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THERE'S NO PLACE LIKE HOME: REALIZING THE VISION OF COMMUNITY-BASED MENTAL HEALTH TREATMENT FOR CHILDREN

*Yael Zakai Cannon**

The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them . . .

. . . .

There is broad evidence that the nation lacks a unified infrastructure to help these children, many of whom are falling through the cracks. Too often, children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources.¹

INTRODUCTION

Mary,² a sixteen-year-old girl from Washington, D.C., looked out the window of the van that was taking her across state lines and through the countryside to a residential treatment center, a secure facility for youth with serious behavioral, emotional, or mental health problems.³ School was incredibly frustrating for her. According to her doctors, learning was challenging for her because she was born addicted to crack cocaine. Her teachers knew that she had learning

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1. OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTION AGENDA 1, 11 (2000) [hereinafter MENTAL HEALTH: A NATIONAL ACTION AGENDA].

2. Mary's story is based on a composite of several clients with whom the author worked in her legal practice.

3. Christine F. Vaughn, *Residential Treatment Centers: Not a Solution for Children with Mental Health Needs*, 39 CLEARINGHOUSE REV. J. POVERTY L. & POL'Y 274, 274 (2005).

disabilities, but she was not receiving all of the special education services she required. She would sit in class and think about how angry she was at her birth mother for abandoning her in the hospital. She would fight with her classmates, which frequently resulted in her suspension from school. She had been arrested for one of her bigger fights and spent a few months sitting in an overcrowded juvenile hall.

School was not the only difficult place for her. After a stranger raped her a few years earlier in the alley behind her foster mother's home, she would lie awake at night fearing that she might be raped again. Mary told her foster mother and her pediatrician about the rape, and the pediatrician referred her for counseling to the city mental health agency, which would connect her with a provider that accepted her Medicaid health insurance. However, the agency said it would be several months before Mary could be squeezed in for an intake appointment and advised her to talk to her probation officer about obtaining counseling services. The probation officer told Mary and her foster mother to ask her child welfare agency social worker to help them identify a counseling provider, and her child welfare social worker told them that Mary's school was supposed to be providing her with counseling. However, her school had not included counseling services as part of her special education program. In the end, she went without counseling. Frustrated with Mary's behavior and ashamed about talk in the neighborhood that Mary was "crazy," her foster mother grounded her in the hope that Mary would "snap out of it."

Mary's fear and lack of sleep kept her on edge and defensive much of the time. She tried to end her life by swallowing a bottle of her foster mother's blood pressure pills and landed in a psychiatric hospital, only to leave a few weeks later with diagnoses for several mental health disorders but without any services. Mary continued to fail in school. At a meeting of Mary's special education team, school officials decided to send Mary to a residential treatment center. They explained to Mary's foster mother that a residential treatment facility is an institution that typically provides children with emotional and behavioral problems with constant supervision and care through a longer term program than a psychiatric hospital could offer.⁴ The first

4. *Glossary of Terms Used in Children's and Adolescents' Mental Health*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., http://crextras.com/lib/articles/therapy/types/glossary-children/2/#toc_d-s (last visited Jan. 25, 2012). There is no agreed-upon, standardized definition for residential treatment centers (RTCs), sometimes referred to as residential treatment facilities (RTCs). The American Association of Children's Residential Centers defines an RTC as "an organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seri-

available bed was located at a facility hundreds of miles from her community, in a rural area several states away.

While at the facility, Mary was isolated in a small room when staff viewed her as insubordinate, and the many hours she spent in isolation only made her more anxious. She was far from home, making it difficult for her foster mother to be involved in her treatment and for the state education agency that placed her and funded her stay at the facility to monitor her treatment, safety, and health. Her stay at the facility lasted more than a year. At the time of Mary's discharge, there was no plan in place for her to receive mental health treatment upon her return home. When she returned, she again found herself without the necessary community-based mental health services and struggled with transferring any positive treatment effects she might have experienced in the highly structured, rural facility to her hectic, unstructured, and urban daily life. She fell back into the same behavioral problems she experienced prior to her institutionalization and recidivated, cycling yet again through the juvenile delinquency system.

There are a number of federal legal regimes⁵ explicitly structured to ensure that children like Mary are provided with timely community-

ously emotionally disturbed children and youth, ages 17 and younger." *Residential Treatment Centers*, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION (OJJDP), <http://www.ojjdp.gov/mpg/progTypesResidentialTreatment.aspx> (last visited Jan. 25, 2012). A wide variety of programs can fall into this category. See U.S. GOV'T ACCOUNTABILITY OFFICE (GAO), *RESIDENTIAL TREATMENT PROGRAMS: CONCERNS REGARDING ABUSE AND DEATH IN CERTAIN PROGRAMS FOR TROUBLED YOUTH 4-5* (2007) [hereinafter *RESIDENTIAL TREATMENT PROGRAMS*] (reporting that state officials identified 71 different types of residential treatment programs for youth with mental illness). Programs often claim to provide a range of services, either on-site or through links with community programs, including educational, medical, psychiatric, and clinical or mental health services. "The Juvenile Residential Facility Census, a biennial survey conducted by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), found that more than 900 facilities identified themselves as residential treatment centers," and many also described themselves as detention centers, training schools, group homes, ranches or wilderness camps, boot camps, diagnostic centers, or homeless or runaway shelters. *Residential Treatment Centers*, *supra*. The number of residents held in facilities that self-identified as RTCs varied, with most reporting that they currently hold eleven to fifty residents in their individual facilities. *Id.* A subset of residential facilities qualifies as psychiatric residential treatment facilities (PRTFs) under federal regulations. 42 C.F.R. § 483.352 (2010). The federal Centers for Medicare and Medicaid Services note that PRTFs are for children who require more intensive services and must be certified as PRTFs. Memorandum from Ctr. for Medicare & Medicaid Servs. to State Survey Agency Dirs. (Feb. 16, 2007), available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter07-15.pdf>. This Article uses the broader term "RTCs" to include those facilities that qualify as certified PRTFs under the Medicaid regulations, but also the other types of facilities described in this footnote.

5. The term "legal regime" is used to describe a variety of components that govern a particular system, such as statutes, regulations, and case law, as well as policies, guidance, and orders from executive agencies.

based mental health treatment. This Article argues that local and state public agencies often fail to comply with their duties and fulfill the aims of these federal regimes, leading to unnecessary institutionalization of youth. Mary's placement in a residential treatment facility reflects a failure of the multiple systems in which she was involved to achieve the goals of related federal legal regimes. Like Mary, a child living in poverty may be entangled in the child welfare and juvenile justice systems and may have unmet special education and health care needs. Rather than coordinating to address a child's needs holistically, these systems typically operate as though they are in silos. For example, officials from the child welfare agency responsible for a child's foster care placement might never communicate with the school officials responsible for the child's special education needs. This can lead to failure and crisis in both the foster home and the school, resulting in the child's placement in a more restrictive institutional setting.

Just as public agencies often operate in silos, the examination of problems affecting low-income youth also typically occurs through singular, myopic lenses. Scholars often engage in an individual assessment of challenges related to one system, such as the child welfare system or the juvenile justice system.⁶ In addition, courts usually segregate hearings related to children, with family court judges handling an "abuse/neglect docket" *and* handling a "juvenile delinquency docket" in different family court hearings and different administrative hearing officers handling special education and Medicaid-related claims in other fora. Moreover, attorneys are appointed by courts or offer themselves for hire for a particular category of matters and typically remain in their own silos.⁷ This Article expands the analysis of

6. This Article builds on the work of those scholars who analyze the intersections between two different legal systems that affect children by examining connections among the multitude of legal regimes that can have an impact on the lives of children living in poverty. *See, e.g.,* Joseph B. Tulman, *Special Education Advocacy for Youth in the Delinquency System*, in *SPECIAL EDUCATION ADVOCACY* 401 (Ruth Colker & Julie K. Waterstone eds., 2011) (examining intersections between the special education and juvenile delinquency systems).

7. For example, juvenile public defenders are explicitly appointed to defend a child client in connection with a delinquency charge and are typically only provided with the resources and armed with the expertise to focus on that particular problem. For the many children involved with multiple systems, coordination and communication by a juvenile public defender with a child's attorney or *guardian ad litem* in a dependency matter or counsel for the child's parent in a special education matter rarely occurs. There are important merits in specialization by family court judges and attorneys, as well as public agencies, which could cut against a more coordinated model, such as the "one family, one judge" model sometimes used in the family court in the District of Columbia's Superior Court. *See* D.C. CODE § 11-1104 (LexisNexis 2001 & repl. vol. 2008) (providing for the consolidation, where practical and feasible, of cases involving the same individual or family before one family court judge). Moreover, attorneys may strategically

the legal systems affecting at-risk youth by looking at them holistically, analyzing their intersections, and evaluating the harmful effects of the compartmentalization. As a result of this compartmentalization and other factors, the common goals of federal legal regimes related to child welfare, special education, health care, juvenile justice, and disability rights continue to go unrealized, resulting in the denial to children of much-needed treatment and educational services and their subsequent placement in restrictive settings.

Part II examines the over-institutionalization of children in harmful and costly residential treatment centers (RTCs), a largely invisible problem about which policymakers, judges, attorneys, and taxpayers should all be concerned.⁸ Part III reviews the various legal regimes structured to ensure that children with mental health needs receive community-based services and remain out of these institutions.⁹ Through their statutes, regulations, case law, and policies, federal legal regimes related to child welfare, special education, health care, juvenile justice, and disability rights share these common aims, which remain unrealized. Part IV assesses the reasons for the disjunction between the shared goals of these legal regimes and the reality that many children living in poverty are unnecessarily institutionalized due to their inability to access community-based services.¹⁰ The stigma surrounding mental illness, compartmentalization among child-serving public agencies,¹¹ and the scarcity of providers contribute collectively to this disjunction, with devastating consequences.

In Part V, the Article concludes by calling for the fulfillment of the goals of these legal regimes through the implementation of principles and best practices in the field of children's mental health identified by researchers in other disciplines, such as psychiatry, psychology, social

choose to avoid coordination because challenges can occur if sensitive information is shared across systems. Despite these tensions, coordination among different stakeholders and actors in a child's life can promote more positive outcomes in many cases, especially if the coordination can occur before a child is entangled in the child welfare or juvenile justice systems. Even if a child is already court-involved, a holistic approach to the child's needs can sometimes prove beneficial. For example, the education of a juvenile court judge about a child's disability could have a positive impact on the adjudication of a delinquency charge. Tulman, *supra* note 6, at 416–21.

8. See *infra* notes 15–58 and accompanying text.

9. See *infra* notes 59–299 and accompanying text.

10. See *infra* notes 300–39 and accompanying text.

11. See April Land, *Dead to Rights: A Father's Struggle to Secure Mental Health Services for His Son*, 10 GEO. J. ON POVERTY L. & POL'Y 279, 281 (2003) ("The agencies responsible for administering federal law must not be permitted to continue to avoid compliance with clear statutory mandates. They are failing to meet their legal responsibilities by asserting that services should be provided by other agencies, rather than coordinating efforts with those other agencies to ensure that children get services that are necessary and required by federal law.").

work, and health policy.¹² Public agencies should adopt and make operational the “system of care” philosophy, an approach to children’s mental health developed by the National Institute of Mental Health that emphasizes coordination among various child-serving public agencies.¹³ Local and state agencies should also ensure the provision of specific mental health services proven to be effective through valid and robust scientific studies, known as “evidence-based practices,”¹⁴ to keep children at home and in their communities.

