

Fordham Law School

FLASH: The Fordham Law Archive of Scholarship and History

Faculty Scholarship

2015

Children's Health in a Legal Framework

Clare Huntington

Fordham University School of Law, chuntington@law.fordham.edu

Elizabeth S. Scott

Columbia Law School, es2054@columbia.edu

Follow this and additional works at: http://ir.lawnet.fordham.edu/faculty_scholarship



Part of the [Family Law Commons](#), and the [Juvenile Law Commons](#)

Recommended Citation

Clare Huntington and Elizabeth S. Scott, *Children's Health in a Legal Framework*, 25 *Future of Child*. 177 (2015)

Available at: http://ir.lawnet.fordham.edu/faculty_scholarship/574

This Article is brought to you for free and open access by FLASH: The Fordham Law Archive of Scholarship and History. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of FLASH: The Fordham Law Archive of Scholarship and History. For more information, please contact tmelnick@law.fordham.edu.

Children's Health in a Legal Framework

Clare Huntington and Elizabeth Scott

Summary

The U.S. legal system gives parents the authority and responsibility to make decisions about their children's health care, and favors parental rights over society's collective responsibility to provide for children's welfare. Neither the federal government nor state governments have an affirmative obligation to protect and promote children's health, nor do children have a right to such protection. In this sense, write Clare Huntington and Elizabeth Scott, policies to promote child health in this country, such as those discussed elsewhere in this issue, are optional.

Our libertarian legal framework grants parents broad authority to raise their children as they see fit. Parents can refuse recommended medical treatment for their children, and when they do so, courts respond with deference, particularly when parents' objections are based on religious beliefs. Parental authority has its limits, however. For example, the government can intervene to protect children's welfare in cases of medical neglect or when the child's life is in danger. Additionally, the law sometimes limits parental authority over older children. For example, teenagers may be able to refuse some treatments, such as psychiatric hospitalization, over their parents' objections. Older minors may also have access to treatments such as family planning services without their parents' consent.

Because the government has no positive obligation to promote children's health, write Huntington and Scott, children's health programs are often underfunded and vulnerable to political pressure. Programs are also more likely to focus on responding to family crises than on helping parents raise healthy children. In this environment, policy makers, researchers, and advocates must build political support by showing that investments in children's health not only benefit children but also promote social welfare.

www.futureofchildren.org

Clare Huntington is a professor at the Fordham University School of Law. Elizabeth Scott is a professor at Columbia Law School. Mark Courtney of the University of Chicago reviewed and critiqued a draft of this article.

In the United States, parents have primary responsibility for their children's health and have a corresponding right to make health-care decisions for their children. This parental power, however, is not absolute. Under its police power, the state can sometimes override parental rights to promote social welfare: thus, for example, the state can require that children be vaccinated against disease.¹ The state can also protect the welfare of individual children, if, for example, their parents act in ways that threaten their health. Parental rights are qualified in another way as well. Lawmakers have authorized adolescents to make some health-care decisions without involving their parents. Pregnant minors have a limited right to obtain abortions and, in many states, birth control treatment is available to teenagers.² Finally, although not a legal exception, in practice the government tends to defer less to the parental rights of low-income parents and to condition public assistance on considerable intrusion into the family. The legal system deals very differently with most families, whose parental rights are strongly protected, and low-income families, whose parental rights may receive little consideration.

In this legal regime based on parental rights, the state has the power to limit parental authority, but it has no affirmative obligation to help parents care for their children's health needs unless it undertakes to do so, as with Medicaid and the Children's Health Insurance Program (CHIP). Moreover, the government's deference to parents may deter the state from providing useful services and support.

An important implication of the United States' approach to children's health and

wellbeing is that efforts to improve children's health must be undertaken within the reality of this libertarian framework. The U.S. legal framework is germane to the other articles in this issue because it demonstrates that any policy proposal should be understood as optional from the state's perspective. It also underscores the need to develop political support for any initiative to improve health services for children. Often, as this article shows, the state intervenes to promote children's health only in response to compelling social welfare needs such as reducing teenage pregnancy, juvenile crime, and communicable diseases, or to crises in which parents abuse their children or fail to provide adequate care.

In this article, we flesh out the legal framework that shapes and constrains children's health policy under American law. We focus first on parental rights doctrine under constitutional and statutory law, its justification, and the limits of parental rights. We examine an important conflict between parental rights and the state's interest in children's health involving cases where parents' religious beliefs deter them from seeking medical treatment for their children. We then explore the policy implications of the libertarian framework, explaining that because no support for families is legally mandated, the libertarian framework encourages a reactive approach to child wellbeing based on crisis intervention rather than prevention. Finally, we examine adolescent health policy, an area where the law has sometimes departed from the parental rights approach, first by giving adolescents authority to make some treatment decisions and, second, by intervening through juvenile justice policies that mandate rehabilitation programs for delinquent youth and their families.

Legal Framework: Parental Rights and State Authority

The U.S. legal system is based on strong principles of individual liberty and autonomy and relatively weak commitment to collective responsibility for the welfare of individual members of society. This libertarian strain in our political and legal history is embodied in constitutional parental rights doctrine elaborated by the Supreme Court in the twentieth century. But the court has also recognized that parents' authority has limits when the health and welfare of their children are at stake and, in a series of important opinions, it has sought to strike a balance between parental rights and the state's authority to intervene to protect children.

Beginning with two landmark opinions in the 1920s, the court has held that parents have a liberty interest, protected under the 14th Amendment of the U.S. Constitution, to raise their children as they see fit, free from undue interference from the state. The early Supreme Court opinions, *Meyer v. Nebraska* and *Pierce v. Society of Sisters*, both dealt with state statutes seeking to limit parents' freedom to guide their children's education, by requiring that instruction be in English and that children attend public school, respectively.³ In each case, the Supreme Court struck down the statute as unreasonable interference with the parents' liberty to direct their children's education and upbringing, a role that parents have "the right, together with the high duty" to perform.⁴ The court has been particularly deferential when the claim of parental rights is combined with a First Amendment claim that a state law interferes with the parents' right to teach their religious faith to their children. In *Wisconsin v. Yoder*, for example, the court held that Amish parents could not

be found in violation of the state's compulsory school attendance law for withdrawing their children from public school after the eighth grade to train them for their religious roles in the Amish community.⁵

The Supreme Court has also made clear that parental rights are not absolute.⁶ A statute that limits parental authority may be justified because it promotes child welfare (or social welfare in general) under the government's police power. This was the justification for Progressive Era laws in the early twentieth century requiring school attendance and prohibiting child labor. The state also has the authority to protect the welfare of individual children and other vulnerable members of society who are unable to look out for their own interests. This authority is the basis for policies that allow the state to intervene in families in child maltreatment cases.

