme Court held that the Fourteenth Amendment governed a claim of inadequate treatment by a mentally retarded adult who had been civilly committed, adopting a “professional judgment” test, rather than the Eighth Amendment “deliberate indifference” test, as the standard to assess the sufficiency of the services provided by the state.¹⁹⁶ Although the Supreme Court has not addressed juvenile offenders specifically, other courts have indicated that the test applied to gauge the appropriateness of treatment provided to individuals who have been civilly committed is more responsive to a juvenile offender’s inadequate treatment claims than the “deliberate indifference” test applied to adult offenders.¹⁹⁷ Because a central focus of the juvenile justice system remains rehabilitation, a goal roughly akin to the aims of the civil commitment system, the treatment standard applied to civilly committed adults may apply to juvenile offenders as well and provide juvenile offenders with a greater entitlement to treatment.¹⁹⁸

For detained juvenile offenders, the claim to a right to substance abuse treatment may be potentially greater under the Fourteenth Amendment than under the Eighth Amendment. Because juvenile offenders may be able to pursue claims for “recklessness” or “gross negligence” under the Fourteenth Amendment and demand treatment for conditions that might not qualify as a “serious illness” under the Eighth Amendment, the nature of available claims under the Fourteenth Amendment is likely broader than that which is available to adult inmates with substance abuse problems.¹⁹⁹ At the same time, the guarantees in the prohibition in the Eighth Amendment of cruel and unusual punishment have been said to expand with “the evolving standards of decency that mark the progress of a maturing

¹⁹⁶ 457 U.S. 307 (1982). The Fourth Circuit applied this test in *Patten v. Nichols*, holding that “liability may be imposed only when the decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.” 274 F.3d 829, 836 (4th Cir. 2001).

¹⁹⁷ *Gary H. v. Hegstrom*, 831 F.2d 1430, 1432 (9th Cir. 1987) (referring to the “more protective fourteenth amendment standard”); *Alexander S.*, 876 F. Supp. at 779, n.8 (“the Fourteenth Amendment provides more protection to confined juveniles than does the Eighth Amendment”).

¹⁹⁸ WALLACE, *supra* note 161, at 5-6.

¹⁹⁹ Greene, *supra* note 158, at 33. In *Patten v. Nichols*, the Fourth Circuit articulated a middle ground of cases when recovery might be obtained under the Fourteenth Amendment for governmental conduct that is something more than negligence but less than intentional conduct. 274 F.3d at 834.

society.”²⁰⁰ This suggests that if the idea of substance abuse as a disease or disorder gains greater acceptance, treatment necessary to address this disease or disorder may come to be more widely viewed as required under the Eighth Amendment for both adult and juvenile offenders.

The Supreme Court has not indicated whether either or both of the relevant constitutional provisions would establish a right to substance abuse treatment for detained juvenile offenders.²⁰¹ Recently, the United States District Court for the Eastern District of Virginia ruled that it should be the Fourteenth Amendment Due Process Clause rather than the Eighth Amendment that is used in examining conditions at juvenile correctional centers.²⁰² Other courts have held that it is not relevant whether the analysis of conditions at juvenile correctional centers is conducted under the Eighth or the Fourteenth Amendments²⁰³ or have found that the analysis is the same when either of these amendments is utilized.²⁰⁴

B. Federal Statutory Right

Whether detained juvenile offenders have a constitutional right to substance abuse treatment is uncertain. There are, however, other means by which such a right might be established. Federal statutes, for example, provide several avenues through which a detained juvenile offender with a substance abuse problem may assert claims of a right to treatment.

First and foremost is the Americans with Disabilities Act of 1990 (ADA).²⁰⁵ Its enactment was driven by concerns that society isolates and segregates individuals with disabilities and that discrimination against individuals with disabilities is a pervasive problem.²⁰⁶ An ADA claim might assert that a substance abuse problem

²⁰⁰ *Atkins v. Virginia*, 122 S. Ct. 2242, 2247 (2002); *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

²⁰¹ *Reaves v. Peace*, 1996 U.S. Dist. LEXIS 7482, *18 (E.D. Va. 1996) (“The Supreme Court of the United States has not articulated the appropriate federal constitutional standard by which to measure conditions in juvenile detention facilities.”).

²⁰² *Id.*

²⁰³ *Barney v. City of Greenville*, 898 F. Supp. 372, 377 (N.D. Miss. 1995).

²⁰⁴ *Hill v. Dekalb Reg'l Youth Det. Ctr.*, 40 F.3d 1176, 1186 n.19 (11th Cir. 1994).

²⁰⁵ 42 U.S.C. §§ 12101-12213 (2003).

²⁰⁶ T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 328 (1997).

is a protected disability and that because of this disability a detained juvenile offender is being denied the benefits of programs, services and activities that the offender would otherwise enjoy. For example, a juvenile offender with a substance abuse problem might argue that he or she is unable to gain the full benefit of the educational or vocational programs otherwise offered to juvenile offenders because his or her untreated substance abuse problems leave him or her unable to concentrate or otherwise take advantage of these programs.²⁰⁷

Title II of the ADA establishes the obligations of public entities to individuals with disabilities.²⁰⁸ The ADA also specifically abrogates Eleventh Amendment state immunity²⁰⁹ as a defense to a state violation of the statute.²¹⁰ In addition, the Supreme Court has held that a prison is considered a “public entity” and, therefore, claims against prisons may be pursued under Title II.²¹¹

A central question associated with an ADA claim is whether a substance abuse problem fulfills the definition of a “disability.” While an individual with a disability cannot be excluded from participation or be denied benefits or services for which the individual would otherwise be qualified,²¹² “disability” under the ADA means “(A) a physical or mental impairment that substantially limits the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such impairment.”²¹³ The ADA goes on, however, to specifically address

²⁰⁷ This is slightly different from how a constitutional claim would be posed because although an ADA claimant can assert that he or she is being denied a service afforded other juvenile offenders because of his or her status as a substance abuser, there is little basis to argue that the ADA provides the juvenile with an independent right to substance abuse services. *See Garrett v. Anglone*, 940 F. Supp. 933 (W.D. Va. 1996) (holding that to state a claim under the ADA, an inmate must allege that a desirable program was available to others and that access was denied to him on the basis of his handicap).

²⁰⁸ 42 U.S.C. § 12132 (2003) (“[N]o qualified individual with a disability shall, by reason of such disability be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by any such entity.”).

²⁰⁹ U.S. CONST. amend. XI.

²¹⁰ 42 U.S.C. § 12202 (2003).

²¹¹ *Pennsylvania Dep’t of Corrections v. Yeskey*, 524 U.S. 206 (1998).