II. THE UNWARRANTED AND COSTLY INSTITUTIONALIZATION OF CHILDREN IN RESIDENTIAL TREATMENT FACILITIES

“Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills.”¹⁵ However, mental health disorders that at least minimally impair a child’s functioning and quality of life affect almost twenty-one percent of children aged nine to seventeen,¹⁶ and these disorders occur frequently among children living in poverty,¹⁷ who are also most likely to have their mental health needs go

12. See *infra* notes 340–460 and accompanying text.

13. See JANICE L. COOPER ET AL., NAT’L CTR. FOR CHILDREN IN POVERTY, UNCLAIMED CHILDREN REVISITED: THE STATUS OF CHILDREN’S MENTAL HEALTH POLICY IN THE UNITED STATES 6 (2008), available at http://www.nccp.org/publications/pdf/text_853.pdf. The system of care philosophy has been adopted in name by many states, but has not been made operational through the development of policies or practices by most states. *Id.* When meaningfully implemented, the approach reflects the intentions of federal legal regimes by emphasizing access to:

Comprehensive service array; Individualized services based on individualized needs and service plans; Clinically-appropriate, least-restrictive service settings; Families as full partners in service planning, decision-making, and delivery; Integrated service delivery; Case coordination and seamless service delivery; Early identification and intervention; Seamless transitions to adulthood; Culturally responsive services and supports; [and] Youth and family rights and advocacy.

Id. at 7.

14. *Id.* at 42; see also Edward J. Mullen, *Facilitating Practitioner Use of Evidence-Based Practice*, in *DESK REFERENCE FOR EVIDENCE-BASED PRACTICE IN HEALTHCARE AND HUMAN SERVICES* (A. R. Roberts & K. Yeager eds., 2004), available at www.columbia.edu/cu/musher/EBP%20Oxford%20Press%20Chapter.doc.

15. OFFICE OF THE SURGEON GEN., U.S. DEP’T OF HEALTH & HUMAN SERVS., *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* 123 (1999) [hereinafter *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL*].

16. *Id.*

17. *MENTAL HEALTH: A NATIONAL ACTION AGENDA*, *supra* note 1, at 21. Economic hardship can indirectly increase a child’s risk of developing a behavioral disorder because it may lead to behavioral problems in the child’s parents or increase the risk of child abuse. Exposure to acts of violence, which may be more likely for children in impoverished communities, can also cause stress-related mental health problems. Overcrowding or large family size can also predispose children to certain mental health disorders. For a discussion of “psychosocial risk factors” that can endanger a child’s mental health, see *MENTAL HEALTH: A REPORT OF THE SURGEON*

unmet.¹⁸ The burden these children suffer can be crippling. Out of all of the health conditions that children might experience, emotional and behavioral impairments are most likely to lower their quality of life and reduce their opportunities for success in adulthood. "No other set of conditions is close in the magnitude of its deleterious effects on children and youth"¹⁹

There are a variety of mental health disorders that can affect youth, such as anxiety disorders, mood or depressive disorders (including bipolar disorder), conduct disorders, and Attention Deficit Hyperactivity Disorder (ADHD).²⁰ These and other mental health disorders can affect a child's ability to function at home, at school, and in his community more generally.²¹ Children who experience emotional or behavioral problems can often benefit from mental health evaluations and treatment regardless of whether doctors have formally diagnosed or identified one of these disorders.²² A child whose functioning is significantly impaired as a result of a mental health disorder is characterized as having a "serious emotional disturbance."²³

States struggle to respond to the needs of these children, especially those with complex needs.²⁴ While some states are trying to develop appropriate public health frameworks to address these needs, progress

GENERAL, *supra* note 15, at 130, and MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 21.

18. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 121.

19. *Id.* at 17.

20. For a detailed description of mental health disorders affecting children and youth, including assessment and diagnosis considerations, prevalence, causes, and treatment modalities, see MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 136–67. These disorders can manifest in different ways. Anxiety disorders include post-traumatic stress disorders, phobias, panic disorders, and obsessive compulsive disorders. *Id.* at 160. Five percent of children have ADHD, and these children can be impulsive, inattentive, hyperactive, aggressive, or some combination thereof. Susan P. Leviton, *Children of Color with Mental Health Problems: Stuck in All the Wrong Places*, 2 MARGINS 13, 15 (2002).

21. See MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 123.

22. Due to a variety of reasons, including lack of insurance, limited insurance coverage of mental health services, the stigma surrounding mental health problems in their families and communities, and inaccurate diagnoses, poor children and children of color with mental health disorders often go undiagnosed and go without needed services. See *id.* at 20.

23. BAZELON CTR. FOR MENTAL HEALTH LAW, MAKING SENSE OF MEDICAID FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE 2 (1999), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=KZ5bUO8S1yM%3d&tabid=104> [hereinafter BAZELON CTR. FOR MENTAL HEALTH LAW, MAKING SENSE OF MEDICAID] ("About one in five children suffers from a diagnosable mental, emotional or behavioral disorder, and a significant proportion of these children have disorders that have a substantial impact on their ability to function. According to recent estimates, 9–13% of children aged 9–17 have a serious emotional disturbance which causes a 'substantial functional impairment;' 5–9% have a serious emotional disturbance which causes 'extreme functional impairment.'") (footnote omitted).

24. COOPER ET AL., *supra* note 13, at 6.

is slow.²⁵ Although most states have some programs in place to address the mental health needs of children, only a small number are addressing these problems for children from birth to age twenty-one.²⁶ Today's calls for reform in the field of children's mental health echo many of the concerns articulated in the 1960s: most children in need of mental health services are not getting them, and those served are often placed in excessively restrictive settings.²⁷ More community-based treatment options short of hospitalization and residential treatment are needed.²⁸ Mental health services that are proven to achieve stability for a child without institutionalization are underutilized.²⁹

One of the most troublesome consequences of the failure of public agencies to ensure that children are provided with these community-based services is the unnecessary institutionalization of children, a consequence that Mary suffered when all of the systems that were responsible for her mental health, education, and stability failed her. This institutionalization often occurs at RTCs, which provide varying types of services³⁰ and range from structured facilities resembling hospitals to those that are more similar to group homes or halfway houses.³¹ These facilities may describe themselves as "wilderness therapy programs, boarding schools, academies, behavioral modification facilities, and boot camps, among other names."³² Many of these facilities are privately owned, and parents with financial resources can directly place their children in these centers. However, most children from low-income families are placed in RTCs through a number of different state and local agencies, including health care, mental health,

25. *Id.* See generally BAZELON CTR. FOR MENTAL HEALTH LAW, STILL WAITING . . . THE UNFULFILLED PROMISE OF OLMSTEAD 1, 2 (2009) (finding that ten years after the Court's decision in *Olmstead*, public mental health systems have yet to adequately shift toward more cost-effective, community-based approaches to mental health) [hereinafter BAZELON CTR. FOR MENTAL HEALTH LAW, STILL WAITING].

26. COOPER ET AL., *supra* note 13, at 6.

27. BETH A. STROUL, SYSTEMS OF CARE: A FRAMEWORK FOR SYSTEM REFORM IN CHILDREN'S MENTAL HEALTH 2 (2002), available at <http://gucchd.georgetown.edu/products/SOCISueBrief.pdf>.

28. *Id.*

29. See discussion *infra* Part IV. For a discussion of services that can benefit youth with mental health disorders, particularly those of color and those involved in the delinquency system, see Leviton, *supra* note 20, at 17, 33–35.

30. RESIDENTIAL TREATMENT PROGRAMS, *supra* note 4, at i. RTCs typically market themselves for "boys and girls with a variety of addiction, behavioral, and emotional problems" and "provide a range of services, including drug and alcohol treatment, confidence building, military-style discipline, and psychological counseling" for illnesses such as depression and attention deficit disorder. *Id.*

31. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 170.

32. RESIDENTIAL TREATMENT PROGRAMS, *supra* note 4, at 1.

juvenile justice, child welfare, and special education agencies.³³ Poor children are disproportionately sent to RTCs, meaning that federal and state funding—and therefore taxpayers—pay for most of this institutionalization.³⁴ Children can remain in these facilities, at a cost of hundreds of dollars per child per day for many months or even years,³⁵ long after they are ready for discharge, as a result of the unavailability and inadequacy of mental health services in their home communities.³⁶ By funneling children into these high-cost treatment centers, states are spending money that they could otherwise be using to build robust, effective, and less expensive community-based mental health services.³⁷ While only eight percent of children treated for mental health disorders spend time in a residential facility, “nearly one-fourth of the national outlay on child mental health is spent on care in these settings.”³⁸

Despite arguments in favor of RTCs citing community protection, child protection, and the benefits of residential treatment, “none of these justifications have stood up to research scrutiny.”³⁹ The growing

33. See Lenore Behar et al., *Protecting Youth Placed in Unlicensed, Unregulated Residential “Treatment” Facilities*, 45 FAM. CT. REV. 399, 408 (2007); RESIDENTIAL TREATMENT PROGRAMS, *supra* note 4, at 1.

34. Vaughn, *supra* note 3, at 274. Medicaid and state mental health agencies pay for approximately 31% of RTCs, and other public agencies, such as child welfare and juvenile justice agencies, pay for another 50%. *Id.*

35. The court monitor in *Dixon v. Gray* reported on estimates by the District of Columbia Office of the City Administrator that the city spends approximately \$37.5 million per year to place 425 youth in RTCs. That means, on average, that the city spends \$88,235 per year, or \$241 per day, to fund a child’s residential treatment placement. DENNIS R. JONES, COURT MONITOR, REPORT TO THE COURT 36 (2008). The Justice Policy Institute compiled data of state spending on post-adjudication commitment of youth in the delinquency system to residential facilities and found that the cost per day per youth in some states can be more than \$400. JUSTICE POLICY INST., THE COSTS OF CONFINEMENT: WHY GOOD JUVENILE JUSTICE POLICIES MAKE GOOD FISCAL SENSE 4 (2009), available at http://www.justicepolicy.org/images/upload/09_05_REP_CostsOfConfinement_JJ_PS.pdf. The Bazelon Center cites the cost at up to \$700 per day. BAZELON CTR. FOR MENTAL HEALTH LAW, FACT SHEET: CHILDREN IN RESIDENTIAL TREATMENT CENTERS 6, available at http://bazelon.org/LinkClick.aspx?fileticket=D5NL7igV_CA%3D&tabid=247.