The upshot is that parents have broad constitutional authority to guide their children's upbringing, subject to some constraints embodied in the state's legitimate interest in protecting children. But the state has no *obligation* to protect children or promote their welfare, nor do children have a *right* to state protection. Indeed, in a famous case that arose in the 1980s, the Supreme Court held that the state had no liability when an abusive father grievously injured and disabled his child, even when the Department of Social Services had been notified several times of the father's abuse and failed to intervene.⁷ Unless the state has actually taken a child into custody or otherwise assumed responsibility for her, the government has no duty to provide for her welfare.

Furthermore, the United States has not undertaken any obligation to promote children's health and wellbeing under

international law. The United Nations Convention on the Rights of the Child (CRC), for example, states that “the family, as the fundamental group of society and the natural environment for the growth and wellbeing of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.”⁸ Signatory countries have several obligations, including a duty to ensure that children have health care, adequate food, and education.⁹ Additionally, countries must address “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment, or exploitation, including sexual abuse.”¹⁰ Every member of the United Nations has ratified the CRC except the United States and Somalia. The United States’ stance appears to express the libertarian values that shape its policy toward children generally.

Justifications for Parental Authority

The constitutional framework in which parental rights play such a prominent role has shaped legal regulation of the parent-child relationship in many domains, including health care. But deference to parental authority under American law is entrenched, in part, because it is supported by pragmatic justifications as well as by libertarian principles. The law assumes that most parents love their children, are motivated to make decisions that promote their welfare, and are best positioned to know their needs. In this view, a parental-rights approach ultimately promotes children’s interests more effectively than any alternative. Parents’ legal authority comes in exchange for the responsibility that they bear in caring for their children and guiding

their upbringing.¹¹ Giving parents responsibility also reduces the direct financial burden on and cost to society.

In health care, parents’ authority includes the right to consent to medical treatment for their children, and also the right to reject recommended treatment, discussed below. Medical decisions require informed consent by the patient—the ability to understand treatment information, compare the risks and benefits of treatment options, and make a decision.¹² Children are assumed to be incompetent to make their own treatment decisions because of their immaturity, and thus, under the law, a competent adult must provide consent. Because parents are presumed competent and know their children better than other adults do, the law views them as best situated to perform this function. Moreover, parents are financially responsible for their children’s health care. Parental control over health-care decisions is challenged only when parents are deficient or negligent in carrying out this role, or when they reveal a conflict of interest with their children.

The assumption that children can’t make their own treatment decisions is probably accurate for younger children, but likely not for teenagers.

The assumption that children can’t make their own treatment decisions is probably accurate for younger children, but likely not for teenagers. Indeed, research has found

that by age 14, adolescents' cognitive ability to understand and reason is sufficiently developed that most teenagers are capable of making informed medical decisions.¹³ But in a legal framework based on parental rights, children have little autonomy, and even adolescents have limited authority to make health-care decisions. As we discuss below, the law has carved out some exceptions to this general principle, where constitutional interests or public health concerns are implicated. For routine health-care decisions, however, all minors are subject to their parents' legal authority, and parents must generally consent to treatment.

Parents' Failure to Provide Medical Treatment

Parental control includes the right to decline as well as consent to medical treatment for their children. This authority is far from absolute, however, and legal regulation constrains parents' authority to refuse or fail to obtain treatment deemed important for their children's health. In general, when parents fail in this regard, the child welfare system may intervene on the basis of child maltreatment. State statutes that define parental abuse or neglect usually include a provision that in cases of "willful or negligent failure of the parent or guardian to provide the child with adequate ... medical treatment," the state may order the parents to obtain treatment or even remove the child to state custody.¹⁴ As with other forms of maltreatment, low-income families are more likely than others to be subject to intervention on the basis of medical neglect, which may be one component of a determination that a parent has generally failed to provide for the child's needs. In these cases, the family might be offered help in obtaining medical treatment for the

child, or, if the state determines that the parents will not provide necessary medical treatment, the child might be placed in foster care.¹⁵

In striking contrast, the general legal response to parents who refuse to consent to beneficial treatment for their children is quite deferential. For example, the state can require parents to have their children vaccinated against communicable diseases, but many states are reluctant to challenge parents who refuse to do so.¹⁶ This has sometimes led to outbreaks of measles and other preventable diseases.

State deference is particularly strong when parents refuse to provide treatment for their children on religious grounds. These cases have been treated as a special category, distinct from other medical neglect cases. Some religious sects oppose medical treatment, and members may either decline to obtain treatment for their children or refuse treatment urged by physicians. For example, Christian Scientists believe that physical ailments should be treated by Christian Science practitioners rather than medical doctors.¹⁷ These parents assert that they can refuse medical treatment for their children on the basis of their parental rights and their First Amendment right to raise their children in their religious faith.

In contrast to their response to medical neglect cases, legislatures and courts have largely respected these parents' claims. For example, in response to lobbying by Christian Scientists and other groups, many states have enacted civil and criminal religious accommodation statutes. These laws define child neglect to exclude parents' good-faith decisions to treat their children solely by spiritual means, according to the

tenets of an organized religion.¹⁸ Thus, such parents face neither liability nor the stigma and intrusion associated with a finding of child abuse or neglect. These statutes do not preclude the state from intervening to direct that a child receive medical treatment if nontreatment poses a serious threat to her life or health. But such intervention occurs only if the child's condition is dire and becomes known to authorities. Most courts have found that parents who seek spiritual treatment bear no liability if their children die because the children did not receive medical assistance.¹⁹

A great deal of litigation has revolved around states' efforts to override parental authority when parents refuse to allow their children to receive necessary medical treatment for religious reasons. In general, the judicial response has been to order treatment when the parents' refusal seriously threatens the child's life or is likely to have severe and lasting health consequences, and when the proposed treatment is likely to have beneficial effects.²⁰ Sometimes, courts have been criticized for intervening too aggressively: In a famous case involving a 15-year-old with disfiguring neurofibromatosis, the court ordered dangerous surgery requiring blood transfusions over the religious objections of both the mother and the child, even though the surgery would have been safer if postponed until the boy was an adult.²¹ But, in general, courts have been very deferential to parents' religious objections to conventional medical treatment, occasionally even when treatment represented the only hope for a child's survival. A Delaware court upheld the right of Christian Scientist parents to refuse painful chemotherapy that offered their young child, who suffered from Birkhett's Lymphoma, a 40 percent chance of survival, even though he faced certain death without

the treatment.²² Several legal scholars have sharply criticized this respectful approach, but parental rights continue to be robust in this context.²³

How the Framework Affects Policy Choices

The libertarian framework, which favors parental rights over collective responsibility, influences policy making in two significant ways. First, without an affirmative legal obligation to promote children's health, governmental investment is optional. Although many children's health programs exist, they are often underfunded and are vulnerable to budgetary and political pressures. Moreover, in our federalist system, broad discretion translates into considerable variability among states in children's health programs. Second, the libertarian framework encourages a reactive rather than preventive approach to children's health and wellbeing. Deference to parental authority has produced a system that primarily responds to family crises rather than helping parents generally to raise healthy children.