²¹² The Act states that a protected person is “an individual with a disability who, with or without reasonable modifications to rules, policies, or practices . . . or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” 42 U.S.C. § 12131(2) (2003).

²¹³ 42 U.S.C. § 12102(2) (2003).

whether drug users qualify for the protections of the Act. It states that an “individual with a disability” does not encompass an individual “who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.”²¹⁴ However, it is further noted that this restriction does not prevent one from qualifying as an “individual with a disability” if the individual:

- (A) has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;
- (B) is participating in a supervised rehabilitation program and is no longer engaging in such use; or
- (C) is erroneously regarded as engaging in such use, but is not engaging in such use[.]²¹⁵

Much of the current debate over these provisions centers on what it means to be “currently” engaging in the use of drugs.²¹⁶

Some view the ADA as a mechanism by which a right to rehabilitation for detained substance abusers may be asserted when the Fourteenth Amendment has failed.²¹⁷ Although the application of the ADA to juvenile offenders with substance abuse disorders has not been resolved, it is certainly possible that at least some detained juvenile offenders might qualify as an “individual with a disability” for purposes of the statute. Should an offender be entitled to ADA protection by his or her status as a “rehabilitating drug user,” the offender might assert rights to counseling or educational services, among other things, when these services have been denied due to the offender’s status as a substance abuser. Although such a claim would not directly invoke a “right to treatment,” it might indirectly provide juveniles with treatment targeting substance abuse problems.

²¹⁴ 42 U.S.C. § 12210(a) (2003).

²¹⁵ 42 U.S.C. § 12210 (b)(1)-(3) (2003).

²¹⁶ *Shafer v. Preston Mem'l Hosp. Corp.*, 107 F.3d 274 (4th Cir. 1997); *Smith v. Eastman Kodak Co.*, 1999 U.S. Dist. LEXIS 17506 (D.N.J. 1999).

²¹⁷ WALLACE, *supra* note 161, at 7-8.

Another federal act, The Rehabilitation Act of 1973, provides that otherwise qualified individuals cannot, solely because of their handicap, be subjected to discrimination by any program operated or funded by the federal government.²¹⁸ The later-enacted ADA is broader and bars discrimination in a wide variety of non-federal programs, both public and private.²¹⁹ However, because both the ADA and section 504 of the Rehabilitation Act use the same definition of “disability,” if a detained juvenile offender with a substance abuse problem qualifies for relief under one statute, he or she will generally qualify under the other as well.²²⁰ Courts have held that one who seeks treatment for a drug-dependency or alcohol problem is disabled within the meaning of the Rehabilitation Act.²²¹ Furthermore, section 504 has been ruled specifically applicable to jails and prisons²²² and seems likely to be similarly applicable to juvenile correctional facilities.

Another federal statute that might form the basis of a lawsuit asserting inadequate substance abuse treatment is the Civil Rights of Institutionalized Persons Act (CRIPA).²²³ This act authorizes claims against a state or local government for violations of the federal civil rights of an individual residing in a publicly operated facility.²²⁴ One provision of CRIPA authorizes the Attorney General of the United States to file suits to correct “egregious or flagrant conditions”²²⁵ in prisons and other institutions including facilities where juveniles are residing for “any State

²¹⁸ 29 U.S.C. § 794 (2003).

²¹⁹ RALPH REISNER, CHRISTOPHER SLOBOGIN, & ARTI RAI, *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 1131 (1999).

²²⁰ *See Gates v. Rowland*, 39 F.3d 1439, 1446 (9th Cir. 1994).

²²¹ *Regional Econ. Community Action Program, Inc. v. City of Middletown*, 281 F.3d 333 (2d Cir. 2002) (holding that when alcoholics are unable to maintain abstinence and continued recovery in independent living situation, they are substantially limited in their ability to care for themselves and thus they are disabled for purposes of the Rehabilitation Act); *Burka v. New York City Transit Auth.*, 680 F. Supp. 590 (S.D.N.Y. 1988) (holding that although § 504 does not protect illegal narcotics abusers who are not seeking treatment, it protects those otherwise qualified drug users who have been or are being rehabilitated); *Grimes v. United States Postal Serv.*, 872 F. Supp. 668 (W.D. Mo. 1994) (holding that an employee is not protected by § 504 because he was using drugs at the time, although he would have been protected if he was seeking rehabilitation).

²²² *See Harris v. Thigpen*, 941 F.2d 1495, 1523-24 (11th Cir. 1991); *Casey v. Lewis*, 834 F. Supp. 1569, 1583 (D. Ariz. 1993).

²²³ 42 U.S.C. §§ 1997-1997j (2003).

²²⁴ Conward, *supra* note 76, at 68.

²²⁵ 42 U.S.C. § 1997a (2003).

purpose.”²²⁶ The Attorney General may also intervene in pending lawsuits of the same character.²²⁷

CRIPA also contains a provision requiring persons in correctional facilities to exhaust their administrative remedies before pursuing litigation under the Act.²²⁸ Originally, these provisions did not apply to juveniles, which meant that juvenile offenders could seek redress in court for civil rights violations without having first exhausted administrative remedies.²²⁹ The exhaustion requirements of CRIPA were updated in the Prison Litigation Reform Act of 1996 (PLRA), which contained among its purposes the goal of curbing the flood of frivolous lawsuits by prisoners.²³⁰ PLRA modified the exhaustion requirements of CRIPA so that it now applies to all “prisoners,” including juveniles.²³¹

C. Virginia Statutory Rights

While constitutional and federal statutory law provide means by which detained juvenile offenders may be able to obtain substance abuse treatment, state law supplies an alternative vehicle for asserting such claims. Indeed, there may be instances when the protections provided by state law are greater than those provided by federal law.²³² Codes of several states contain provisions that require that juvenile offenders be supplied the treatment services needed to promote their rehabilitation.²³³ Some state codes even specifically require that substance abuse treatment services be afforded juvenile offenders.²³⁴

²²⁶ 42 U.S.C. § 1997 (2003).

²²⁷ 42 U.S.C. § 1997c (2003).

²²⁸ 42 U.S.C. § 1997e (2003).

²²⁹ *Id.*

²³⁰ 18 U.S.C. § 3624(b), § 3626, and in scattered sections of 28 and 42 of the United States Code.

²³¹ 42 U.S.C. § 1997e(h) (2003) defines “prisoner” as “any person incarcerated or detained in any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program.”

²³² Holland & Mlyniec, *supra* note 77, at 1822.

²³³ *See, e.g.*, KY. REV. STAT. ANN. 600.010(2)(d) (Michie 2003) (a juvenile under court jurisdiction has “a right to treatment reasonably calculated to bring about an improvement in his or her condition”).