36. These children, who remain in psychiatric hospitals and RTCs after they are ready for discharge due to the unavailability of necessary community-based mental health services to make their return possible, are sometimes referred to as “stuck kids.” Alyssa E. Scaparotti, *Serious Emotional Disturbances: Children’s Fight for Community-Based Services Through Medicaid Litigation*, 41 SUFFOLK U. L. REV. 193, 196 (2007); Lois Weithorn, *Envisioning Second-Order Change in America’s Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1310 (2005).

37. Scaparotti, *supra* note 36.

38. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 169. As of 2005, up to 50,000 children per year are housed in RTCs. Vaughn, *supra* note 3, at 274.

39. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15; see also Vaughn, *supra* note 3, at 274.

body of research in this area reveals that a child's stay in these costly facilities does not result in better outcomes for the child and that evidence-based mental health treatment in the community more effectively serves the child.⁴⁰ A U.S. Surgeon General report describes various factors leading to ineffective treatment in these facilities, including the failure of children in those placements to learn behavior needed in the community, the possibility of trauma associated with the separation from the family, difficulty reentering the family, and even actual abandonment by the family following a child's release from the facility.⁴¹

When a child is placed in residential treatment, the facility is often locked, highly structured, and located far from the child's home. In these ways and others, the experience does not mirror the home and community to which the child will eventually return and in which she will need to function.⁴² A child does not learn how to live with her family in her own community at an RTC, and her family does not learn how to effectively include her in the household and address her needs.⁴³ The distance from home often makes meaningful contact and involvement in the child's treatment by family members or other important individuals impossible, especially for families with limited resources, reducing the efficacy of treatment.⁴⁴ A child's removal from her home and community "deprive[s] the child of important connections and developmental opportunities."⁴⁵ These youth are also at risk of learning antisocial or bizarre behavior from intensive exposure to other disturbed children.⁴⁶ Research shows that community-based mental health treatment, through which children can develop and maintain relationships with their families and a broader range of

40. See, e.g., MODELS FOR CHANGE, RESEARCH ON PATHWAYS TO DESISTANCE 5 (2009), available at <http://www.modelsforchange.net/publications/239>; MAGELLAN HEALTH SERVS., PERSPECTIVES ON RESIDENTIAL AND COMMUNITY-BASED TREATMENT FOR YOUTH AND FAMILIES 2 (2008), available at <http://www.mtfc.com/2008%20Magellan%20RTC%20White%20Paper.pdf>. There is no evidence that youth with violent or aggressive tendencies improve in RTCs. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 170.

41. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15.

42. See COMMONWEALTH OF PA. OFFICE OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., WHITE PAPER COMMUNITY ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES 2 (2008), available at [http://www.pccyfs.org/dpw_ocyfs/OMHSAS-PRTF_Paper\(Final\)04%2704%2708.pdf](http://www.pccyfs.org/dpw_ocyfs/OMHSAS-PRTF_Paper(Final)04%2704%2708.pdf) ("Furthermore, there is no evidence of a relationship between any outcomes achieved in residential treatment and subsequent functioning in the community.").

43. See Weithorn, *supra* note 36, at 1505 ("[P]olicy responses that rely primarily on out-of-home placements are likely to provide little more than short-term containment of a crisis and will undoubtedly fail.").

44. Vaughn, *supra* note 3, at 274.

45. Weithorn, *supra* note 36, at 1452.

46. See MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 170.

peers, is both more effective and less costly than residential services, making the nationwide shortage of community-based services for children with mental health disorders all the more distressing.⁴⁷

Children are also at risk of abuse and neglect at RTCs.⁴⁸ A report by the American Bar Association's Youth at Risk Initiative detailed numerous basic human rights violations at RTCs, including youth deaths, inhumane and degrading discipline,⁴⁹ inappropriate and dangerous use of seclusion and restraint,⁵⁰ medical and nutritional neglect,⁵¹ and severe restrictions on communications and visits with parents, attorneys, and advocates.⁵² In a report investigating abuse and deaths in residential treatment programs for youth, the U.S. Government Accountability Office identified thousands of allegations of abuse at RTCs across the country, some of which resulted in death.⁵³ With many children placed in RTCs far from home, often in other states,⁵⁴ the lack of resources, bureaucratic hurdles, geographic limita-

47. Dennis E. Cichon, *The Ignored Populations: Children in the Mental Health System*, 17 T.M. COOLEY L. REV. 9, 9 (2000).

48. Vaughn, *supra* note 3, at 274.

49. Although the American Bar Association specifically focused on unregulated private RTCs, its report noted that forty-five percent of respondents stated that they were sometimes or often emotionally, physically, or sexually abused by staff. Behar et al., *supra* note 33, at 406. Specific reports of inhumane treatment included reports of forced labor, restricted access to the bathroom, scare tactics, and exposure to harsh elements like extreme heat, snow, or rain. *Id.*

50. One survey respondent noted:

They had a room with tile flooring where the kids went at 6:00 am until 10:00 pm, where each hour you would rotate positions. One hour would be lying on your stomach with your chin on the ground, the next position was standing on your knees for an hour and the next one was standing for an hour with your nose to the wall.

. . . .

They would duct tape your hands behind your back then your legs together then wrap you up in a blanket like a burrito and duct tape that tighter so you couldn't move or get out. Sometimes it would be so tight kids would be screaming that they couldn't breathe and really start panicking. They made the students do this to other students.

Id. at 405.

51. Respondents reported food and nutritional deprivation, sleep deprivation, and excessive exercise. *Id.* at 406.

52. Letters and conversations were filtered, restricted, or interrupted; similarly, calls, visits, and other parental contact were limited, sometimes for as long as six months. *Id.* at 401, 405.

53. In looking at data from the years 1990 through 2007, the allegations examined by the GAO included

reports of abuse and death recorded by state agencies and the Department of Health and Human Services, allegations detailed in pending civil and criminal trials with hundreds of plaintiffs, and claims of abuse and death that were posted on the Internet. For example, during 2005 alone, 33 states reported 1,619 staff members involved in incidents of abuse in residential programs.

RESIDENTIAL TREATMENT PROGRAMS, *supra* note 4, at i.

54. See *Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions*, MENTAL HEALTH AM., <http://www.nmha.org/go/position-statements/44> (last visited Jan. 26, 2012).

tions, and other obstacles facing state and local agencies funding these placements make it difficult for agency officials to visit children in these facilities and provide effective oversight and monitoring.⁵⁵ The infrequency of visits from family members and state officials compounds the risk of abuse, neglect, and dangerous restraint and seclusion practices.⁵⁶

Despite the overwhelming costs to both taxpayers and to many of the children who are sent there by public agencies, the overuse of RTCs is not a widely known or discussed problem among policymakers, courts, or scholars. The range of names for these types of facilities masks their true character. In most instances, RTCs are “total institutions,” closed worlds where the residents are regimented, surrounded only by other residents, and unable to leave the premises.⁵⁷ However, the terminology used to describe these facilities as “centers” or “homes” that provide “care,” rather than “institutions” or “hospitals,” may contribute to the invisibility of the problem by making it seem more benign. The more prominent concerns regarding the institutionalization of adults with mental disabilities in state psychiatric hospitals, for example, have not typically been extended to the discussion of the placement of children in RTCs. Family court judges and attorneys usually do not engage in intensive due process considerations or exercise significant caution and scrutiny when a public agency proposes to send a child to residential treatment. Because these facilities are not treated as institutions, such placements may never come before a court for review. However, due to the high financial cost, the unnecessary restriction on the liberty interests of children, the likelihood of poor outcomes for these children, and the societal costs that can result from a child’s continued instability, policymakers, courts, attorneys, and the general public should all be concerned about the overuse of

55. RESIDENTIAL TREATMENT PROGRAMS, *supra* note 4, at i; Vaughn, *supra* note 3, at 274; Amended Complaint at 43–44, *Charlie H. v. Whitman*, No. 99-3678 (GEB) (D.N.J. Oct. 6, 2000).

56. See, e.g., UNIV. LEGAL SERVS., INC., OUT OF STATE, OUT OF MIND: THE HIDDEN LIVES OF D.C. YOUTH IN RESIDENTIAL TREATMENT CENTERS 5–6 (2009), available at <http://www.uls-dc.org/out%20of%20state%20out%20of%20mind%20revision%20final.pdf>. The *Washington City Paper* noted that many incidents of violence in RTCs go unreported. Jason Cherkis, *Boxed In*, WASH. CITY PAPER (Jan. 7, 2011), <http://www.washingtoncitypaper.com/articles/40237/outsourcing-troubled-dc-kids/full>.

57. See ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES 12 (1961) (analyzing the characteristics of “total institutions” and arguing that the most important factor affecting a patient in a mental hospital is the institution, not his illness, and that his reactions and adjustments are the same as those of inmates in other types of institutions, such as prisons).

residential treatment for children with mental health needs, especially as the rates of admission to these facilities continue to increase.⁵⁸

III. LEGAL REGIMES THAT PROMOTE THE PROVISION OF MENTAL HEALTH TREATMENT IN THE COMMUNITY AND FREEDOM FROM INSTITUTIONALIZATION

Various federal legal regimes that affect children with mental health disorders are structured to ensure that these children receive services and treatment in the community and remain out of institutional settings whenever possible. While most scholars, courts, attorneys, and government agencies view the needs of at-risk children through one particular lens, a broader analysis of the intersections among federal legal regimes related to child welfare, juvenile justice, disability rights, healthcare, and special education reveals that all of these regimes share common goals. Federal statutes, their accompanying regulations, and case law in all of these realms require local and state agencies to provide children with necessary mental health and educational services in their communities, not just in institutions. These federal legal regimes also mandate that different child-serving public agencies coordinate with one another to ensure that children receive timely services to address their mental health disorders and behavioral problems in their homes, schools, and communities. If the aims of these legal regimes were carried out as intended, more children would receive the treatment they need, thereby avoiding needless institutionalization in ineffective and costly RTCs.

A. *The Child Welfare Legal Regime*

Children in foster care are routinely denied adequate education, and mental and physical health care. . . .

. . . .

Despite benevolent interventions and billions of dollars, the government has proven to be a poor surrogate parent—seemingly incapable of ensuring that these children receive the education, medical care and counseling that all children need. In the end, troubled children end up as troubled adults. The personal anguish becomes a public calamity.⁵⁹

Children involved in the child welfare system have high rates of mental health needs. Some children enter the system because their

58. Weithorn, *supra* note 36, at 1310.

59. STATE OF CAL. LITTLE HOOVER COMM'N, STILL IN OUR HANDS: NO LEADER, NO ACCOUNTABILITY 1, 2 (2003), available at <http://www.lhc.ca.gov/studies/168/report168.pdf> (internal quotation marks omitted) (providing a report to California Governor Gray Davis on the state of the foster care system in California).

parents are unable to control their behavior or because the children are in a constant state of emotional crisis. As a result, it appears to the child welfare system that the parents cannot adequately supervise the child or that they have abused the child. Child welfare agencies might also mistakenly view the parent's inability to control the child or the child's instability as neglect. Other parents may actually abuse or neglect a child in response to the child's attention deficits, behavior problems, difficult temperaments, or aggression.⁶⁰ Such problems on a child's part, or parental perception of these problems, are associated with a higher risk of child maltreatment.⁶¹ When parents have poor coping skills, difficulty controlling their emotions, or difficulty empathizing with their child, they are even more likely to maltreat a child with mental health or behavioral problems.⁶² The maltreatment might only serve to reinforce the behavioral problems and create conditions that lead to a reoccurrence of the maltreatment, such as when a physically abused child exhibits increased aggression, eliciting further harsh reactions from his parents.⁶³ A parent may be charged with abuse or neglect as a result of her attempts to curb the child's out-of-control behavior or to keep that child or his siblings safe.