As Maya Rossin-Slater and Lawrence Berger and Sarah Font write elsewhere in this issue, when it comes to funding, the government has chosen to promote children's health and family functioning through income supplements such as the Earned Income Tax Credit, food voucher programs such as the Special Supplemental Program for Women, Infants, and Children, parenting support initiatives such as the Triple P—Positive Parenting Program and visiting nurse programs, and child development efforts such as Head Start. These authors show that many such programs effectively promote children's health and wellbeing as well as society's interests.

The authors show that many of these programs are also highly cost-effective. The programs that Rossin-Slater categorizes as intensive center-based early childhood care, for example, improve both cognitive and noncognitive outcomes for children and have a benefit-cost ratio larger than one. And for every \$1.00 invested in visiting nurse programs, which cost \$7,300 per child, society saves \$5.70 in the long run for high-risk populations and \$1.26 for lower-risk populations.²⁴

Indirect investments in children's health and family wellbeing differ from state to state.

Despite the social and economic benefits of broad-based preventive programs, the absence of any affirmative legal obligation to promote children's health means that these programs are vulnerable to shifting budgetary and political priorities. Moreover, the government often declines to respond to pressing family needs, for example, by failing to ensure paid parental leave or to provide adequate subsidies for quality child care. As Rossin-Slater writes in this issue, the United States is one of the only countries that does not guarantee new mothers some form of paid leave.²⁵ The federal Family and Medical Leave Act requires employers to allow workers to take up to 12 weeks to care for a new child or an ailing family member, but not all employers and employees are covered. More important, the leave is unpaid, which does not help parents who must work to support the family.²⁶ Similarly, government subsidies for child care do not come close to satisfying the demand.

Additionally, the combination of optional government funding and the federalist system of government in the United States means that efforts to promote children's health vary greatly among the states. Eligibility for CHIP, for example, differs from one state to the next. For example, Alabama and Oklahoma have a similar percentage of low-income children. But Alabama caps CHIP eligibility for young children at 300 percent of the federal poverty level and Oklahoma caps eligibility at 185 percent of the federal poverty level.²⁷

Indirect investments in children's health and family wellbeing also differ from state to state. As Berger and Font explain in this issue, the federal Earned Income Tax Credit is one of the most important antipoverty programs, and it is associated with better health among children. Twenty-five states, the District of Columbia, and two localities have chosen to supplement the federal program by offering a similar tax credit, providing additional support for family incomes.²⁸ But this means that 25 states don't offer a state tax credit to low-income families. Moreover, the existing state programs vary in generosity. Maryland's Earned Income Tax Credit, for example, provides up to 50 percent of the federal credit and is fully refundable; thus, families receive a payment from the state government for the amount of the credit rather than simply an offset against taxes owed (a nonrefundable tax credit).²⁹ By contrast, Ohio's Earned Income Tax Credit is only 5 percent of the federal credit and is nonrefundable.³⁰

The federalist system certainly has advantages. It allows states to experiment with different approaches to child health and wellbeing, and states can thus learn from one another. But the federalist system also

allows states to offer greatly varying levels of support for families, and services depend on a state's political values and financial resources, underscoring the point that government investment in children's health is optional.

The second major policy implication of the libertarian framework is that it encourages the government to take a reactive, rather than preventive, approach to children's health and wellbeing. Because of the importance of family autonomy, the government seldom intervenes in family life unless parents have seriously defaulted on their responsibility to care for their children. Of course, sometimes the government preempts parental authority, for example, through regulations mandating the use of car seats or requiring certain vaccinations, but even these preventive measures can be controversial, at least initially. Moreover, they do not target particular families and are justified on public health grounds.

By contrast, when parents default on their responsibilities, the state intervenes directly, and often intrusively, providing an array of services to the family and child. As Berger and Font write, the child welfare system profoundly affects the lives of many families, particularly low-income and minority families. The child welfare system uses two approaches to pursue its goals of protecting children believed to be abused or neglected by their families and strengthening families where children are at imminent risk for abuse and neglect.³¹ First, if child welfare officials believe a child can remain safely at home with additional support, the family receives preventive services, such as family or individual counseling, substance-abuse treatment, domestic-violence intervention, or parenting classes. These services aim to

strengthen the family and keep the child out of foster care. But when officials determine that the child cannot remain safely in the home or that preventive services have not been effective, they follow the second approach: the child is placed in foster care with a relative, an unrelated family, or an institution. The state typically has a duty to reunite the children with their families, but when this is not possible, it can move to terminate parental rights and place the child with an adoptive family.

Both of these approaches to child wellbeing follow a crisis-intervention model. The preventive services—counseling, substance abuse treatment, etc.—are provided only after the family has come to the attention of the authorities and the child is deemed to be at risk. Too often at this point, an adversarial relationship develops between the state and the family. Parents who face the threat of losing their children are understandably suspicious of state involvement. And the state is wary of the parents, because by the time intervention occurs, the functioning of at least one of the parents is likely at a nadir. As Berger and Font show, preventive services offered at this stage are largely ineffective.

Most cases in the child welfare system involve parental neglect rather than abuse, among families struggling with substance abuse, inadequate housing, or inappropriate child-care arrangements.³² These problems may indeed threaten a child's wellbeing, but the child welfare system, with its late-stage intervention and extreme sanction of removing children and placing them in foster care, often fails to adequately address the underlying issues, which are grounded in poverty.

Although the crisis-intervention approach stems partly from the law's respect for family

autonomy, in practice it offers little protection for parents who become involved in the child welfare system. This fact raises serious questions about socioeconomic discrimination. Children in the system overwhelmingly come from low-income families.³³ The fact that parental rights are constitutionally protected ensures that the state must meet a high standard of harm before it removes a child, but parental rights do not give parents a right to any state assistance before they face the risk of losing a child.