²³⁴ FLA. STAT. ANN. §§ 984.02(2), 985.02(2) (West 2003) (charging the state delinquency system with providing substance abuse treatment to juveniles and their families “as resources permit”). Florida’s statute is read to mean that the agency “must exhaust all resources in providing such services.” Holland & Mlyniec, *supra* note 77, at 1817.

When addressing Virginia law pertaining to a juvenile offender's right to substance abuse treatment, the Commonwealth's approach to adult prisoners should first be considered. Section 53.1-32 of the Virginia Code contains general provisions regarding the treatment of prisoners.²³⁵ It provides that among the purposes of the state correctional facilities is the goal of providing "proper . . . medical and mental health care and treatment."²³⁶ Further, the statute tracks the requirements of federal constitutional law enunciated in the *Estelle* decision when it states that no prisoner shall be denied "medically necessary" services due to an inability to pay for such services.²³⁷ The statute also takes specific note of the treatment of substance abuse problems in prisons, providing:

The Director may establish, with consultation from the Department of Mental Health, Mental Retardation and Substance Abuse Services, a comprehensive substance abuse treatment program which may include utilization of acupuncture and other treatment modalities, and may make such program available to any prisoner requiring the services provided by the program.²³⁸

While the language of the statute does not mandate a substance abuse treatment program, related administrative regulations for the Department of Corrections indicate that substance abuse services are to be provided at each adult correctional facility as part of its core programs.²³⁹ Assuming that juveniles are to be provided, at the very least, the same amount of treatment and counseling services given to adults, these provisions suggest that substance abuse treatment services must also be part of the "core program" available in juvenile correctional centers.

²³⁵ VA. CODE ANN. § 53.1-32 (Michie 2002).

²³⁶ *Id.* at § 53.1-32(A).

²³⁷ *Id.*

²³⁸ *Id.* at § 53.1-32(B).

²³⁹ See 6 VA. ADMIN. CODE § 15-31-390(A) (West 2002) ("Written procedure and practice shall provide for a system of core programs at each facility appropriate to the needs of inmates which shall include, at a minimum, life skills, *substance abuse*, and other counseling services as appropriate") (*italics added*); 6 VA. ADMIN. CODE § 15-31-390 (L) (West 2002) (requiring treatment staff to "receive appropriate training for the services they deliver, *such as specialized programs of substance abuse* or sex offender treatment") (*italics added*). See also 6 VA. ADMIN. CODE § 15-45-10 (West 2002) (for privately managed prison facilities, "core programs" are defined as "services to fit the inmate's needs. Such services may include life skills, substance abuse programs, counseling services, sex offender counseling, and mental health programs.").

An entitlement to substance abuse treatment can also be found in state law specifically applicable to juvenile offenders. Section 16.1-273 of the Virginia Code provides that a juvenile adjudged delinquent for an act that would have been a felony or a Class 1 or Class 2 misdemeanor if committed by an adult must be ordered by the court to undergo drug screening.²⁴⁰ If the drug screening reveals that the juvenile has a “substance abuse or dependence problem,” an assessment must then be conducted by a substance abuse counselor.²⁴¹ A substance abuse screening is also required for juveniles found delinquent for the first time where the offense involves the use of drugs.²⁴²

In the Standards for Juvenile Residential Facilities portion of the Department of Juvenile Justice Regulations, it is provided that “all residents shall immediately upon admission undergo a preliminary health screening consisting of a structured interview and observation by health care personnel or health-trained staff.”²⁴³ It is noted that those juveniles who pose a risk to themselves or others will not be admitted to the general population but will receive comparable services.²⁴⁴ Furthermore, it is stated that “[i]mmmediate health care is provided to residents who need it.”²⁴⁵ Because of the health consequences associated with a substance abuse problem, these regulations can be read to indicate that a juvenile offender entering a residential facility, including a juvenile correctional center, is entitled to be screened for substance abuse problems and, when identified as a health concern in need of attention, may receive appropriate care and treatment.

A detained juvenile offender may also have a state common law right to substance abuse treatment and a failure to provide such treatment may form the basis for a tort claim for malpractice.²⁴⁶ The common law test for malpractice will probably be easier to satisfy than the federal constitutional standard because while the constitutional test requires a “substantial departure” from accepted professional judgment, “in malpractice cases brought under state law, liability typically is based

²⁴⁰ VA. CODE ANN. § 16.1-273 (A) (Michie 2002).

²⁴¹ *Id.*

²⁴² VA. CODE ANN. § 16.1-278.8:01 (Michie 2002).

²⁴³ 6 VA. ADMIN. CODE § 35-140-190(1) (West 2003).

²⁴⁴ 6 VA. ADMIN. CODE § 35-140-190(2) (West 2003).

²⁴⁵ 6 VA. ADMIN. CODE § 35-140-190(3) (West 2003).

²⁴⁶ Greene, *supra* note 158, at 19.

on negligence, which can be established by showing *any* departure from the applicable standard of care.”²⁴⁷

Three parties that may be named in a suit alleging inadequate substance abuse treatment are the juvenile court judge, the custodial agency or the correctional center staff responsible for providing care. The likely success of a claim will vary greatly depending on which of these parties is targeted.

For a Virginia juvenile court judge who has ordered a juvenile offender’s placement, liability will only arise when the judge “acts ‘in the clear absence of all jurisdiction’ or when the actions giving rise to the claim are not taken in a judicial capacity.”²⁴⁸ This same level of immunity applies to agencies and individuals that are acting in compliance with the order of a juvenile court judge.²⁴⁹

Even in the absence of a court order, agencies and individuals in Virginia often avoid tort liability under the doctrine of sovereign immunity, which holds that absent a specific waiver of this immunity, the state cannot be sued by its citizens and is immune from liability for the tortious acts of its agents.²⁵⁰ However, Virginia limited this broad doctrine with the enactment of the Virginia Tort Claims Act,²⁵¹ which holds the state liable “for claims . . . of damage to or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee while acting within the scope of his employment” if, under the circumstances, “a private person would be liable to the claimant for such damage, loss, injury or death.”²⁵²

While the Virginia Tort Claims Act allows suits against the agency with custody of the juvenile (in the case of committed juvenile offenders, the DJJ), the Act may not permit suits against individual employees or agents of the state who provided the treatment. A court considering a claim against an individual treatment

²⁴⁷ Patten v. Nichols, 274 F.2d 829, 843 (4th Cir. 2001).

²⁴⁸ Reaves v. Peace, 1996 U.S. Dist. LEXIS 7482, 8-9 (E.D. Va. 1996).

²⁴⁹ *Id.* at 9.

²⁵⁰ See Atkinson v. Sachno, 261 Va. 278, 541 S.E.2d 902 (2001) (finding the “doctrine of sovereign immunity is indeed alive and well in Virginia”).