Other parents who have clearly not engaged in any abuse or neglect are so desperate to secure mental health services for their children that they agree to give up custody of their children to child welfare agencies in the hopes of obtaining needed treatment for their children. For example, some parents are denied needed services by their health insurance, cannot afford out-of-pocket mental health expenses, or have not been able to otherwise secure necessary mental health services for their children. These parents sometimes engage in a phenomenon known as "custody relinquishment" by filing a petition in dependency court in an effort to force the state to provide mental health services.⁶⁴ In extreme cases, some innocent parents even claim

60. JILL GOLDMAN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., A COORDINATED RESPONSE TO CHILD ABUSE AND NEGLECT: THE FOUNDATION FOR PRACTICE 33 (2003), available at <http://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf>.

61. *Id.*

62. *Id.*

63. *Id.*

64. *See, e.g.*, North v. D.C. Bd. of Educ., 471 F. Supp. 136, 139 (D.C. 1979); Cichon, *supra* note 47, at 11 (noting that in South Dakota, a sparsely populated state, at least seventy-five families annually relinquished custody of a child with an emotional impairment by filing Child in Need of Supervision petitions with the juvenile court because they were unable to access services by other means).

that they have abused or neglected their children in order to obtain services.⁶⁵

The *New York Times* described the difficulties faced by these parents, who are often dealing not only with a child who has mental illness, but also with the child's siblings' reactions, as well as the parents' own exhaustion and frustration in trying to access needed services.⁶⁶ The challenges these parents faced in trying to secure necessary mental health services for their children reflect the frequent failure of private insurance to pay for intensive treatment, the small number of state-financed beds for mental health patients, and the long wait list for mental health services.⁶⁷

When a parent turns over his child to obtain services or the child enters foster care as a result of an abuse or neglect allegation, the parent cannot just ask for the child back; he has to obtain the approval of a judge. The parent has no control over where his child is sent or, in some cases, what treatment the child receives. Some parents who have relinquished custody have even lost track of their children entirely.⁶⁸ When these children enter the foster care system, that system must often turn to the same overburdened community of mental health clinics that could not initially meet the needs of these children.⁶⁹ Local child welfare agencies are likely to place these children with foster parents who are unaware of their mental health problems and lack the necessary training to deal with them.⁷⁰ Many of these children inevitably end up admitted to psychiatric hospitals or RTCs.⁷¹ These problems are not limited to the state of New York. Unfortu-

65. See Rebecca G. W. Random, *Custody Relinquishment to Obtain Mental Health Services*, 7 J.L. & FAM. STUD. 475, 478 (2005).

66. See Shaila K. Dewan, *Parents of Mentally Ill Children Trade Custody for Care*, N.Y. TIMES, Feb. 16, 2003, at N35; see also Ericka S. Garcia, *Where Do Foster Children with Disabilities Fit?: How the State Legislatures Must Create the Programs for Specialized Services to Ensure the Proper Fit*, 30 U. LA VERNE L. REV. 131, 149 (2008); Tracy J. Simmons, *Relinquishing Custody in Exchange for Mental Healthcare Services: Undermining the Adoption and Safe Families Act's Promise of Reasonable Efforts Towards Family Preservation and Reunification*, 10 J.L. & FAM. STUD. 377 (2008).

67. See Dewan, *supra* note 66. At the time, there were only 610 spots in New York for a Medicaid program that pays for services such as in-home counseling for children who are at risk of being hospitalized. *Id.* Theoretically, children in foster care can be sent to facilities that have many more openings and at least some mental health services. Officials at the New York City Administration for Children's Services estimated that half their intensive-care beds were filled not with children who had been abused or neglected, but with children who were "placed there directly by their parents or through a court program for troubled youths that parents enter voluntarily." *Id.*

68. *Id.*

69. See *id.*

70. Cichon, *supra* note 47, at 11.

71. *Id.* at 11-12.

nately, "the quandary of custody versus care is a phenomenon throughout the country."⁷²

In *North v. D.C. Board of Education*, the district court examined a situation in which the local school board was urging a couple to relinquish custody to secure mental health treatment for their child.⁷³ The court concluded that a neglect proceeding was inappropriate and credited expert testimony that a neglect proceeding would have a devastating impact on the child's course of treatment.⁷⁴

The child's emotional problems have been significantly exacerbated by his perception that he has been abandoned by his parents, and the unrefuted medical opinion is that the stigma of having his parents adjudicated neglectful and unwilling to care for him would seriously cripple efforts to deal with his problems and to reunite his family.⁷⁵

The court admonished the Board of Education, which forced the family to "face the Hobson's choice" of giving up the necessary treatment or suffering the emotional damage that would accompany a neglect finding, finding that either choice would cause irreparable injury.⁷⁶

When children enter the child welfare system, whether their parents voluntarily relinquished custody or were involuntarily subject to allegations of abuse and neglect, they are likely to require some form of mental health treatment. Many of these children have unmet mental health needs associated with the maltreatment they suffered or the effects of separation from their families. The federal statutes that govern the child welfare system aim to provide children with necessary community-based mental health treatment both prior to removal from their biological homes and while in out-of-home placements, such as foster homes.⁷⁷ These statutes also intend for children to be placed in

72. Dewan, *supra* note 66.

73. *North v. D.C. Bd. of Educ.*, 471 F. Supp. 136, 136-37 (D.C. 1979). The school board argued the appropriate procedure for the child to receive required mental health services was for his family to pursue a neglect action so that he could be placed in the custody of the city's child welfare agency, which could only fund necessary treatment if the child was adjudicated neglected and placed in the agency's permanent custody. *Id.* at 139-41.

74. *Id.* at 140.

75. *Id.*

76. *Id.* at 141.

77. The Child Abuse Prevention and Treatment Act was enacted in 1974 to require states to establish child abuse reporting procedures and provides guidelines for agencies to work together in that process. 42 U.S.C. § 5106 (2006). The Adoption Assistance and Child Welfare Act of 1980 was established to protect children, while maintaining and reunifying families and requires reasonable efforts to prevent unnecessary removal of a child from his home. Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.). The Adoption and Safe Families Act amended the Adoption Assistance and Child Welfare Act of 1997, with a focus on promoting the adoption of children in foster care. Pub. L. No. 105-89, 111 Stat. 2116 (codified in scattered sections of 42 U.S.C.). The Child and Family Services Improvement Act of 2006 was passed with

the most family-like setting near their parents' home, rather than in congregate care facilities like RTCs.

Federal child welfare laws require states to take affirmative steps to try to maintain the family unit, and discourage out-of-home placements.⁷⁸ To prevent removal from the home, states in receipt of federal funding must make "reasonable efforts" to preserve and reunify

the intent to promote stable families. Pub. L. No. 109-288, 120 Stat. 1233 (codified in scattered sections of 42 U.S.C.). The Fostering Connections to Success and Increasing Adoptions Act of 2008 improved outcomes for children in foster care and improved incentives for adoption. Pub. L. No. 110-351, 122 Stat. 3949 (codified in scattered sections of 42 U.S.C.). These statutes incentivize states to provide mental health treatment, coordinate with other agencies, and place children in family-like settings close to their parents' homes through grants and through conditioning federal funding on compliance.

78. Although this Article focuses on statutory regimes, the Fourteenth Amendment of the Constitution might also serve to protect the rights of children in the custody of state child welfare systems to a minimum level of mental health treatment. In *Youngberg v. Romeo*, the Supreme Court assessed the rights of an individual with intellectual disabilities who was involuntarily committed to a state institution under the Due Process Clause of the Fourteenth Amendment. 457 U.S. 307 (1982). The Court determined that the Due Process Clause does confer rights to "safe conditions of confinement, freedom from bodily restraint, and training or 'habilitation'" as considered reasonable in the judgment of a qualified professional. *Id.* at 307. After acknowledging the right to certain basic provisions as food, clothing, shelter, and medical care, the Court determined that "the State is under a duty to provide respondent with such training as an appropriate professional would consider reasonable to ensure his safety and to facilitate his ability to function free from bodily restraints." *Id.* at 324. The Court later limited its holding in *Youngberg* to "stand only for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being." *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 199-200 (1989). In a footnote, the Court noted that although such a duty was not found in the *DeShaney* case where the child was not in state custody, a constitutional duty under the Due Process Clause might exist for children in foster care, analogous to the duty owed when an individual is institutionalized or incarcerated, as those children have been removed by a state agency from their parents and placed into state custody. *Id.* at 201 n.9.

Several federal courts have found that states are not required under the Constitution to provide children in foster care with an optimal level of treatment or with the least restrictive arrangement. *See, e.g.*, *Baby Neal v. Casey*, 821 F. Supp. 320, 337 (E.D. Pa. 1993); *DeI A. v. Roemer*, 777 F. Supp. 1297, 1319-20 (E.D. La. 1991). Despite these interpretations of *DeShaney*, the Court did note in *Youngberg* that patients involuntarily confined to institutions should be afforded a minimal degree of habilitation or training if it will allow them to "significantly reduce the need for restraints or the likelihood of violence." *Youngberg*, 457 U.S. at 324. This principle can be analogized to require the provision of services to children in foster care that would reduce or eliminate the need for ineffective, detrimental, involuntary institutionalization in an overly restrictive placement, such as an RTC. Because *Youngberg* looks to the judgment of a qualified professional to determine the reasonableness of conditions of confinement and the growing body of research on residential treatment is beginning to show its ineffectiveness and harmfulness, it might be possible to satisfy the standards set by *Youngberg* and *DeShaney* to argue for necessary community-based mental health treatment and freedom from institutionalization in RTCs under the Due Process Clause of the Fourteenth Amendment. However, with the subsequent passage of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead* interpreting the ADA to prohibit unnecessary institutionalization of individuals with disabilities, it is likely that a court would look to the ADA, rather

families.⁷⁹ A child can only be removed from her home and placed in foster care if a voluntary placement agreement is entered into by a parent or guardian, or if a judicial determination has been made that the child's current living situation is "contrary to the welfare of the child" after reasonable efforts have been made to preserve the family.⁸⁰ To maintain the family unit, at-risk families frequently require appropriate and effective mental health services for both the children and adults, and therefore, a child welfare agency's "reasonable efforts" to preserve a family should often include these services. Each state must also create a plan for child welfare services, which includes, among other things, "a preplacement preventive services program designed to help children at risk of foster care placement to remain safely with their families."⁸¹ Behavioral and emotional problems that can lead to abuse or neglect, or that flow from abuse or neglect,⁸² can prevent a family from staying together. Therefore, preventive programs should include community-based mental health services for a child at risk of removal from the home.⁸³ Through these reasonable-efforts and preventive-services-program requirements, child welfare laws are structured to ensure that children and families receive community-based mental health services to prevent their removal from the home and placement into foster care.⁸⁴

Pursuant to the federal child welfare regime, children who are ultimately removed from their homes and placed in other settings should also receive necessary community-based mental health treatment. Effective mental health treatment is critical for children who have entered the child welfare system and have been placed in foster care, whether the goal is reunification with the biological family or another form of permanency, such as adoption or guardianship. These children often require mental health treatment to address the abuse or neglect that led to their entry into the system, the trauma associated with removal from their home and biological families, or their under-

than the constitutional standards discussed in *Youngberg*, in assessing the rights of children with disabilities to freedom from institutionalization in RTCs. See discussion *infra* Part III.E.