Even outside the child welfare system, when the government offers to help low-income parents improve their children's health, the assistance often comes at a cost to personal autonomy and privacy. New York, for example, offers the Medicaid-funded Prenatal Care Assistance Program (PCAP), which seeks to decrease infant mortality and increase birth weight among babies born to low-income mothers. But to participate in PCAP, low-income women must divulge extensive personal information that women with private insurance would not be required to tell their doctors. Women are asked questions about their immigration status, sources of income (including questions about criminal activity and working off the books), prior involvement with the child welfare system, and many questions about their eating habits and psychosocial history. Although the PCAP is well-intentioned, the state's stance toward the participants appears to be distrustful rather than collaborative.³⁴

In sum, the libertarian legal framework, with its emphasis on parental rights and responsibilities, deeply influences programs and policies affecting children's health. Because the government has no obligation to promote children's welfare, every program is optional and vulnerable to the vagaries of politics.

Under the federalist system, states are free to adopt widely varying levels of support for children's health and wellbeing. And libertarian values discourage a preventive approach to family welfare, despite evidence that preventive programs can enhance children's health. Instead, the state often offers support only after a family hits a crisis. To be sure, there is much to like about a regime that values parental autonomy and encourages pluralism. But the libertarian legal framework together with our federalist system can hinder efforts to provide comprehensive health services for children and families.

Adolescent Health and Parental Authority

Adolescents are more capable than are young children of making health-care decisions, and once they reach the age of majority at 18, they become legal adults with the authority and presumed competence to do so. Until then, as we have seen, parental consent is required, and parents continue to bear responsibility for their children's health care. But there are exceptions to this general rule, and in some treatment contexts, consent by adolescents to medical treatment is legally valid with limited or no parental involvement. Further, an adolescent's *refusal* of treatment is occasionally given some weight; for example, parents' authority to admit their children to inpatient psychiatric facilities is subject to restrictions. In this section, we discuss four areas in which the law treats adolescents differently from younger children: the mature minor doctrine; public health laws sometimes called minors' consent statutes; minor's refusal of treatment; and the right of access to reproductive health services, including abortion and contraception. In each setting, for different reasons, parental involvement in their

children's health-care decisions is deemed unnecessary or is restricted. Sometimes, mature minors' consent is deemed legally adequate to shield physicians from liability. Occasionally, parental authority is limited because the parent and child may have a conflict of interest (as when parents seek to admit children to psychiatric facilities); in other situations, a parental consent requirement might deter adolescents from seeking needed services, and public health concerns favor letting them get treatment without involving parents (minors' consent laws). Finally, abortion decisions represent a unique category of health-care decisions that involve key constitutional values.

The Mature Minor Doctrine

Under the long-recognized mature minor rule, parental consent to medical treatment is sometimes deemed unnecessary for adolescents mature enough to make their own decisions.³⁵ Courts developed the mature minor doctrine to protect physicians from legal liability when they treat minors under circumstances in which obtaining parental consent is either impossible or difficult and waiting to provide treatment would be risky. A physician who fails to obtain informed consent before providing treatment can incur legal liability for committing a battery on the patient. Because minors are presumed to be incompetent to make informed treatment decisions, treating physicians could incur tort liability for providing treatment without valid parental consent. Mature minor doctrine recognizes that the presumption of incompetence as applied to older minors is based more on administrative convenience than on scientific reality.

When is the mature minor doctrine applied? Courts have focused on the following factors in concluding that parental consent is not

necessary: 1) The treatment must be undertaken for the benefit of the minor; 2) the minor must be mature enough to understand the procedure and its consequences; and 3) the procedure cannot be of a serious nature (except for emergency treatment).³⁶ In the case of a serious procedure, parents should be consulted or a guardian appointed.

The mature minor doctrine indirectly acknowledges that adolescents are competent to make medical decisions, but it should not be understood to confer "rights" on teenagers on this basis. The doctrine's purpose is to protect physicians from liability if parents later bring suit against them on the grounds that informed consent was not obtained before the teen was treated. The mature minor doctrine is also not a general rule authorizing adolescents' consent, although a recent study found that physicians believe this is the case.³⁷ Instead, the adolescent's consent constitutes a valid substitute for the absent parent only under limited conditions.

Minor Consent Statutes

Many states have enacted minor consent statutes that allow minors to obtain particular health-care services without parental consent or involvement.³⁸ These services typically include outpatient treatment for substance abuse; outpatient mental health therapy; treatment for sexually transmitted diseases; and contraceptive, pregnancy, and family planning services. Although such statutes do not explicitly target adolescents, the nature of the designated treatments is such that application to younger children would be unusual. Thus, presumably, most patients who obtain treatment under such statutes are likely competent to consent to treatment.

The primary purpose of these statutes is not to protect physicians from liability (although

they in fact do so) or to expand adolescents' rights. Instead, minor consent statutes have an important public health purpose—they encourage teenagers to get treatment that they might be deterred from seeking if parental consent or involvement were required. These sensitive treatments involve private concerns and behaviors that adolescents may be loath to share with parents. At one level, the statutes recognize and respect individual privacy, but their purpose is also pragmatic. Society has an important interest in contraceptive use by teenagers who are sexually active and in appropriate treatment for those who have STDs or substance abuse problems—both for their own welfare and that of society. Legislatures enacting these statutes believe that removing obstacles to treatment in these cases serves both public health and teen welfare goals. Further, even if most parents likely would help their teenager obtain these sensitive treatments, the intuition is that some might not, and the laws allow children to receive treatments without confronting their parents' objections.

Adolescents' Refusal of Treatment

Parents' general authority is sometimes restricted either because the parent seeking treatment may have a conflict of interest with the child or because the adolescent child objects to the treatment. Both of these elements may be present when parents seek admission to inpatient psychiatric facilities for their children. Psychiatric hospitalization generally is assumed to differ from conventional medical treatment because it often involves restrictions on personal liberty to protect mentally ill patients from harming themselves or others. For these reasons, in the 1970s and 1980s, state lawmakers, partly responding to constitutional concerns raised by the Supreme Court, greatly reduced long-term institutionalization of mentally ill

people and restricted involuntary commitment.³⁹ These policies indirectly affected parents' authority to admit their children to psychiatric hospitals.