²⁵¹ VA. CODE ANN. §§ 8.01-195.1 to -195.9 (Michie 2002).

²⁵² VA. CODE ANN. § 8.01-195.3 (Michie 2002). There are several limitations to the Act including a maximum liability of \$100,000, no punitive damages, and the claimant must file a written statement of the nature of the claim within one year of the alleged violation. *Id.* at §§ 8.01-195.3, -195.6.

provider will consider first if the individual is covered by the doctrine of sovereign immunity because he or she is a state employee or agent.²⁵³ If not, the full range of tort actions will be available to the juvenile. If the treatment provider is found to be an employee or agent of the state, the court will next consider if the actions amounted to gross negligence or an intentional tort, a finding of which would defeat a claim of immunity by the employee or agent.²⁵⁴ If the actions of the treatment provider are found to amount to merely simple negligence, the provider is entitled to immunity from the tort claim.²⁵⁵

It will be difficult for a juvenile offender to pursue a tort claim against a judge, an agency or individual acting pursuant to a court order, or an employee or agent of the state exhibiting simple negligence. Despite this, a juvenile can succeed in a suit claiming negligence on the part of the state, the DJJ or an individual who does not qualify as a state employee or agent, or in a suit alleging gross negligence against state employees or agents. Further, these constraints on tort liability will not limit constitutional or federal statutory claims alleging that the juvenile offender's right to substance abuse treatment in a correctional center was violated.

VI. The Right to Substance Abuse Treatment for Detained Juvenile Offenders: What Is Required?

That detained juvenile offenders have a general right to substance abuse treatment is not a foregone conclusion. However, considering the continuing rehabilitative purposes of the juvenile justice system and the possibility that juvenile

²⁵³ See *Atkinson*, at 284-85, 541 S.E.2d at 905 (holding that factors to consider in determining if an individual was an employee or agent of the state included "(1) selection and engagement, (2) payment of compensation, (3) power of dismissal, and (4) power to control the work of the individual").

²⁵⁴ *Fox v. Deese*, 234 Va. 412, 362 S.E.2d 699 (1987). Virginia courts have attempted a number of times to establish what constitutes "gross negligence." See *Frazier v. City of Norfolk*, 234 Va. 388, 362 S.E.2d 688 (1987) (defining gross negligence as the "absence of slight diligence, or the want even of scant care"); *Laster v. Tatum*, 206 Va. 804, 146 S.E.2d 231 (1966) (defining gross negligence as the "degree of negligence that should shock fair-minded men although something less than willful recklessness").

²⁵⁵ Even though a suit may not be precluded by sovereign immunity, there may still be statutory limits on the amount a plaintiff may recover in a tort suit lodged against a treatment provider. In Virginia, the total amount recoverable for any injury to or death of a patient was limited to \$1.5 million, with this amount increasing by \$50,000 each year beginning in 2000. VA. CODE ANN. § 8.01-581.15 (*Michie* 2002).

offenders may have severe and debilitating substance abuse problems, there is probably a limited right to some substance abuse treatment for at least some juvenile substance abusers. This section addresses who those juveniles might be and what sort of treatment is necessary.

A. Who Must Be Provided Treatment?

As noted above, “substance abuse” is a concept with an amorphous meaning that might be limited to individuals with some sort of physical or psychological dependence or may encapsulate all individuals who have ever illegally used a drug. If juvenile offenders have a right to substance abuse treatment, this right needs some bounds. There is little practical or legal justification for mandating treatment for detained juvenile offenders who have merely experimented with drugs or alcohol on a limited basis but show no indication of a current substance abuse problem.²⁵⁶

For example, courts may be more likely to recognize a right to treatment of substance abuse withdrawal symptoms than a right to substance abuse treatment in general. Courts may view substance abuse withdrawal as a more pressing medical need because it is clearly linked to physical problems such as dehydration, abnormal blood pressure and other potential life-threatening conditions.²⁵⁷ In *Pedraza v. Meyer*, the Fifth Circuit allowed an inmate’s claim that he was improperly denied treatment of his withdrawal symptoms to proceed even though the time that he was denied treatment amounted to only a few days.²⁵⁸ In addition, several states have statutes guaranteeing detoxification treatment to juveniles and adults in correctional centers.²⁵⁹ No such statute exists in Virginia. Even in the case of a denial of treatment for withdrawal symptoms, courts will require a showing that the defendant agency or

²⁵⁶ Such an approach could quickly overwhelm state resources. It has been determined, for example, that 78.2% of all high school students in the United States have had a drink of alcohol at some point in their lives. Jo Anne Grunbaum et al., *Youth Risk Behavior Surveillance—United States 2001* (visited May 8, 2003) <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5104a1.htm>.

²⁵⁷ See, e.g., *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 160 (D.P.R. 1998).

²⁵⁸ 919 F.2d 317 (5th Cir. 1990). See also *Meriwether v. Faulkner*, 821 F.2d 408 (7th Cir. 1987). *But see* *Fredericks v. Huggins*, 711 F.2d 31 (4th Cir. 1983) (holding that jail’s refusal to treat pretrial detainees with methadone detoxification does not constitute unconstitutional punishment or a statutory violation when there are safety reasons for denying the treatment).

²⁵⁹ PA. STAT. ANN. tit. 71, § 1690.106 (West 2002); MD. ANN. CODE art. 27 § 700F (2002).

individual had some knowledge or a reason to believe that the claimant was suffering from withdrawal symptoms.²⁶⁰

Courts may also consider whether there is any evidence of a physical or psychological addiction to a drug when determining which individuals should be provided with treatment. For example, a federal district court in Rhode Island ordered the establishment of “a program for the treatment of [adult] inmates physiologically addicted to drugs or alcohol.”²⁶¹

As discussed earlier, juvenile offenders residing in correctional centers may have a more comprehensive or extensive right to treatment of substance abuse problems than adult inmates. Nevertheless, it is likely that courts will view substance abuse treatment as something that is required for only the most severely affected individuals, such as those experiencing withdrawal symptoms.²⁶² It has been asserted that any claim for substance abuse treatment will have the greatest chance of success when “presented in the larger framework of an overall failure to provide adequate medical or psychological care” to a particular individual.²⁶³

B. What Sort of Treatment Must Be Provided?

In *Williams v. McKeithen*, the Department of Justice reached a settlement with the State of Louisiana concerning what services must be provided in secure facilities used to house juvenile offenders.²⁶⁴ It is instructive to note the terms of the settlement with regard to substance abuse treatment:

²⁶⁰ *Kerr v. Pieschek*, 1996 U.S. App. LEXIS 986 (7th Cir. 1995) (applying an *Estelle*-like test to find that defendants did not show deliberate indifference when they failed to provide medical treatment to an inmate suffering from withdrawal symptoms when the inmate failed to indicate that he was suffering from such symptoms and the symptoms were not life-threatening).