79. To receive payment under the Adoption and Safe Families Act of 1997, states must make "reasonable efforts" to "preserve and reunify families." 42 U.S.C. § 671(a)(15)(B) (2006).

80. *Id.* § 672(a)(2)(A).

81. *Id.* § 622(b)(8)(A)(iv).

82. For a discussion of the connection between childhood maltreatment and mental health disorders, see MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 132.

83. See 42 U.S.C. § 629g(f)(4)(B) (promoting a reduction in out-of-home placements).

84. See, e.g., Complaint, *H.B. v. Emkes*, No. 3:11-cv-00663 (M.D. Tenn. July 11, 2011) (describing the situation of multiple plaintiffs who have been forced into residential treatment because the state had reduced the availability of at-home services available to families and persons with disabilities).

lying mental health disorders. State child welfare agencies are generally responsible for ensuring adequate health and mental health services⁸⁵ and appropriate school placements for children in foster care.⁸⁶ To receive federal funding for their child welfare systems, states must develop a plan for the delivery of health care services for children in foster care, including care for mental health needs.⁸⁷ States must have a strategy in place to identify and respond to these needs.⁸⁸ The ongoing oversight and coordination of health care services for any child in a foster care placement is critical to “ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs.”⁸⁹

The federal legal regime is also structured to prevent the institutionalization of children in the foster care system in RTCs through a case-planning and review process intended to ensure that a child is placed close to home in a family-like, rather than institutional, setting.⁹⁰ The “case review system” aims to assure that a child’s case plan is “designed to achieve placement in a safe setting that is the least restrictive (most family like) and most appropriate setting available and in close proximity to the parents’ home, consistent with the best interest and special needs of the child.”⁹¹ For most children, the least restrictive and the most family-like setting in close proximity to their parents’ home will not be an RTC, given that these centers are institutional in nature, provide congregate care rather than family care, and are often located far from where many of the children’s families reside.

Federal statutes provide for a check on the placement situation of a child who has been removed from his biological home by the child welfare system. A six-month administrative or court review evaluates the safety of the child as well as the necessity and appropriateness of the placement, the extent of progress made toward alleviating the causes necessitating the placement, and a likely date by which the child can be returned home or be placed for adoption or guardianship.⁹² This review hearing provides an opportunity for family court

85. See 42 U.S.C. § 622(b)(15).

86. *Id.* § 671(a)(30). Children in foster care unfortunately end up in more restrictive school placements than are necessary. NAT’L COUNCIL ON DISABILITY, YOUTH WITH DISABILITIES IN THE FOSTER CARE SYSTEM: BARRIERS TO SUCCESS AND PROPOSED POLICY SOLUTIONS 66 (2008).

87. 42 U.S.C. § 622(b)(15)(A).

88. *Id.*

89. 42 U.S.C.A. § 622(b)(15)(A) (2011).

90. See 42 U.S.C. § 671(a)(16).

91. *Id.* § 675(5)(A).

92. *Id.* § 675(5)(B).

judges, attorneys, and social workers to ensure that a child is in the least restrictive setting in close proximity to the parents' home. If not, the hearing provides an opportunity to put in place any supports and services the child might require to be successful in a less restrictive, closer placement, such as any needed mental health services.

Federal law further disfavors distant placements by requiring a caseworker to justify any placements that are a "substantial distance from the home" or in a different state, including any distant RTC placements.⁹³ If a child is placed in a different state, a caseworker must visit the child no less than every six months and submit a report to the state agency in the child's parents' state that includes the justification for the child's distant placement.⁹⁴

Federal child welfare statutes also reflect a strong interest in coordination among various state agencies that addresses the needs of children generally and mental health care in particular. In particular, child welfare statutes encourage the improvement of collaboration between state child welfare and juvenile justice⁹⁵ and health agencies.⁹⁶ Federal grants are provided to states for training to improve communication between child welfare agencies and health care agencies,⁹⁷ and to states that are implementing some form of collaboration.⁹⁸ A description of policies that support this collaboration must be in a state's proposal in order to receive federal funding.⁹⁹ Grants are also available to promote partnerships between agencies aimed at reconnecting children in foster care with their families.¹⁰⁰ In addition, Congress requires the Secretary of the Department of Health and Human Services to coordinate between federal agencies in order to maximize services provided to children.¹⁰¹

Impact litigation aimed at reform of child welfare systems across the country evidences the continued failure of states to realize the intentions of this legal regime.¹⁰² In the District of Columbia, for exam-

93. *Id.* § 675(5)(A)(i).

94. *Id.* § 675(5)(A)(ii). The caseworker can be from either the state where the child is placed, the state where the child's parents live, or a private agency under contract with either state.

95. *Id.* § 5106a(a)(13).

96. 42 U.S.C. § 5106a(a)(14).

97. *Id.* § 5106(a)(1)(D).

98. *Id.* § 5106(a)(2), (a)(5).

99. *Id.* § 5106a(b)(2)(D).

100. *Id.* § 627(a)(1)(E) (repealed).

101. *Id.* § 5113(b)(8).

102. *See, e.g.,* Kenny A. v. Perdue, No. 1:02-cv-1686-MHS, 2004 WL 5503780 (N.D. Ga. Dec. 13, 2004); R.C. v. Nachman, 969 F. Supp. 682 (M.D. Ala. 1997); Consent Decree, B.H. v. Suter, No. 88-C-5599 (N.D. Ill. Dec. 20, 1991), available at <http://www.clearinghouse.net/chDocs/public/JI-IL-0001-0001.pdf>; Complaint, Henry A. v. Willden, No. 2:10-CV-00528 (D. Nev. Apr. 13,

ple, the ongoing jurisdiction of the federal court in overseeing a long-standing class action litigation originally aimed at reforming the city's child welfare system reveals the system's continued deficiencies. When the plaintiffs in *LaShawn A. v. Barry* originally filed their complaint in 1989, they painted a picture of a broken system, one in which children in foster care were sent to congregate care placements across the country, instead of family-like settings in the District of Columbia or in a nearby jurisdiction.¹⁰³ No services were available to stabilize children and families, and assist them with reunification.¹⁰⁴ The named plaintiff was kept in emergency care for over two years with no plans for placement,¹⁰⁵ and no efforts were made to provide her mother with services.¹⁰⁶

Over twenty years later, many of the same problems persist and the Implementation and Exit Plan developed by the parties remains unfulfilled, with the D.C. Child and Family Services Agency closely watched by a court monitor.¹⁰⁷ Despite the requirement in the Exit Plan that 90% of families like LaShawn's—families deemed to be in need of services—be referred to community-based organizations,¹⁰⁸ only thirty-three percent of those families are currently receiving such referrals.¹⁰⁹ Children remain in congregate care settings like group homes and RTCs,¹¹⁰ and the child welfare agency continues to place

2010). In *B.H.*, the plaintiffs, children in Illinois, alleged they were taken from their homes due to alleged abuse or neglect, but then were subjected to conditions that damaged their mental health and provided little improvement to their safety. Consent Decree, *B.H.*, at 2. Once placed outside the home, they faced violence in shelters and abuse in foster homes; many were moved six or more times. *Id.* As of 2009, the goal of keeping children in their homes whenever possible was only being met 70.8% of the time, as opposed to the requisite 95%. CHILDREN & FAMILY RESEARCH CTR., CONDITIONS OF CHILDREN IN OR AT RISK OF FOSTER CARE IN ILLINOIS 1-15 (Tamara L. Fuller & Kathleen A. Kearney eds., 2009), available at http://www.aclu-il.org/wp-content/uploads/2011/02/CFRC_UIUC_BH_2009.pdf. The agency also needs to improve its provision of assessments and services to children and families to prevent placement outside the home and meet the needs of children in foster care in areas including education and mental health. *See id.* at 5-16.

103. Complaint for Injunctive Relief at 2, *LaShawn A. v. Barry*, No. 89CV1754 (D.D.C. June 20, 1989), available at http://www.childrensrights.org/wp-content/uploads/2008/06/1989-6-20_dc_lashawn_complaint.pdf.

104. *Id.*

105. *Id.* at 13.

106. *Id.* at 14.

107. *See* CTR. FOR THE STUDY OF SOC. POL'Y, LASHAWN A. V. GRAY PROGRESS REPORT FOR THE PERIOD JULY 1–DECEMBER 31, 2010, at 20 tbl.1 (2011), available at <http://www.cssp.org/publications/child-welfare/class-action-reform/LaShawn-A-v.-Fenty-Monitoring-Report-May-2-2011.pdf>.

108. *Id.* at 33 tbl.1.

109. *Id.*

110. *See id.* at 21 tbl.1.

children more than 100 miles from the District of Columbia.¹¹¹ Many children remain in settings that are more restrictive than they require.¹¹²

The intention of Congress for the child welfare system to ensure the provision of necessary mental health services to children in foster care was also not carried out in Mary's case. Mary's child welfare social worker did not take steps to connect her with the counseling services she required. The child welfare system also failed to coordinate with her pediatrician or the health care, juvenile justice, and special education systems, as intended by federal child welfare law. Moreover, Mary's case demonstrates the failure of the child welfare system to prevent her placement in a restrictive, distant, and out-of-state congregate care facility, rather than ensuring her continued placement in a family-like setting in her community. The agency would need to justify why such a placement was in Mary's best interests, given that federal child welfare laws explicitly disfavor this type of placement. Because Mary is placed in a facility out of state, if her child welfare agency caseworker fails to visit her at least every six months, the aims of the child welfare laws to ensure monitoring of such placements would also go unheeded.

B. *The Special Education Legal Regime*

[T]he educational needs of millions of children with disabilities were not being fully met because—

....

(B) the children were excluded entirely from the public school system and from being educated with their peers;

(C) undiagnosed disabilities prevented the children from having a successful educational experience; or

(D) a lack of adequate resources within the public school system forced families to find services outside the public school system. . . .

....

(5) Almost 30 years of research and experiences has demonstrated that the education of children with disabilities can be made more effective by—

(A) having high expectations for such children and ensuring their access to the general education curriculum in the regular classroom, to the maximum extent possible, in order to—

111. *Id.* at 96.