A conflict of interest may arise when a parent's decision to place a child in an inpatient facility is prompted by the child's disruptive and perhaps offensive behavior rather than a serious mental illness. In response, lawmakers have created special regulations that apply to parents' decisions to admit their children to psychiatric hospitals. Most importantly, in 1979, the Supreme Court held that because minors have a liberty interest in not being confined unnecessarily and not being subject to the stigma of inappropriate placement, special procedures are required to admit minors to inpatient psychiatric treatment.⁴⁰ The court decreed that a neutral fact finder (who could be a psychiatrist not involved with the minor's treatment) must confirm that institutional placement is medically indicated; the court also required an independent review after an initial period of treatment to determine whether continued commitment is necessary. Some states have required more rigorous procedures when an adolescent objects to psychiatric hospitalization, such as appointing an attorney to represent the minor in a judicial hearing. Further, in some states, the standard for involuntary commitment is adapted from the standard applied to adults—the minor must present a serious danger to himself or others or be unable to care for himself in an age-appropriate manner.⁴¹

Sex Education and Reproductive Services

Minors' access to sex education and reproductive health services—and particularly to abortion—has generated far more political controversy than other issues affecting children's health care. On the one hand,

some religious and political advocates argue that sexual activity should be reserved for marriage and generally view teenage sexual activity as immoral; many oppose minors' access to abortion as well. Those who hold these views also often believe that parents' authority in this realm is critically important. In their eyes, sex education is the parents' role, and teenagers need parental guidance when they make decisions about sexual behavior. Thus they oppose sex education in public schools and object to the notion that teens have a right of privacy. On the other hand, pragmatic public health advocates and others assume that teenage sexual activity is inevitable and see reducing teenage pregnancy as a major policy goal. From this perspective, the most effective way to reduce teenage pregnancy and limit the need for abortion is to provide comprehensive sex education and make contraceptive services readily available to teenagers. In this view, abortion should be available to pregnant minors to avoid teenage childbearing and rearing, but avoiding teen pregnancy altogether is the primary policy goal.

Since public schools began to offer sex education classes in the 1970s, some religious parents have objected on the ground that the instruction conflicts with the religious and moral values that they want their children to learn, and that the state is interfering with a parental prerogative. In response, many school districts have voluntarily established policies allowing parents to exempt their children from classes and programs that deal directly or indirectly with sexuality. When school districts have declined to do so, courts have been divided on the question of whether parents have a constitutional right to exempt their children from exposure to material that they find offensive on grounds

of their religious faith. Increasingly, courts have rejected parents' claims, pointing to public schools' broad discretion to control curriculum, as well as to the state's substantial public health interest in combating AIDS, other STDs, and teenage pregnancy.⁴² As public schools have become the forum for instruction on important public health issues, parental rights have been accorded less weight in that context.

As public schools have become the forum for instruction on important public health issues, parental rights have been accorded less weight in that context.

The battle over contraception has also largely been won by public health advocates. Teen pregnancy has declined in recent years, but its costs to the young parents, their children, and society are substantial. Teenage parents' educational attainment and socioeconomic status are lower than that of people who postpone childbearing into their twenties, and their children have lower educational achievement and poorer health than do children born to older parents.⁴³ Many states now have statutes (sometimes as part of broader minor consent statutes, described above) allowing minors to obtain contraceptive services without parental consent. Making contraceptives available through public school nurses' offices has been more controversial, though some urban public school systems allow high school students to get contraceptives this way, often with the provision that

parents can exclude their children by signing a form.⁴⁴ Many experts believe that policies making it easy for teenagers to obtain contraceptives, together with neutral educational programs that tell them how to avoid pregnancy, have played a major role in the dramatic reduction in teenage pregnancy and childbearing over the past decade.⁴⁵

Independent access to abortion by pregnant minors continues to be far more contentious. Currently, minors who are willing to involve their parents can obtain abortions subject only to the restrictions that have been found legally acceptable for adult women. The disputes arise when states restrict minors' ability to get an abortion without parental consent or involvement. In general, although the political and legal debate is often framed in terms of parental rights or teen welfare, the issue of minors' access to abortion also represents another setting in which the right to abortion itself is disputed; advocates for restricting access for minors often oppose abortion altogether.

Abortion decisions are distinctive in many ways. The issue is constitutionally important, of course; partly for this reason, many see the decision to get an abortion as fundamentally different from routine medical decisions that require parental consent. Parents may have a conflict of interest with their pregnant daughter, because of their views either about abortion or about her sexual activity and pregnancy; minors may fear their parents' anger or objection to the abortion.⁴⁶ Moreover, abortion (like other reproductive decisions) involves a private and sensitive matter that adolescents may be reluctant to discuss with their parents. Finally, the teenager considering an abortion will become a parent if the pregnancy is not terminated,

making her status as a minor subject to her parents' authority somewhat discordant.

Since it decided *Roe v. Wade* in 1972, the Supreme Court, in several opinions, has examined the constitutionality of state statutes that restrict minors' access to abortion by requiring either parental consent or parental notification.⁴⁷ In these decisions, the court has sought to balance the reproductive rights of pregnant teenagers against the parents' right to be involved in important decisions affecting their children's welfare, while also recognizing the independent interest of the state in the welfare of minors.

In *Bellotti v. Baird*, a landmark 1979 decision, the court provided a framework for regulating minors' access to abortion in states seeking to design a constitutionally acceptable process that accommodates some level of parental involvement.⁴⁸ In *Bellotti*, the court reiterated that pregnant minors have constitutionally protected reproductive rights, but it held that the state may limit minors' rights to a greater extent than would be acceptable for adult women.⁴⁹ The court justified such limits on three grounds: minors' greater vulnerability and need for protection; their lack of the "experience, perspective and judgment" needed to make sound decisions; and parents' constitutionally protected authority to guide their children's upbringing. *Bellotti* held that a state may require parental consent to abortion, but it must also provide an alternative procedure in which a minor can demonstrate that she is mature enough to make the decision without her parents' consent. If a minor is found to lack the requisite maturity, the judge (or other designated official) should decide whether abortion without parental consent is in her best interest. Thus, under the court's

guidelines, parental consent to abortion should be required only when it is in the minor's interest.

The Supreme Court has also upheld statutes that require parental notification (but not consent) before a minor can get an abortion.⁵⁰ In theory, these statutes infringe less on the pregnant minor's rights, because parents, once notified, lack the authority to block the abortion by withholding consent. But the prospect of notifying their parents constitutes a major deterrent for many teenagers, who fear their parents' response.⁵¹ Although the court did not explicitly exclude mature minors from the notification requirement, most states have established a procedure by which mature minors can avoid notification.