²⁶¹ *Palmigiano v. Garrahy*, 443 F. Supp. 956, 989 (D.R.I. 1977). The court added that the withdrawal method employed had to be more than one of “abrupt denial or ‘cold turkey.’” *Id.*

²⁶² *Cf. Johnson v. Solomon*, 484 F. Supp. 278, 313-14 (D. Md. 1979) (addressing juveniles committed to a state mental hospital, the court determined that every juvenile has a constitutional right to treatment and that the decision as to which juveniles should receive specific treatments will involve “a professional evaluation of the patient” with the treatment “designed to meet the patient’s individual condition” and afford “a realistic opportunity to be cured or to improve his mental condition”).

²⁶³ COHEN, *supra* note 155, at 8-2[2].

²⁶⁴ 121 F. Supp. 2d 943 (M.D. La. 2000).

Based on the outcomes of the screenings and assessments . . . , juveniles with the highest need for substance abuse treatment shall either be scheduled for assignment to a therapeutic environment or other stand-alone or integrated program designed for substance abuse counseling and treatment . . . Parents/legal guardians and family members shall be given the opportunity and shall be encouraged to be involved in the treatment . . . All other juveniles shall be provided substance abuse education as part of their intervention plan. Substance abuse education and intervention programs shall be modified to accommodate the needs of juveniles with learning or developmental disabilities.²⁶⁵

The terms of the settlement address most of the major components of what might possibly be required as part of a substance abuse treatment program for juvenile offenders, namely, screenings and assessments, individualized treatment plans, family counseling and involvement, and education.

Screenings and Assessments. Based on section 16.1-273 of the Virginia Code, it appears the Virginia legislature saw a screening and assessment element as vital to a successful treatment program for substance abuse problems.²⁶⁶ Although the statute makes it optional for a juvenile court judge to order a pre-dispositional social history that would include a drug screening and an assessment of the juvenile's "physical, mental and social conditions," the statute provides that "the court *shall* order" a drug screening if a juvenile commits an act that would be a felony or a Class 1 or 2 misdemeanor for an adult.²⁶⁷ This and other statutes indicate that the legislature assigns a high priority to the screening and assessment of juvenile offenders in Virginia.²⁶⁸ The DJJ Regulations also charge the Department with conducting a complete health screening at admission to a correctional facility, which would presumably include a substance abuse assessment.²⁶⁹

²⁶⁵ *Id.* at 971.

²⁶⁶ VA. CODE ANN. § 16.1-273 (Michie 2002). *See also* VA. CODE ANN. § 19.2-299.2 (Michie 2002) (requiring a substance abuse screening, and in the case of a potential problem, an assessment of an adult found guilty of a number of drug-related Class 1 misdemeanors).

²⁶⁷ VA. CODE ANN. § 16.1-273 (Michie 2002). (*italics added*).

²⁶⁸ *See supra* notes 209-211 and accompanying text.

²⁶⁹ 6 VA. ADMIN. CODE § 35-140-190 (West 2002).

Individualized Treatment Plans, Family Counseling, and Family Involvement. Although neither the Virginia Code nor the Virginia Regulations specifically refer to individualized treatment plans or to family involvement in conjunction with substance abuse treatment, the DJJ Regulations that address committed youth in general do indicate that such elements are required when treatment is provided in a juvenile correctional facility. While the juvenile is committed to DJJ custody, staff is required to have monthly contact with the juvenile's parents, guardians or other custodians.²⁷⁰ Also, programs that provide "counseling, treatment or supervision" are required to "develop an individual service plan for each juvenile which [specifies] the number and nature of contacts," provide this information to the supervising probation officer, and document contacts with the juvenile and the juvenile's family.²⁷¹

Substance Abuse Education. As is now required in Louisiana, substance abuse education and prevention may be an effective, important, and beneficial component of a juvenile corrections center substance abuse program. However, such a component has received little explicit support in Virginia law.²⁷²

Specific Treatment Modalities. Finally, as discussed at the beginning of this article, there are varied types of substance abuse treatment that are delivered to detained juvenile offenders, and the relative value of these treatment modalities has received some attention. However, there is little, if any, precedent for an assertion that the absence of a specific form of treatment means a juvenile offender is being denied something to which he or she is rightfully entitled. In general, the courts appear disinclined to modify bona fide treatment programs. With regard to reforming inadequate prison programs, the Supreme Court has noted that "courts are ill equipped to deal with the increasingly urgent problems of prison administration

²⁷⁰ 6 VA. ADMIN. CODE § 35-150-420 (West 2002).

²⁷¹ 6 VA. ADMIN. CODE § 35-150-560 (West 2002).

²⁷² One exception is section 19.2-299.2 of the Virginia Code, which provides that if an adult commits a specified drug-related offense that is a Class 1 misdemeanor and is required to engage in a substance abuse screening and assessment, "[i]f the screening indicates that the person has a substance abuse or dependence problem, an assessment shall be completed and if the assessment confirms that the person has a substance abuse or dependence problem, as a condition of a suspended sentence and probation, the court shall order the person to complete the substance abuse education and intervention component, or both as appropriate, of the local alcohol safety action program or such other treatment program . . . such as in the opinion of the court would be best suited to the needs of the person." VA. CODE ANN. § 19.2-299.2 (Michie 2002).

and reform”²⁷³ and “the operation of our correctional facilities is peculiarly the province of the Legislative and Executive Branches of our Government, not the Judicial.”²⁷⁴ Similar positions have been adopted by lower level federal courts addressing the resources provided confined juvenile offenders in general.²⁷⁵

VII. Authority of Juvenile Courts to Order Specific Substance Abuse Treatment

While courts may feel constrained in their ability to order a general restructuring of the system of care provided detained juvenile offenders, juvenile court judges may conclude they have substantially more discretion to render dispositions in individual cases that enhance the treatment provided. Although a juvenile court judge in Virginia is limited to the alternatives listed in the Code by the General Assembly, the judge has extensive latitude under the Code to craft a disposition in the best interests of the juvenile.

With regard to non-detained juveniles, judges often render dispositions that require treatment for a drug or alcohol problem.²⁷⁶ For instance, the Code states that for juveniles found to be delinquent, a judge can place the juvenile on probation and mandate treatment for alcohol or drug use in a licensed program.²⁷⁷ To impose such an order, the juvenile must have already received a screening and assessment indicating the commission of the offense was related to the substance abuse, and the juvenile must have no history of violent felonies.²⁷⁸ As noted earlier, the Code also authorizes dispositions involving substance abuse treatment for juveniles found delinquent of a first drug offense.²⁷⁹ In addition, the judge can order parents to participate in a program the juvenile is ordered to complete and to cooperate in this treatment.²⁸⁰

²⁷³ Rhodes v. Chapman, 452 U.S. 337, 351 n.16 (1981).