112. *See id.* at 20 tbl.1. A recent evaluation of the mental health treatment available for children in the District of Columbia found that the Child & Family Services Agency needs a more detailed and comprehensive structure for identifying mental health needs. D.C. CITIZENS REVIEW PANEL, FINDINGS AND RECOMMENDATIONS REGARDING THE DISTRICT OF COLUMBIA GOVERNMENT'S IMPLEMENTATION OF THE 2007 DEPARTMENT OF MENTAL HEALTH AND CHILD & FAMILY SERVICES AGENCY MENTAL HEALTH NEEDS ASSESSMENT (Feb. 2010).

...
 (ii) be prepared to lead productive and independent adult lives¹¹³

The Individuals with Disabilities Education Act (IDEA), the federal special education statute, mandates that children who require special education be “identified, located and evaluated.”¹¹⁴ It further requires that such children receive individualized education programs (IEPs) with appropriate services and accommodations so that they can receive meaningful academic benefit.¹¹⁵ Children whose rights are violated and go without needed services can reach a point of crisis and end up in RTCs.¹¹⁶

The IDEA aims to provide children with disabilities with a free appropriate public education.¹¹⁷ Congress intended for schools to keep their doors open to students with disabilities, rather than institutionalizing them or excluding them altogether, in recognition of the long history of schools excluding children who were “difficult” to educate.¹¹⁸ The IDEA aims not only to address the academic needs of children with disabilities, but also to comprehensively address their behavioral needs and prepare them for transition to adult life.¹¹⁹ Effective protection of rights under special education law should almost always result in the child’s receipt of special education services in a school in her community, rather than in residential treatment.

The process of identifying and serving a child through special education involves a number of steps that are structured to allow students to receive appropriate services in their communities and in the least restrictive environment.¹²⁰ First, states must identify, locate, and evaluate all children in need of special education.¹²¹ Known as “child find,” this obligation means that school districts must take affirmative steps to initiate the special education process for any child who requires it regardless of whether the parent has brought a child’s disabil-

113. 20 U.S.C. § 1400(c)(2) (2006) (articulating Congress’s findings as part of its statements and declarations introducing the Individuals with Disabilities Education Act).

114. *Id.* § 1412(a)(3).

115. *Id.* § 1400(d). An IEP is a written plan, developed by a team that includes critical school staff and the parent, that documents the special education services, accommodations, and goals.

116. Unlike some of the other statutes discussed in this Article, the IDEA is privately enforceable, after administrative remedies are exhausted, through the filing of a civil action in federal court. *Id.* § 1415(i)(2)(A).

117. *Id.* § 1412(a)(1).

118. See *Honig v. Doe*, 484 U.S. 305, 323 (1988) (“Congress very much meant to strip schools of the *unilateral* authority they had traditionally employed to exclude disabled students . . .”).

119. 20 U.S.C. § 1400(d)(1)(A).

120. *Id.* § 1412(a)(5).

121. *Id.* § 1412(a)(3).

ities to the attention of a school or made a request for special education.¹²² Evaluations must assess children in all areas of suspected disability.¹²³ For a child with social, emotional, or behavioral difficulties, a clinical psychological evaluation might be necessary because it may provide a vehicle for a clinical psychologist to determine whether the child is suffering from a diagnosable mental health disorder or is otherwise in need of school-based services or other mental health treatment.¹²⁴

Once the evaluation process is complete, a child must meet eligibility criteria for one of the enumerated special education disability classifications,¹²⁵ as determined by a multidisciplinary team that reviews the evaluations and any other relevant data and information about the child.¹²⁶ Children with emotional or behavioral challenges might be found eligible for special education classified under the classification of "emotional disturbance," defined as

a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.¹²⁷

Interestingly, this definition does not require any specific diagnosis. Children who do not meet the criteria for a particular mental health disorder under the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals to diagnose individuals, but otherwise meet one of the listed criteria for eligibility as a child with emotional disturbance, such as children who exhibit inappropriate behavior, have a general pervasive mood of unhappiness, or have fears associated with school, are still entitled to special education services under this disability classification so long as the problem has occurred to a marked degree, has lasted over a long period of time, and has

122. *Id.*

123. *See id.* § 1414(b)(3)(B).

124. *See generally* Ruth Colker, *Educational Evaluations and Assessments*, in *SPECIAL EDUCATION ADVOCACY*, *supra* note 6, at 83.

125. *See* 20 U.S.C. §§ 1401(3), 1414(b)(4).

126. *See id.* § 1414(b)-(c).

127. 34 C.F.R. § 300.8(c)(4)(i) (2010).

adversely affected the child's educational performance. Because neither the statute nor regulations defines what is meant by "to a marked degree" or "a long period of time," these terms are open to interpretation. Two children exhibiting similar behaviors could end up with different results when the multidisciplinary team discusses the question of their eligibility under the "emotional disturbance" classification. The regulations also specify that children who are "socially maladjusted" are explicitly excluded unless they meet the definition above.¹²⁸ Some schools might try to avoid a finding of eligibility and the provision of services to a child with behavioral problems by arguing that the child is simply socially maladjusted, while other schools have over-identified poor and minority children as requiring special education under the emotional disturbance label.¹²⁹ Some children struggling with emotional or behavioral deficits could also meet the criteria for ADHD, in which case they would qualify for special education under the disability classification of "other health impaired," a catch all category of disabilities under the IDEA that explicitly includes ADHD.¹³⁰

Children with behavioral or emotional difficulties can still qualify for special education services to address those needs, even without a special education disability classification that is directly related to those needs, such as emotional disturbance or other health impaired. In fact, many children might be acting out or suffer from anxiety or low self-esteem as a result of their school's failure to identify or adequately address another disability, such as a learning disability¹³¹ or a speech or language impairment.¹³² Despite the "widespread misunderstanding that only children who are labeled as 'emotionally disturbed' are entitled to mental health services in the school setting," under special education requirements, if a child requires counseling or other mental health services in order to make educational progress,

128. *Id.* § 300.8(c)(4)(ii).

129. Joseph B. Tulman, *Disability and Delinquency: How Failures to Identify, Accommodate, and Serve Youth with Education-Related Disabilities Leads to Their Disproportionate Representation in the Delinquency System*, 3 WHITTIER J. CHILD & FAM. ADVOC. 3, 31 (2003).

130. 34 C.F.R. § 300.8(c)(9).

131. "Specific learning disability" is one of the enumerated special education disability classifications, and it includes any disorder in one or more basic psychological processes involved in understanding or using written or spoken language that may manifest itself in the imperfect ability to listen, think, speak, read, write, or do mathematical calculations. *Id.* § 300.8(b)(10).

132. "Speech or language impairment" is another one of the specified disability classifications in the IDEA, defined in the regulations as a "communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child's educational performance." *Id.* § 300.8(b)(11).

his service should be included on the IEP and provided.¹³³ This misunderstanding reflects a broader myth that special education services flow from the child's special education label.¹³⁴ Instead, a child should receive any services that he needs in order to make progress in an educational setting, regardless of his diagnosis or label.¹³⁵ Consequently, special education students can receive services and accommodations to address behavioral or emotional deficits regardless of their disability classification. "[A] child may need positive behavioral interventions and supports or psychological counseling even though the child is not identified as 'emotionally disturbed.'"¹³⁶

The failure to evaluate and identify children with disabilities can contribute to the exacerbation of their mental health needs. When children are not timely evaluated for special education and go without the necessary special education services, they can experience academic failures, instability at home, and behavioral problems in schools—all of which are more likely to lead to their entry into the "school-to-prison pipeline"¹³⁷ and to their placement out of the home in RTCs. School administrators have historically misused disciplinary measures to suspend and expel students with disabilities at disproportionate rates and have increasingly criminalized misbehavior in school through "zero tolerance" laws and policies.¹³⁸

Once a child is evaluated and found eligible for special education, the IDEA and its accompanying regulations provide for a variety of mechanisms that can help to ensure that a child with emotional or behavioral needs makes educational progress, contributing to his stability and ability to remain at home and in the community. The child's

133. Ellen A. Callegary, *The IDEA's Promise Unfulfilled: A Second Look at Special Education & Related Services for Children with Mental Health Needs After Garret F.*, 5 J. HEALTH CARE L. & POL'Y 164, 181 (2002).

134. *Id.* at 181–82. The emotional disturbance label can also lead school officials to overlook a learning disability or other disability that is driving behavioral problems, leaving that disability unaddressed.

A child who has an unaddressed learning disability, hearing impairment, or other education-related disability might develop over time a tendency to act out in school, as well as at home. If teachers and school administrators convince parents to label the child as emotionally disturbed *without identifying and addressing the underlying learning problems*, they might be condemning the child to a downward spiral.

Tulman, *supra* note 6, at 407.

135. Nothing in the IDEA requires that children even be classified by their disability, so long as each child has one of the enumerated disabilities and needs special education and related services as a result. See 20 U.S.C. § 1412(a)(4) (2006).

136. Tulman, *supra* note 6, at 406.

137. Julia C. Dimoff, *The Inadequacy of the IDEA in Assessing Mental Health for Adolescents: A Call for School-Based Mental Health*, 6 DEPAUL J. HEALTH CARE L. 319, 321 (2003); Dean Hill Rivkin, *Decriminalizing Students with Disabilities*, 54 N.Y.L. SCH. L. REV. 909 (2010).

138. See Tulman, *supra* note 6, at 405.

IEP can include specialized or individualized instruction taught by a special education teacher, as well as related services that could provide support to a child with a mental health disorder. Related services can include counseling services for the child or his parents (or both), therapeutic recreation, psychological services, and social work services in schools,¹³⁹ all of which could provide support to a child with a mental health disorder. Moreover, the goals in an IEP, which are designed to meet the child's needs and enable him to be involved and make progress in the general education curriculum whenever possible, are "not limited to academic benefits, but also include behavioral and emotional growth."¹⁴⁰ Consequently, an effective program that helps a child reach well-designed, measurable goals can significantly contribute to the development and stability of a child with mental health needs.

There are elements built into the special education legal regime specifically aimed at addressing a child's behavioral problems in school in a nonpunitive way. For example, an IEP should "consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior,"¹⁴¹ which promote good behavior rather than punish bad behavior. When a child exhibits behavioral problems, a behavioral intervention plan or functional behavioral assessment can be developed as part of the IEP that identifies the nature of those problems, triggers for behavioral incidents, and effective positive behavioral interventions that should be used to curb the behavior.¹⁴² These interventions could include implementing strategies the child and teacher can use to de-escalate the behavior (such as breathing techniques), teaching a student new skills to replace the problem behaviors, developing social skills groups, or creating a reward system to motivate the child toward positive behavior. When an appropriate IEP is not developed for a child who qualifies for special education or a school is not implementing a student's IEP, these violations of special education law can result in emotional and behavioral problems in

139. 20 U.S.C. § 1401(26)(A).

140. *Cnty. of San Diego v. Cal. Special Educ. Hearing Office*, 93 F.3d 1458, 1468 (9th Cir. 1996) (discussing the goals of a seriously emotionally disturbed student).

141. 20 U.S.C. § 1414(d)(3)(B)(i).