Some states do not distinguish between pregnant minors and adults, allowing minors to consent to abortion without parental consent or notification. But a majority of states have responded to the Supreme Court decisions by enacting statutes that establish judicial bypass hearings, in which a judge can evaluate the maturity and (sometimes) best interest of the minor seeking abortion without involving the parents.⁵² The Supreme Court did not provide any criteria to guide judges in evaluating whether a minor is "mature enough and well enough informed to make the abortion decision independently of her parents' wishes," or whether abortion without parental consent would be in her best interest.⁵³ Thus courts have broad discretion to interpret these terms and to apply the constitutionally mandated requirements.

Implementation of statutes requiring judicial bypass proceedings and the obstacles facing minors who seek abortions vary considerably across and even within states. In some states, each minor is provided an attorney to assist

her in the hearing (often through the pro bono services of bar associations); in other states, teenagers receive little assistance.⁵⁴ Further, courts take different approaches to evaluating the maturity of petitioning minors. Some courts focus narrowly on the minor's basic understanding of the medical procedure and its consequences, while others undertake a broad evaluation of the minor's maturity. Courts that use the latter approach are more likely to find the minor "immature," pointing to such factors as her financial dependence on her parents, nervousness in the hearing, and even carelessness in engaging in unprotected sex.⁵⁵ The outcomes of these proceedings also vary in different areas, although most petitions are granted. In Massachusetts, a study found that judges virtually always approve the minor's petition, either finding her sufficiently mature to make the decision or concluding that the abortion is in her best interest.⁵⁶ Courts in other states, applying rigorous maturity criteria, reject some petitions; more importantly, they likely deter some pregnant teens from petitioning in a timely manner, or at all. Further, in some areas, bypass proceedings and abortion facilities may not be available near a minor's home—a greater impediment to access for minors than for adults.

Many legal scholars have criticized judicial bypass proceedings for creating burdensome obstacles for pregnant teenagers, many of whom are already experiencing extraordinary stress.⁵⁷ The procedure itself creates delay, sometimes increasing the risk of the abortion. Moreover, although bypass hearings are supposed to be confidential, petitioning teens must reveal in court the very intimate facts of their sexual activity and condition, as well other highly personal information. As legal scholar Carol Sanger has put it, bypass hearings, despite their purportedly benign

purposes, can serve as a form of punishment for pregnant teens.⁵⁸

Treatment in the Juvenile Justice System

When juveniles commit a crime and are adjudicated delinquent, they are subject to the authority of the juvenile justice system. As part of their disposition, they may be required to participate in rehabilitative treatment. This treatment aims to reduce the risk of reoffending and to promote healthy psychological development, increasing the likelihood that delinquent youths will mature into productive adults. Moreover, adolescents in the justice system are more likely to suffer from untreated mental health problems than are youths not involved in the system, including depression, attention deficit disorders and substance abuse problems. Diagnosing and treating these problems is often essential to rehabilitation. The parents of delinquent youths may also be required to participate in treatment programs on the well-substantiated theory that parents and family may directly or indirectly contribute to adolescents' criminal activity and are often critically important to rehabilitation.⁵⁹

In the early twenty-first century, juvenile justice policy has undergone a major shift toward a more rehabilitative approach, supported by a growing consensus that juvenile offenders, due to their developmental immaturity, differ in important ways from their adult counterparts, and that, for most young offenders, treatment is more effective than harsh punishment in furthering the law's goal of reducing reoffending. This trend represents a departure from the punitive policies of the 1990s, when elevated rates of juvenile crime led many states to enact laws making it easier to prosecute and punish juveniles as adults. In the juvenile system

also, incarceration became the norm.⁶⁰ In part, the momentum behind the recent rehabilitative trend comes from a growing body of evidence that incarcerated youths have high recidivism rates and that some community-based programs not only cost less than incarceration but are quite effective at reducing reoffending.⁶¹ Moreover, research in developmental neuroscience and psychology has reinvigorated the traditional assumptions about youthful immaturity and the potential of young offenders to reform that animated juvenile courts for much of the twentieth century but fell out of favor in the 1990s.

Many states have embraced this research, as well as an evidence-based approach to juvenile crime regulation, and have diverted resources from state institutions to community-based correctional programs that are tailored to the needs of adolescent offenders. In New York, for example, a governor's task force in 2009 issued a scathing report describing abusive conditions and lack of treatment in juvenile institutions, most of which were far from offenders' homes.⁶² In response to the report and other investigations, New York City Mayor Michael Bloomberg announced that city youths would no longer be sent to these facilities. Many have been closed, with youths being sent to smaller therapeutic programs in their communities.⁶³ In 2013, a National Academy of Sciences committee issued a National Research Council report advocating a developmentally informed, research-based approach to juvenile justice policy.⁶⁴ The report cites a large body of research in strongly recommending that most youths be treated in rehabilitative programs in the community, that those who require residential treatment be placed in small facilities near their homes, and that parents play a key role in treatment.

The most effective correctional treatment programs seek to encourage healthy psychosocial development by giving juvenile offenders developmental tools and support in their social context. A critical dimension of treatment in most programs, as the NRC report suggests, is parents' participation, even for youths in residential facilities. Experts on adolescent development emphasize that authoritative parent figures are important to psychosocial maturation, and parents are frequently directed by juvenile court judges to participate in treatment programs. Thus parents whose children are in the justice system do not enjoy the deference to parental authority that other parents enjoy. Parental involvement is a core component of tested programs such as Functional Family Therapy, Multi-dimensional Treatment Foster Care, and Multisystemic Therapy (MST).⁶⁵

MST is thoroughly grounded in developmental knowledge and is one of the most effective treatment programs for adolescent offenders; it has been carefully evaluated for more than 20 years with a broad range of offenders.⁶⁶ MST combines cognitive behavioral therapy with an ecological approach that deals with individual youths in the multiple social contexts that they inhabit—their families, peer groups, schools, and communities. It focuses on giving parents the skills and resources they need to avoid problem behaviors, and it helps delinquent youths cope with family, peer, and school problems that contribute to their criminal activity. The success of MST and other programs in reducing recidivism has been instrumental in creating support for a community-based rehabilitative approach to juvenile justice policy.