²⁷⁴ Bell v. Wolfish, 441 U.S. 520, 548 (1979).

²⁷⁵ See e.g., Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir. 1987).

²⁷⁶ Interview with Judge Janice Brice, Prince William County Juvenile & Domestic Relations Court, in Manassas, Va. (Mar. 7, 2003).

²⁷⁷ VA. CODE ANN. § 16.1-278.8(A)(7a) (Michie 2002).

²⁷⁸ *Id.*

²⁷⁹ See VA. CODE ANN. § 16.1-278.8:01 (Michie 2002).

²⁸⁰ See VA. CODE ANN. § 16.1-278.8(A)(3),(6) (Michie 2002).

The authority of a judge to dictate substance abuse treatment is more limited if the judge commits the juvenile to the custody of the DJJ. Section 278.8 of the Code enumerates a series of dispositional options from which judges can choose for juveniles who have been found delinquent. Although it appears that some of these dispositions can be used in conjunction with one another, such as ordering substance abuse treatment as part of probation and requiring the juvenile's parents to participate in this program, a decision to commit the juvenile to the custody of the DJJ is widely viewed as assigning treatment decision authority to the Department.²⁸¹ Although this reading of the Code is not explicit, as a practical matter, a judge will not order specific substance abuse treatment in a DJJ facility as a component of commitment.²⁸²

The effect of this apparent limitation on a judge's authority may vary from judge to judge. When a judge has prior experience with juvenile offenders in general or the offender before them in particular, he or she may find this limitation particularly frustrating as it seems to prevent the judge from using this experience to shape the treatment provided the juvenile once custody is assigned to DJJ.²⁸³ Although commitment will always be viewed as a last resort, some judges will be particularly reluctant to order the commitment of a juvenile over whom they would like to maintain treatment decision-making authority.²⁸⁴ Although the judge will regain authority over the juvenile if the juvenile is subsequently discharged from a DJJ facility and placed on probation, the judge may see the time period immediately after the initial disposition as a critical time for the delivery of needed substance abuse treatment.

Other judges may view goals other than rehabilitation as more important and be less concerned about ensuring and supervising the juvenile's immediate substance abuse treatment. For some, the primary reason for commitment is to remove the juvenile from society so that he or she cannot harm others. Many juvenile offenders for whom commitment is appropriate have a number of severe problems that require attention, and substance abuse problems may not be the

²⁸¹ Interview with Judge Mary Grace O'Brien, Prince William County Juvenile & Domestic Relations Court, in Manassas, Va. (Mar. 5, 2003).

²⁸² Interview with Judge Janice Brice, *supra* note 245.

²⁸³ Holland & Mlyniec, *supra* note 77, at 1826.

²⁸⁴ Interview with Judge Mary Grace O'Brien, *supra* note 250.

most immediate concern. Treatment may have to be deferred until the period of commitment has ended.²⁸⁵

Other judges feel that they need not avoid commitment to DJJ to influence the substance abuse treatment of the juvenile. A judge who commits a juvenile to the DJJ may lose considerable authority over the juvenile, but he or she remains authorized to “maintain contact with the juvenile during the juvenile’s commitment.”²⁸⁶ The judge may make requests for information concerning the juvenile to the DJJ, which it is required to provide anytime the court so requires.²⁸⁷ The judge also has the unilateral authority to reopen any order of commitment within sixty days for modification or revocation.²⁸⁸ Furthermore, a juvenile in need of substance abuse treatment in a DJJ facility might have his or her needs advocated by the juvenile’s probation officer who was assigned to the juvenile before disposition and can maintain contact following commitment.²⁸⁹ If a juvenile is in need of substance abuse treatment, the judge might feel reassured that the probation officer will communicate this to the DJJ facility.

Some argue that judicial authority should be extended to allow for judge-made treatment orders for committed juveniles.²⁹⁰ However, the practical limitations of scrutinizing individual treatment should be acknowledged. Giving juvenile court judges jurisdiction over treatment decisions for committed offenders might lead to inappropriate micro-management of the DJJ. Furthermore, due to limited resources within the state, ordering treatment for one juvenile may prevent another, potentially more needy, juvenile from receiving treatment. It might, however, be possible to limit judicial scrutiny by mandating that any reasonable professional treatment decision by DJJ staff must be approved by a reviewing judge. This would still give a judge the ability to apply special insights and address those juveniles who have significant treatment needs.²⁹¹ Even an extremely limited scope of judicial review may help ensure that the treatment needs of a given juvenile are adequately addressed.²⁹²

²⁸⁵ Interview with Judge Janice Brice, *supra* note 245.

²⁸⁶ VA. CODE ANN. § 16.1-293 (Michie 2002).

²⁸⁷ VA. CODE ANN. § 16.1-287 (Michie 2002).

²⁸⁸ VA. CODE ANN. § 16.1-289 (Michie 2002).

²⁸⁹ Interview with Judge William Alan Becker, Prince William County Juvenile & Domestic Relations Court, in Manassas, Va. (Mar. 5, 2003).

²⁹⁰ Holland & Mlyniec, *supra* note 77, at 1827.

²⁹¹ *Id.* at 1828.

²⁹² *Id.* at 1829.

VIII. Right of Juvenile Offenders to Refuse Substance Abuse Treatment

While the ability of a court to order substance abuse treatment for a committed juvenile offender may be limited by law or, as a practical matter, is an option not employed by judges, the ability to provide substance abuse treatment to juvenile offenders may be further circumscribed if juveniles themselves have a right to refuse such treatment.²⁹³ In determining whether a juvenile has a right to refuse treatment, it must first be determined whether a juvenile has a right to consent to treatment, for without a right to consent it is unlikely that there is a right to refuse.²⁹⁴

The common law view was that a juvenile could not consent to medical or surgical treatment, and a physician was required to obtain the consent of a parent or guardian when such treatment was necessary.²⁹⁵ In sporadic rulings over the years, the Supreme Court has imposed slight variations on this rule but, in general, has stood by the common law view.²⁹⁶

Although the basic common law view has not changed, there are a number of exceptions that allow for minors to consent to treatment in certain situations. First, there has always been an exception to requiring parental consent in emergencies, and some courts have used this as a springboard for allowing emergency treatment to be provided based solely on the consent of the minor.²⁹⁷

²⁹³ Although not a focus of discussion here, it is widely acknowledged that substance abuse treatment is more likely to be effective when it is voluntary rather than involuntary.