142. *Id.* § 1415(k)(1)(F)(i). The law specifically provides for a functional behavioral assessment to be conducted and a behavioral intervention plan to be developed in certain situations where a school proposes to suspend a child for more than ten days. For extensive information on functional behavioral assessments, behavioral intervention plans, and positive behavioral interventions generally, see POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS, www.pbis.org (last visited Apr. 26, 2012). For a discussion of functional behavioral assessment and behavioral intervention plans, see Julie K. Waterstone & Jane R. Wettach, *School Discipline and Students with Special Needs*, in *SPECIAL EDUCATION ADVOCACY*, *supra* note 6, at 251–52.

school and at home, as well as academic failures, all of which can lead to a child's placement in an RTC.

Special education law specifically disfavors the placement of children in institutions such as RTCs. The IDEA explicitly requires that children be educated in an environment that maximizes the child's opportunities for interactions with nondisabled peers.¹⁴³ This obligation reflects the congressional preference for "inclusion" of special education students in their regular classrooms and schools (also known as "mainstreaming"),¹⁴⁴ based on a recognition that children with disabilities can be more effectively educated when schools "hav[e] high expectations for such children and ensur[e] their access to the general education curriculum in the regular classroom, to the maximum extent possible."¹⁴⁵ "Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."¹⁴⁶ Students should be educated in the school that they would attend if they were not disabled unless the IEP requires another arrangement for the child to receive a free appropriate public education.¹⁴⁷

As some children will require instruction outside of the regular education classroom or their neighborhood school to make educational progress, public education agencies "must ensure that a continuum of alternative placements is available to meet the needs of children with disabilities."¹⁴⁸ From least restrictive to most restrictive, this continuum must include "instruction in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions."¹⁴⁹ In determining which of these placements would be most appropriate for a particular child, the IEP team should begin with the first, least restrictive option, which is regular classes, before moving down the list to more restrictive alternatives.¹⁵⁰ Removal of the child from the regular education setting should be avoided whenever possible and must be justified by a finding that the benefits of inclusion in the regular education are "far outweighed by the benefits

143. 20 U.S.C. § 1412(a)(5)(A).

144. Jane R. Wettach & Brenda Berlin, *The IEP*, in *SPECIAL EDUCATION ADVOCACY*, *supra* note 6, at 149, 176.

145. 20 U.S.C. § 1400(c)(5)(A).

146. 34 C.F.R. § 300.114(a)(2)(ii) (2011).

147. *Id.* § 300.116(c).

148. *Id.* § 300.115(a).

149. *Id.* § 300.115(b)(1).

150. Wettach & Berlin, *supra* note 144, at 177.

gained from services which could not feasibly be provided in the non-segregated setting.”¹⁵¹ The law also intends for a child who is removed from her regular neighborhood school to be placed in a school in close proximity to her home.¹⁵²

Instruction in an RTC is an example of instruction in an institution separate from not only the child’s regular classroom, but also from the child’s school, home, and community. It also often involves a long-term removal from the child’s neighborhood school and community,¹⁵³ and placement in an environment that is far from the child’s home, in contradiction with the intentions of the IDEA. This type of instruction is, in fact, the most restrictive possibility for special education students contemplated under the law, and thus the most disfavored. Under the IDEA, an RTC is too restrictive for almost all children.¹⁵⁴ If a child’s right to appropriate educational services in the least restrictive environment were enforced, she could almost always remain in her home and out of residential treatment.

The IDEA and the regulations issued by the Department of Education also emphasize the importance of coordination with agencies and resources outside of school. For example, where a child receives social work services on his IEP, those services should include partnerships with parents and other individuals regarding problems that affect a child’s situation at home and in the community and the mobilization of community resources outside of the school to enable the child to learn as effectively as possible.¹⁵⁵ Additionally, the statute and regulations require coordination with other public agencies regarding the provision of services to teenagers preparing to make the transition to adulthood.¹⁵⁶ “Transition services can include specialized instruction and related services designed to focus on the development of employment skills, independent living skills, and self-advocacy skills” and provide opportunities for connecting with other public

151. *Roncker v. Walter*, 700 F.2d 1058, 1063 (6th Cir. 1983).

152. 34 C.F.R. § 300.116(b)(3); *see also* *Murray v. Montrose Cnty. Sch. Dist.*, 51 F.3d 921, 929 (10th Cir. 1995) (“[I]n deciding where the appropriate placement is, geographical proximity to home is relevant, and the child should be placed as close to home as possible.”).

153. *See, e.g.*, D.C. OLMSTEAD COMMUNITY INTEGRATION INITIATIVE: ONE COMMUNITY FOR ALL 30 (Apr. 2012), available at http://dds.dc.gov/DC/DDS/DDS%20Publication%20Files/DDS_files/DDS%20Latest%20Headlines/Olmstead%20Community%20Integration%20Initiative.pdf (reporting that the average length of stay for special education students placed by District of Columbia Public Schools at RTCs is approximately twenty-four months).

154. Despite the recognition that they are the most restrictive form of special education placement, courts have recognized that for some children, an RTC might be the least restrictive environment appropriate to their needs. *Bd. of Educ. v. Diamond*, 808 F.2d 987, 992 (3d Cir. 1986).

155. 34 C.F.R. § 300.34(14).

156. *Id.* §§ 361.5(b)(55), 300.320(b), 300.321(b)(3).

agencies.¹⁵⁷ At least as early as the school year in which a student will turn sixteen years old, transition services must be included in the child's IEP and updated annually.¹⁵⁸ When appropriate and with the consent of the parent or child (when the child has reached the age of majority), the school district must invite to the child's IEP meeting other public agencies responsible for providing or funding a student's transition services.¹⁵⁹

When a school district fails to effectively coordinate with other agencies to address the needs of a teenager nearing adulthood, the child may go without critical services that would allow for his independence as an adult and for his general stability and well-being. Despite the clear intention that school systems coordinate with other public agencies to provide transition services that could help achieve stability and independence for a child with a mental health disability or other disability, such coordination happens too rarely. The National Council on Disability has reported to the U.S. Department of Education that many children continue to leave school without appropriate transition services that could make it possible for them to access higher education or meaningful employment.¹⁶⁰

Mary's school failed her in a number of ways by violating many of IDEA's requirements and regulations. Although Mary was identified as a student with specific learning disabilities under the IDEA and had an IEP, she was not receiving all of the special education services that she required. In addition, her school failed to identify all of her disabilities, as she also met the qualifications for eligibility as a student with emotional disturbance. Mary's anxiety and behavioral issues were affecting her education. Although she only needed to exhibit one of these characteristics to qualify as emotionally disturbed under special education law, she was arguably exhibiting a number of the relevant characteristics, such as an inability to build or maintain satisfactory interpersonal relationships with her peers and teachers, inappropriate types of behavior or feelings under normal circumstances, a general pervasive mood of unhappiness or depression, *and* a tendency to develop physical symptoms or fears associated with personal or

157. Wettach & Berlin, *supra* note 144, at 181.

158. 34 C.F.R. § 300.320(b)(2). Transition services might also be required for students under the age of sixteen, where state regulations set an earlier age or where the IEP determines these services are needed. Wettach & Berlin, *supra* note 144, at 181.

159. 34 C.F.R. § 300.321(b)(3).

160. NAT'L COUNCIL ON DISABILITY, *OLMSTEAD: RECLAIMING INSTITUTIONALIZED LIVES* 188 (2003) (abridged version), available at <http://www.ncd.gov/newsroom/publications/2003/pdf/reclaimabridged.pdf>.

school problems.¹⁶¹ Without identification of her emotional disturbance, her IEP did not include goals aimed at addressing her social and emotional deficits, but instead focused exclusively on her academic limitations resulting from her learning disabilities.

She also required counseling services to address the impact of her emotional problems on her education, but this service was not incorporated into her IEP, and she went without this critical assistance, which could have allowed her to stabilize and make academic progress. Instead, Mary's school placed her in an RTC, the most restrictive, segregated type of school setting. Rather than providing her with positive behavioral interventions through an individualized behavioral intervention plan, Mary's school treated her punitively, suspended her repeatedly, and inappropriately funneled her into the school-to-prison pipeline. Her school failed to coordinate with other agencies to ensure that she received necessary services that could assist her in transitioning to adulthood. Mary's story illustrates how congressional intentions for educational achievement, integration, independence and positive outcomes for children with disabilities remain unrealized for many children with mental health disorders.

C. *The Health Care Legal Regime*

[C]hildren with serious emotional disabilities are among the most fragile members of our society; their medical needs frequently extend across a spectrum of service providers and state agencies. Prompt, coordinated services that support a child's continuation in the home can allow even the most disabled child a reasonable chance at a happy, fulfilling life. Without such services a child may face a stunted existence, eked out in the shadows and devoid of almost everything that gives meaning to the gift of life.¹⁶²

The legal regime establishing the Medicaid system also serves to protect the rights of children with mental health disorders to medically necessary community-based treatment. The federal Medicaid Act provides relevant protections for children from low-income households through its mandate of early and periodic screening, diagnostic, and treatment services (EPSDT), which requires participating states to ensure that individuals under the age of twenty-one receive all medically necessary health and mental services.¹⁶³ Violations of

161. See 34 C.F.R. § 300.8(c)(4)(i)(B)–(D).

162. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 24 (D. Mass. 2006).

163. 42 U.S.C. § 1396d(a)(4)(B) (2006); *Katie A. v. L.A. Cnty.*, 481 F.3d 1150, 1154 (9th Cir. 2007) (“Although states have the option of not providing certain ‘optional’ services listed in § 1396d(a) to other populations, they must provide all of the services listed in § 1396d(a) to eligible children when such services are found to be medically necessary.”).

this extremely broad mandate often result in Medicaid-eligible children going without the mental health services to which they are entitled. Without medically necessary community-based services, a child's needs can escalate to the point where he is viewed as unsafe at home and school, resulting in placement in an RTC.¹⁶⁴

The Medicaid program is "designed to enable states to furnish medical assistance on behalf of dependent children, aged, blind, and disabled people with insufficient means to meet the costs of medically necessary services,"¹⁶⁵ and aims to enable states to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."¹⁶⁶ The program is voluntary for states, but every state has elected to participate in order to benefit from the portion of the costs of medical assistance that are paid by the federal government, with the exact percentage of the payment dependent on state population.¹⁶⁷

Once states elect to participate, they have to comply with the Medicaid statutory scheme and the regulations promulgated by the U.S. Department of Health and Human Services.¹⁶⁸ Each state submits a detailed plan to the federal government setting forth how it intends to comply with the relevant requirements.¹⁶⁹ States must show how they will provide coverage of medically necessary services "with reasonable promptness to all eligible individuals."¹⁷⁰ Medicaid regulations require participating states to provide all medically necessary services in sufficient amount, duration, and scope to effectively address the condition,¹⁷¹ and the regulations are liberally construed in favor of the beneficiaries.¹⁷² When doctors find that services are medically necessary,¹⁷³ the state must pay for those services and assure that payments

164. See, e.g., *Rosie D.*, 410 F. Supp. 2d at 23–24.

165. Land, *supra* note 11, at 293.

166. 42 U.S.C. § 1396-1 (2006 & Supp. III 2009).