Diagnosing and treating mental health problems of youth in the justice system has taken on greater urgency in recent years, with growing evidence that many delinquent

youths suffer from mental health conditions that likely contribute to their criminal activity. For example, a major study that followed teen offenders over time has found a high correlation between youthful reoffending and substance abuse, suggesting that effective treatment of offenders' drug and alcohol problems may reduce recidivism rates. Many offenders in the study received substance abuse treatment in juvenile facilities, but treatment was less common in the community. The researchers found that substance abuse treatment in the justice system reduced both substance abuse and recidivism, but only when the treatment lasted for a substantial period and involved the parents.⁶⁷

In recent years, the juvenile justice system has responded more effectively to the mental health problems (including substance abuse) of youths in the system with a simple, accurate, and inexpensive screening test. The Massachusetts Youth Screening Instrument, developed by psychologist Thomas Grisso and psychiatrist Richard Barnum, is now widely used in juvenile detention centers and has been credited with reducing suicides and increasing diagnosis and treatment of juvenile offenders' mental health problems.⁶⁸

The recent focus on treatment and rehabilitation of juvenile offenders is both paternalistic and pragmatic. A growing body of research in developmental psychology and brain science has persuaded many people that harsh adult punishment for adolescents is usually inappropriate, and likely more harmful to youths than to adult criminals.⁶⁹ But support for a rehabilitative approach to youthful offending also comes from evidence that it is more effective in reducing recidivism than the punitive sentencing policies of the 1990s. Thus, as in other areas of legal

regulation, social welfare, and not simply the welfare of minors, guides policy in response to issues of children's health.

A rehabilitative approach to juvenile crime is both less costly and likely more effective than incarceration-based policies. But like intervention in child maltreatment cases, juvenile justice dispositions represent a form of crisis intervention—the approach adopted by our libertarian legal system. As we have indicated, early childhood prevention programs that offer support to families and children have been shown to reduce adolescent offending and to produce other positive outcomes. Greater use of programs and policies that provide health care and other services—especially mental health services—to younger children and their families might reduce problem behavior in adolescence, and at a lower social cost than society incurs in responding to juvenile crime.

Conclusions

The libertarian legal framework that regulates children's health care in the United States—protecting parental rights while taking a hands-off approach to child wellbeing—has important consequences for policy. Unlike other developed countries, the United States has not undertaken an affirmative legal obligation to ensure children's health and wellbeing. This lack of a legal mandate to invest in family functioning and child health puts the onus on policy makers, researchers, and advocates to build public and political support for policies promoting child and family welfare. To do so, and to overcome philosophical opposition, requires persuasive arguments that investments in children's health will not only benefit children but will also promote social welfare.

ENDNOTES

1. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
2. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); *Bellotti v. Baird*, 443 U.S. 622 (1979); *H.L. v. Matheson*, 450 U.S. 398 (1981); *Hodgson v. Minnesota*, 497 U.S. 417 (1990).
3. *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925).
4. *Pierce v. Society of Sisters*.
5. *Wisconsin v. Yoder*, 406 U.S. 205 (1972).
6. *Prince v. Massachusetts*, 321 U.S. 158 (1944).
7. *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189 (1989).
8. United Nations Convention on the Rights of the Child, 1577 U.N.T.S. 3, preamble (1990), <https://treaties.un.org/doc/Publication/UNTS/Volume%201577/v1577.pdf>.
9. *Ibid.*, art. 24, 27(3), 28(1).
10. *Ibid.*, art. 19(1).
11. See Elizabeth Scott and Robert Scott, “Parents as Fiduciaries,” *Virginia Law Review* 81 (1995): 2401–76.
12. See Lois Weithorn and S. B. Campbell, “The Competency of Children and Adolescents to Make Informed Treatment Decisions,” *Child Development* 53 (1982): 1589–99, doi: 10.2307/1130087.
13. *Ibid.*
14. California Welfare and Institutions Code Section 300(b).
15. Administration on Children, Youth and Families, U.S. Department Health and Human Services, *Child Maltreatment 2012* (2013): 20–1, Appendix D, Exhibit 3-E, <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf>.
16. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
17. See Caroline Fraser, “Suffering Children and the Christian Science Church,” *The Atlantic* (April 1995): 53–9; see also *In re Sampson*, 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970) (case involving Jehovah’s Witness parents who refused blood transfusions for their children).
18. For a discussion of these statutes, see “Faith Healing and the Law”, Pew Research Center, Religion and Public Life Project, August 31, 2009, www.pewforum.org/2009/08/31/faith-healing-and-the-law.
19. *Hermanson v. State*, 604 So.2d. 775 (Fla. 1992).
20. *Newmark v. Williams*, 588 A.2d. 1108 (Del. 1991).
21. *In re Sampson* 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970).
22. See *Newmark v. Williams*.
23. James Dwyer, “Parent’s Religion and Children’s Welfare: Debunking the Doctrine of Parents’ Rights,” *California Law Review* 82 (1994): 1371–1432.
24. Lynn A. Karoly, M. Rebecca Kilburn, and Jill S. Cannon, *Early Childhood Interventions: Proven Results, Future Promise* (Santa Monica, CA: RAND Corporation, 2005).

25. Sarah Fass, *Paid Leave in the States: A Critical Support for Low-Wage Workers and Their Families*, National Center for Children in Poverty, Mailman School of Public Health, Columbia University, March 2009, 3.
26. See 29 U.S.C. §§ 2601–2654 (2006).
27. National Center for Children in Poverty, *Oklahoma Early Childhood Profile* (New York: Mailman School of Public Health, Columbia University), http://www.nccp.org/profiles/pdf/profile_early_childhood_OK.pdf; National Center for Children in Poverty, *Alabama Early Childhood Profile* (New York: Mailman School of Public Health, Columbia University), http://www.nccp.org/profiles/pdf/profile_early_childhood_AL.pdf.
28. “States and Local Governments with Earned Income Tax Credits,” Internal Revenue Service, last modified April 24, 2014, <http://www.irs.gov/Individuals/States-and-Local-Governments-with-Earned-Income-Tax-Credit>.
29. *Ibid.*
30. *Ibid.*
31. See Child Welfare Information Gateway, U.S. Department Health and Human Services, *How the Child Welfare System Works* (2013), <https://www.childwelfare.gov/pubs/factsheets/cpswork.pdf>, 1.
32. See Jane Waldfogel, *The Future of Child Protection: How to Break the Cycle of Abuse and Neglect* (Cambridge, MA: Harvard University Press, 1998), 124–5; Children’s Bureau, *Child Maltreatment 2012* (Washington: U.S. Department Health and Human Services, 2013), <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf>, 20.
33. See Lawrence M. Berger and Sarah A. Font, “The Role of the Family and Family-Centered Programs and Policies,” *Future of Children* 25, no. 1 (2015): 155–76.
34. See Khiara M. Bridges, “Towards a Theory of State Visibility: Race, Poverty, and Equal Protection,” *Columbia Journal of Gender and Law* 19 (2010): 965, 971–8.
35. See Alastair Bissett-Johnson and Pamela Ferguson, “Consent to Medical Treatment by Older Children in English and Scottish Law,” *Journal of Contemporary Health Law Policy* 12 (1996): 449–73; Walter Wadlington, “Minors and Health Care: The Age of Medical Consent,” *Osgoode Hall Law Journal* 11 (1973): 115–25.
36. Wadlington, “Minors and Health Care”; *Bonner v. Moran*, 126 F.2d 121 (Federal Circuit 1941).
37. Doriane Lambelet Coleman and Phillip M. Rosoff, “The Legal Authority of Mature Minors to Consent to General Medical Treatment,” *Pediatrics* 131 (2013): 786–93, doi: 10.1542/peds.2012-2470.
38. Elizabeth Scott, “The Legal Construction of Adolescence,” *Hofstra Law Review* 29 (2000): 547–98.
39. James Morrissey, “Deinstitutionalizing the Mentally Ill: Processes, Outcomes, and New Directions,” in *Deviance and Mental Illness*, ed. Walter R. Gove (Beverly Hills, CA: Sage Publications, 1982).
40. *Parham v. J.R.*, 442 U.S. 584 (1979).
41. Virginia Code Annotated, Psychiatric Treatment of Minors Act, Section 16.1-338 (2013).
42. *Brown v. Hot, Sexy and Safer Productions*, 68 F 3d 525 (1st Cir 1995).
43. Sara McLanahan and Christine Percheski, “Family Structure and the Reproduction of Inequalities,” *Annual Review of Sociology* 34 (2008): 257–76, doi: 10.1146/annurev.soc.34.040507.134549; Sara S. McLanahan and Irwin Garfinkel, “Fragile Families: Debates, Facts, and Solutions,” in *Marriage at the Crossroads: Law, Policy, and the Brave New World of Twenty-First-Century Families*, ed. Marsha Garrison and Elizabeth Scott (Cambridge, UK: Cambridge University Press, 2012): 142–69.