²⁹⁴ Although a right to consent to treatment may not always be a precondition for a right to refuse treatment, consent and refusal are, at the very least, strongly related to one another. Examining the right to consent to treatment, therefore, can provide useful information about the right to refuse treatment.

²⁹⁵ *In re Hudson*, 126 P.2d 765 (Wash. 1942).

²⁹⁶ *See Ginsburg v. New York*, 390 U.S. 629, 649-50 (1968) (holding “a child . . . is not possessed of that full capacity for individual choice . . . It is only upon such a premise . . . that a State may deprive children of other rights . . . that would be constitutionally intolerable for adults”); *Thompson v. Oklahoma*, 487 U.S. 815, 835-36 (1998) (finding “inexperience, less education, and less intelligence make the teenager less able to evaluate the consequences of his or her conduct . . . (check use of sequential periods: see rule 5.3(b)iii or 5.3(b)(v))The difference that separates children from adults . . . is children’s immature, undeveloped ability to reason in an adult-like manner”).

²⁹⁷ *Belcher v. Charleston Area Medical Center*, 422 S.E.2d 827, 835 (W.Va. 1992) (“The traditional common law approach to minors and consent to treatment has undergone a number of modifications. Medical emergencies have provided an inroad, permitting treatment without parental consent in certain situations”). *See also* FLA. STAT. ANN. § 743.064 (West 2003); VA. CODE ANN. § 54.1-2969(A)-(E) (Michie 2002).

In addition, many state legislatures have enacted statutes that allow juveniles to consent to treatment under specific circumstances. These consent laws are generally of three types: "mature minor" laws, "emancipated minor" laws, and various "age of consent" laws.²⁹⁸ Certain state courts have allowed for juvenile consent to medical treatment in the case of a "mature minor" who, in the totality of the circumstances, exhibits sufficient maturity and knowledge of his or her condition.²⁹⁹ The Virginia legislature has not enacted what might be referred to as a mature minor law. There does exist, however, an emancipated minor statute as well as a series of specific age of consent laws that enable juveniles to make medical decisions under particular circumstances.

Virginia's Emancipation of Minors statute gives a court the right to declare a minor emancipated if, after a hearing, it is found that the minor (1) is or was married, (2) is on active duty in the military, or (3) willingly lives apart from parents and is "capable of supporting himself and competently managing his own financial affairs."³⁰⁰ Once an order of emancipation is rendered, a minor may "consent to medical, dental, or psychiatric care, without parental consent, knowledge, or liability."³⁰¹ If an emancipated minor is tried as a juvenile³⁰² and committed to a juvenile correctional center, the minor could attempt to argue, under the emancipated minor provisions, that because he or she has a right to consent to treatment the minor also has a right to refuse substance abuse treatment. Even if this argument is accepted, however, there are probably not many minors in Virginia who will be classified as emancipated.

In Virginia, a juvenile is also to be treated as an adult when consenting to "[m]edical or health services needed in the case of outpatient care, treatment or

²⁹⁸ FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* (1990).

²⁹⁹ See e.g., *Younts v. St. Francis Hosp. & School of Nursing*, 119 So. 501 (Kan. 1928); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987).

³⁰⁰ VA. CODE ANN. § 16.1-333 (Michie 2002).

³⁰¹ VA. CODE ANN. § 16.1-334(1) (Michie 2002).

³⁰² See *Kluis v. Commonwealth*, 14 Va. 177, 465 S.E.2d 791 (1996). The fact that a minor has been legally emancipated does not automatically mean that he or she will be tried as an adult rather than as a juvenile should he or she be charged with a crime.

rehabilitation for substance abuse.”³⁰³ This law indicates that juveniles in Virginia can exercise at least some decision-making authority regarding substance abuse treatment. However, the Virginia Code fails to resolve whether a juvenile who can consent to treatment can also withhold consent if a legal custodian wants the juvenile to receive such services. Although Virginia law clearly provides juveniles with the ability to consent to substance abuse treatment, at least on an outpatient basis, because a legal custodian may also be authorized to provide this consent, the question remains whose position will prevail when the legal custodian wants the juvenile to receive this treatment but the juvenile wants to refuse it.

This inquiry is further complicated when one considers the case of a juvenile who has been adjudged delinquent. When such juveniles are placed in the custody of an agency, the agency is typically authorized to consent to needed care for the juveniles in its custody.³⁰⁴ In Virginia, while the general authority to consent to treatment decisions for a juvenile offender rests with the court and the DJJ upon commitment,³⁰⁵ DJJ Regulations do provide a role for the juvenile. For example, the Regulations provide for health screening at the time of admission.³⁰⁶ After reaching a conclusion as to the type of health care needed by the juvenile, the Regulations state that “informed consent to health care shall be obtained from the resident, parent, guardian or legal custodian as required by law.”³⁰⁷ Because there are multiple sources for this authorization, this provision indicates that the DJJ does not need authorization from the resident (i.e., juvenile) to commence treatment. However, the Regulations go on to provide that “[r]esidents may refuse, in writing, medical treatment and care” and if health care is given against the will of the juvenile, “it shall be in accordance with applicable laws and regulations.”³⁰⁸ Thus, although the refusal of the juvenile can be overridden, the Regulations do require that the juvenile’s wishes be noted.

³⁰³ VA. CODE ANN. § 54.1-2969(E) (Michie 2002). “Substance abuse” [is defined as] “the use, without compelling medical reason, of alcohol and other drugs which results in psychological or physiological dependency or danger to self or others as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior.” VA. CODE ANN. § 37.1-203 (Michie 2002).

³⁰⁴ See, e.g., ME. REV. STAT. ANN. tit. 22, § 3-B (West 2003).

³⁰⁵ VA. CODE ANN. § 54.1-2969 (West 2003).

³⁰⁶ 6 VA. ADMIN. CODE 35-140-190 (West 2002).

³⁰⁷ 6 VA. ADMIN. CODE 35-140-210(1) (West 2002).

³⁰⁸ 6 VA. ADMIN. CODE 35-140-210(2)-(3) (West 2002).

The fact that the DJJ Regulations give the juvenile a right to record a treatment refusal suggests that there does exist at least a limited right to refuse treatment even when a juvenile has been committed to the custody of the DJJ. Although there are a few states that recognize a broader right of a juvenile to refuse treatment,³⁰⁹ it is reasonable to conclude that DJJ staff will be hesitant to pursue substance abuse treatment for a detained juvenile offender who has formally expressed a desire to refuse this treatment.