44. *Parents United for Better Schools, Inc. v. Philadelphia Board of Education*, 148 F3d. 260 (3rd Cir. 1998).
45. Kathryn Kost and Stanley Henshaw, *U.S. Teenage Pregnancies, Births, and Abortions 2008: National Trends by Age, Race, and Ethnicity* (New York: Guttmacher Institute, 2012), 2, <http://www.guttmacher.org/pubs/USTPTrends08.pdf>; Melissa S. Kearney and Phillip B. Levine, “Why Is the Teen Birth Rate in the United States So High and Why Does It Matter?” *Journal of Economic Perspectives* 26, no. 2 (2012): 141–66, doi: 10.1257/jep.26.2.141.
46. Kost and Henshaw, *U.S. Teenage Pregnancies*.
47. *Jacobson v. Massachusetts*.
48. *Bellotti v. Baird*.
49. *Planned Parenthood of Central Missouri v. Danforth*.
50. *H.L. v. Matheson*; *Hodgson v. Minnesota* (requiring notification of both parents in divorced families).
51. See Kost and Henshaw, *U.S. Teenage Pregnancies*.
52. Carol Sanger, “Decisional Dignity: Teenage Abortion, By-Pass Hearings and the Misuse of Law,” *Columbia Journal of Gender and Law* 18 (2009): 409–99.
53. *Bellotti v. Baird*.
54. Robert H. Mnookin, “Bellotti v. Baird: A Hard Case,” in *In the Interest of Children: Advocacy, Law Reform, and Public Policy*, ed. Robert H. Mnookin (Cambridge, MA: Harvard University Press, 1985), 149–264.
55. *In re Jane Doe*, 566 N.E.2d 1181 (Ohio 1991) (upholding a decision that a young woman lacked “maturity” because she became pregnant twice with two different men); *H.B. v. Wilkinson*, 639 F.Supp. 952 (District of Utah 1986) (finding a 17-year-old who was a good student to be immature because she lived at home, was financially dependent on her parents, sought counsel from friends rather than family members or church officials, did not believe marriage was an option in response to her pregnancy, and had sex several times without using contraceptives).
56. See Mnookin, “Bellotti v. Baird.”
57. Sanger, “Decisional Dignity.”
58. *Ibid.*
59. Laurence Steinberg, He Len Chung, and Michelle Little, “Reentry of Young Offenders from the Justice System: A Developmental Perspective,” *Youth Violence and Juvenile Justice* 2 (2004): 21–38, doi: 10.1177/1541204003260045; see also Elizabeth Scott and Laurence Steinberg, *Rethinking Juvenile Justice* (Cambridge, MA: Harvard University Press, 2008).
60. Scott and Steinberg, *Rethinking*; John DiIullo, “The Coming of the Superpredator,” *Weekly Standard*, November 27, 1995 (coining the term).
61. Elizabeth S. Scott, “*Miller v. Alabama* and the (Past and) Future of Juvenile Crime Regulation,” *Minnesota Journal of Law and Inequality* 31 (2013): 535–58.
62. Task Force on Transforming Juvenile Justice, *Charting a New Course: A Blueprint for Transforming Juvenile Justice in New York State* (New York: Vera Institute of Justice, 2009).
63. Julie Bosnan, “City Signals Intent to Put Fewer Teenagers in Jail,” *New York Times*, January 21, 2010.

64. National Research Council, *Reforming Juvenile Justice: A Developmental Approach*, ed. Richard J. Bonnie et al. (Washington: National Academies Press, 2013).
65. Scott and Steinberg, *Rethinking*.
66. Steve Aos et al., *The Comparative Costs and Benefits of Programs to Reduce Crime* (Olympia, WA: Washington State Institute for Public Policy, 2001), 2, [www://wsipp.wa.gov/ReportFile/756](http://www.wsipp.wa.gov/ReportFile/756); Scott and Steinberg, *Rethinking*.
67. Edmund Mulvey, Carol Schubert, and Laurie Chassin, "Substance Use and Delinquent Behavior Among Serious Adolescent Offenders," *Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin*, December 2010; Laurie Chassin et al., "Substance Use Treatment Outcomes in a Sample of Male Serious Juvenile Offenders," *Journal of Substance Abuse Treatment* 36 (2009): 183–94, doi: 10.1016/j.jsat.2008.06.001.
68. Thomas Grisso et al., "Massachusetts Youth Screening Instrument for Mental Health Needs of Juvenile Justice Youths," *Journal of the American Academy of Child and Adolescent Psychiatry* 40 (2001): 541–8.
69. *Graham v. Florida*, 560 U.S. 48 (2010); *Miller v. Alabama*, 132 S.Ct. 2011 (2012).