This reluctance is reinforced by various practical factors. Due in part to the paucity of resources in the facilities, participation in nearly all forms of treatment, including sex offender treatment, counseling and substance abuse treatment, is voluntary. Because there are not enough resources to service the many juveniles who are in need of and would be receptive to substance abuse treatment, correctional centers are unlikely to waste time and valuable resources on those who have no interest in receiving assistance.³¹⁰

IX. Right of Parent to Authorize Substance Abuse Treatment

In addition to the question of whether juvenile offenders are entitled to refuse substance abuse treatment, another relevant legal inquiry focuses on the respective rights of the parents of a juvenile in need of substance abuse services. The United States Supreme Court has repeatedly held that parents have a general right to raise their children as they see fit without governmental interference.³¹¹ However, this right may not remain intact when juvenile offenders are removed from the custody of their parents and placed in the custody of a state agency.³¹² A potential issue that arises at that point is whether a parent of a juvenile offender has the right to refuse treatment being offered his or her child or whether the entity with legal custody of the juvenile can commence substance abuse treatment for the juvenile without the parent's permission. Although statutory and case law tend

³⁰⁹ See e.g., KY. REV. STAT. ANN. § 645.170 (West 2003) (providing an involuntarily committed juvenile can refuse, in writing, to participate in any or all aspects of his or her treatment plan, and a juvenile may only be involuntarily treated if a court issues an order compelling treatment).

³¹⁰ Interview with Christine Nace, Probation Officer, 31st District Court Services Unit, in Manassas, Va. (Mar. 7, 2003).

³¹¹ See *Wisconsin v. Yoder*, 406 U.S. 205 (1972).

³¹² *Robison v. Via*, 821 F.2d 913, 921 (2d Cir. 1987) (quoting *Duchesne v. Sugarman*, 566 F.2d 817, 826 (2d Cir. 1977) ("it was, and remains . . . well established that officials may temporarily deprive a parent of custody in 'emergency circumstances' without parental consent").

to confer some authority on parents to refuse treatment for their children when the problem is not immediately life-threatening,³¹³ when it comes to treatment for detained juvenile offenders, the rights of parents appear to be considerably limited.

Most states have broad statutes authorizing courts or agencies to consent to the treatment of juvenile delinquents in their custody.³¹⁴ In Virginia, the statute most directly on point is section 54.1-2969, which confers authority to consent “commensurate with that of a parent” on various individuals whenever a minor has been separated from the custody of his or her parent or guardian and is in need of “surgical or medical treatment.”³¹⁵ In addition to giving this authority to judges with respect to minors whose custody is within the control of their court, the statute also confers authority on the Director of the DJJ with respect to a minor who is committed to his or her custody.³¹⁶ At the same time, while the statute does not state that efforts must be made to obtain the consent of the parents in the case of a juvenile that is not in the parents’ custody, it does provide that any authorized individual who consents to surgical or medical treatment “shall make a reasonable effort to notify the minor’s parent or guardian of such action as soon as practicable.”³¹⁷

Thus, section 54.1-2969 indicates that a court or the DJJ can make decisions for detained juvenile offenders with regard to substance abuse treatment without parental consent. Although the statute refers only to procedures for obtaining “medical and surgical treatment,” it seems likely that it applies to substance abuse treatment as well.

³¹³ The issue of parental refusal to consent to treatment for a child usually involves children who are in need of life-sustaining medical treatment and the parents, for religious reasons or otherwise, do not approve of the procedure. Parents are generally presumed to provide for the necessities required by their children, but if a parent fails to do so by refusing to permit appropriate medical care, the state may intervene under its *parens patriae* power. When a child is not afflicted with a life-threatening disease or illness, the courts have been more reluctant to step in and require treatment. For a Virginia court’s resolution of this issue, see *Winchester Dep’t of Soc. Servs. v. Gregory*, 26 Va. 314, 1992 Va. Cir. LEXIS 574 (1992) (holding that when a two-year-old child was in need of immediate surgery to correct a heart problem, and the parents objected to the surgery on religious grounds, the parents were not acting in the child’s best interest and the child should be declared neglected and committed to the Department of Social Services until her medical condition improved following the surgery).

³¹⁴ ROZOVSKY, *supra* note 268, at 305.

³¹⁵ VA. CODE ANN. § 54.1-2969(A) (Michie 2002).

³¹⁶ VA. CODE ANN. § 54.1-2969(A)(1),(3) (Michie 2002).

³¹⁷ VA. CODE ANN. § 54.1-2969(I) (Michie 2002).

As discussed above, Virginia Regulations do stipulate that for juveniles placed within residential facilities “informed consent to health care shall be obtained from the resident, parent, guardian, or legal custodian as required by law.”³¹⁸ Although this language may initially appear to be contrary to section 54.1-2969 in that it appears to contemplate parental consent for treatment of detained juvenile offenders, on further examination it suggests that obtaining parental consent is only one of several means by which treatment can be commenced, and this treatment cannot be blocked by a parental refusal to provide consent. Because upon commitment of a juvenile the DJJ becomes the legal custodian of the minor, it is reasonable to infer that informed consent of the DJJ will be an adequate substitute for consent of the parent. Therefore, as long as the DJJ assesses a need for substance abuse treatment, there is no need to also obtain consent from the juvenile’s parent, although reasonable efforts to notify the parent as soon as practicable of the treatment will be required.³¹⁹

X. Conclusion

This article has examined legal issues associated with the treatment of detained juvenile offenders who have substance abuse problems. The large number of adjudicated juvenile offenders, the considerable use of placements that remove juvenile offenders from the community and the prevalence of substance abuse problems in this population place considerable pressure on the staff of facilities charged with their care. Under the current system, treatment resources tend to be limited and unevenly available. As a result, these offenders may not receive the substance abuse treatment that they need.

As discussed, the right of detained juvenile offenders to substance abuse treatment has been widely addressed but not resolved. Should courts or legislatures more explicitly recognize a general right to substance abuse treatment for at least the most severely affected users, greater attention to these needs might result. Moreover, concerns about the rights of juvenile offenders or their parents to refuse treatment may further impede the delivery of needed treatment.

³¹⁸ 6 VA. ADMIN. CODE 35-140-210 (West 2002).

³¹⁹ VA. CODE ANN. § 54.1-2969(I) (Michie 2002).

Attorneys, judges and probation and parole officers should be alert for juvenile offenders with severe and debilitating substance abuse problems who are not receiving the treatment services they need. When the severity of these problems is viewed as equivalent to a serious disease, the likelihood that courts will intervene is enhanced and legislative action may be more forthcoming.

The legal and practical issues surrounding the substance abuse treatment of detained juvenile offenders are complex. It is difficult to find a proper balance between the needs and interests of the juvenile offenders and their parents, the juvenile court judges rendering and supervising dispositions, and the agencies and staff charged with housing these offenders. Nevertheless, because juvenile offenders continue generally to be viewed as deserving of special attention and efforts, finding means of better responding to the substance abuse problems of these offenders is likely to work to the benefit of both these offenders and society.