167. 42 U.S.C. § 1396d(b) (2006) (listing the federal medical assistance percentage for the District of Columbia at seventy percent).

168. Land, *supra* note 11, at 294.

169. 42 U.S.C. § 1396a (2006 & Supp. III 2009).

170. 42 U.S.C. § 1396a(8) (2006).

171. 42 C.F.R. § 440.230(b) (2011).

172. E.g., *Visser v. Taylor*, 756 F. Supp. 501, 507 (D. Kan. 1990) (citing *Aitchison v. Berger*, 404 F. Supp. 1137, 1149 (S.D.N.Y. 1975)).

173. S. REP. NO. 89-904, pt. 1 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986 ("[T]he physician is to be the key figure in determining utilization of the health services . . ."); see also *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989); *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980). *But see Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1257 (11th Cir. 2011) ("[B]oth the treating physician and the state have roles to play in determining medical necessity. It is accurate that Moore's treating physician is a key figure and initially determines what amount of nursing services are medically necessary. Indeed, the GAPP [Grants Administration Policies

are “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area.”¹⁷⁴

“To address the fact that more than 3.5 million children under five were failing to receive medical assistance, the program was expanded to include the Early Periodic Screening Diagnosis and Treatment Program (EPSDT) in 1967.”¹⁷⁵ With this program, Congress envisioned not only a system in which expenditures on children’s health care were reimbursed, “but also an aggressive search for early detection of child health problems.”¹⁷⁶ EPSDT requires that up until the age of twenty-one, Medicaid-eligible children must receive all “medically necessary services” and “[s]uch other necessary health care . . . to correct or ameliorate defects and physical and mental illness.”¹⁷⁷ These services include comprehensive screenings at regular intervals to determine whether the child has certain illnesses or conditions, including those that are mental, and not just physical, in nature, and treatment for conditions discovered during the screens.¹⁷⁸ The screens must include “a comprehensive health and developmental history (including assessments of both physical and mental health development).”¹⁷⁹ States must provide care, services, and treatment to correct or ameliorate physical or mental illnesses, defects, and conditions discovered by those screenings, “whether or not such services are covered under the State plan.”¹⁸⁰ Medicaid EPSDT covers such mental health services as diagnostic evaluation and intervention, group therapy, individual therapy, family counseling, case management, living skills training, in-

and Procedures Manual] plan pays heed to the salient principle that the treating physician should assume ‘the primary responsibility of determining what treatment should be made available to his patients.’ The GAPP Manual specifies that ‘[t]he primary care physician develops the child’s initial plan of care.’ Nonetheless, a state may still review the medical necessity of the amount of nursing care prescribed by the treating physician and make its own determination of medical necessity.” (citations omitted).

174. 42 U.S.C. § 1396a(30)(A).

175. Land, *supra* note 11, at 293; see also 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396(r); *Stanton v. Bond*, 504 F.2d 1246, 1247 (7th Cir. 1974) (explaining that the EPSDT provision developed from the growing need for adequate health care for needy children).

176. Land, *supra* note 11, at 293 (citing *Stanton*, 504 F.2d at 1251). “EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose.” *Stanton*, 504 F.2d at 1251. “Through this amendment, Congress intended to take aggressive steps to screen, diagnose and treat children with health problems.” *Id.* at 1249.

177. 42 U.S.C. §§ 1396d(a)(4)(B), 1396d(r)(5).

178. See *id.* § 1396d(r).

179. *Id.* § 1396d(r)(1)(B)(i).

180. *Id.* § 1396d(r)(5).

home behavioral aides, enhanced behavioral support and supervision, psychiatric rehabilitation, day treatment, mobile treatment, and crisis intervention.¹⁸¹ Not only is the EPSDT mandate unequivocal and robust, the Medicaid state agency must provide an opportunity for an administrative hearing when a child is denied a necessary service or when the request for that service is not acted upon with reasonable promptness.¹⁸²

The provision of these services can serve to stabilize a child with a mental health disorder and prevent her institutionalization. Medicaid statutes, regulations, and policy have also evolved more recently to explicitly encourage the provision of community-based services over institutionalization.¹⁸³ Medicaid also requires coordination among

181. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(a)(19), 1396n(g)(2); 42 C.F.R. § 440.230 (2010); *Salazar v. District of Columbia*, 954 F. Supp. 278, 303 (D.D.C. 1996).

182. 42 U.S.C. § 1396a(a)(3).

183. The Medicaid program has evolved to favor community-based treatment over institutionalization. Since 1981, Medicaid has provided funding for state-run home- and community-based care through a waiver program. *See* Pub. L. No. 95-35, 95 Stat. 812 (1981) (codified as amended at 42 U.S.C. § 1396n(c)); *see also* Brief for the United States as Amicus Curiae Supporting Respondents, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999) (No. 98-536), 1999 WL 149653, at *20-21. The goal of the waiver program is to provide services in the community and avoid hospitalization. Jane Perkins & Randolph T. Boyle, *Addressing Long Waits for Home and Community-Based Care Through Medicaid and the ADA*, 45 ST. LOUIS U. L.J. 117, 125 (2001). The Department of Health and Human Services “has a policy of encouraging States to take advantage of the waiver program, and often approves more waiver slots than a State ultimately uses.” Brief for the United States as Amicus Curiae Supporting Respondents, *supra*, at *25-26. Moreover, the Tax Equity and Fiscal Responsibility Act of 1982 was added to Medicaid. *See* Pub. L. No. 97-248, 96 Stat. 324 (1982). It is more commonly referred to as the Katie Beckett provision and gives states the *option* to cover non-institutionalized children with disabilities. U.S. DEP’T OF HEALTH & HUMAN SERVS., UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER 14 (2000); BAZELON CTR. FOR MENTAL HEALTH LAW, AVOIDING CRUEL CHOICES: A GUIDE FOR POLICYMAKERS AND FAMILY ORGANIZATIONS ON MEDICAID’S ROLE IN PREVENTING CUSTODY RELINQUISHMENT, at app., at 20 tbl.1 (2002) (providing data on home- and community-based waivers by state); Joseph Shapiro, *Katie Beckett: Patient Turned Home-Care Advocate*, NPR (Nov. 8, 2010), <http://www.npr.org/templates/story/story.php?storyId=131145687> (detailing Katie Beckett’s story). Before the provision, “if a child with disabilities lived at home, the parents’ income and resources were automatically counted (deemed) as available for medical expenses. However, if the same child was institutionalized for 30 days or more, only the child’s own income and resources were counted.” U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra*. This change greatly increased the likelihood that the child could qualify for Medicaid. Many states now use this option, which requires three things: (1) the child must require the level of care that would be provided in an institution; (2) it must be appropriate to provide care outside the facility; and (3) the cost of care at home must not exceed the cost of institutionalized care. Pub. L. No. 97-248, § 134, 96 Stat. 375 (1982). However, while waivers benefit children with medical needs, they may not yet have had the same effect for children with mental health needs. According to the Bazelon Center for Mental Health Law, “Unfortunately, while most states have chosen to use options or waivers or both for children with serious medical needs, to date very few employ either approach to serve children with mental or emotional disorders.” BAZELON CTR. FOR MENTAL HEALTH LAW, TEAMING UP: USING THE IDEA AND MEDICAID TO SECURE COMPREHENSIVE MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH 4 (2003).

public agencies to ensure the provision of needed services. For example, case-management services should aim to assist eligible individuals in gaining access not only to medical services, but also to social, educational, and other services.¹⁸⁴ Public agencies are also required more broadly to coordinate their efforts to provide medical services to poor children.¹⁸⁵

Impact litigation in several states reveals the failures of these legal regimes to achieve their goals of providing children with medically necessary mental health treatment. For example, Medicaid-eligible children in Massachusetts with serious emotional disturbances sued state officials and agencies claiming that they were not receiving the evaluations and intensive home-based services to which they were entitled under Medicaid EPSDT.¹⁸⁶ The district court determined that the state's Medicaid plan did not comply with EPSDT because it failed to provide the proper assessments and services for children with emotional disturbance.¹⁸⁷ These problems resulted from a lack of coordination among public agencies; no single state entity was authorized to oversee the program. This authority and coordination was necessary to "(a) identify promptly a child suffering from a serious emotional disturbance, (b) assess comprehensively the nature of the child's disability, (c) develop an overarching treatment plan for the child, and (d) oversee implementation of this plan."¹⁸⁸ The state also failed to provide in-home behavioral services, leading to the placement of many of these children in RTCs known to exacerbate their symptoms.¹⁸⁹ These in-home services were medically necessary for

184. 42 U.S.C. § 1396n(g)(2).

185. 42 C.F.R. § 441.61(c) (2011); U.S. DEP'T OF HEALTH & HUMAN SERVS., STATE MEDICAID MANUAL, pt. 5, at 5-27 to 5-31 (2005), available at <http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927> (describing requirements under EPSDT for coordination among various agencies).

186. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 22 (D. Mass. 2006). *John B. v. Menke* addressed similar claims in Tennessee. See generally Class Action Complaint, *John B. v. Menke*, No. 3:98-0168 (M.D. Tenn. Feb. 25, 1998), available at <http://www.povertylaw.org/poverty-law-library/case/52200/52228/52228a.pdf>. As of 2007, children in Tennessee still were not receiving appropriate mental health assessments. *John B. v. Goetz*, No. 3:98-0168, 2007 U.S. Dist. LEXIS 75457, at *42 (M.D. Tenn. Oct. 10, 2007).

187. *Rosie D.*, 410 F. Supp. 2d at 23. Still under federal jurisdiction, *Rosie D.* has led to legislative change. On August 20, 2008, the Massachusetts Governor signed into law An Act Relative to Children's Mental Health, 2008 Mass. Acts ch. 321, available at <http://www.malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter321>.

188. *Rosie D.*, 410 F. Supp. 2d at 23.

189. *Id.* at 23-24. Inappropriate placement in residential facilities and hospitals can also have a detrimental impact on the child's mental health. Children may be frightened by these placements or react poorly to the limited privacy and social pressures involved in residential treatment. Bernard P. Perlmutter & Carolyn S. Salisbury, "Please Let Me Be Heard:" *The Right of a*

children with emotional disturbances, and the state's failure to provide this option amounted to a violation of EPSDT.¹⁹⁰

Similarly, in *Emily Q. v. Bonta*, the plaintiffs were children who were entitled to receive mental health benefits through Medicaid.¹⁹¹ All had severe mental health needs and were in institutional placements, although they could have been treated within the community.¹⁹² The plaintiffs alleged that the state failed to provide therapeutic behavioral services (TBS), which involves a trained and experienced staff person working with children and their families at home on a one-on-one basis in order to allow children to remain out of institutional settings.¹⁹³ The court ordered the defendants to provide general information to the heads of Medicaid-eligible households describing EPSDT's supplemental mental health services and the means for accessing those services.¹⁹⁴ The court required the state to provide TBS to Medicaid-eligible children when appropriate.¹⁹⁵ Both cases reflect the intention that the families of children who are eligible for EPSDT services be so informed and that those children are provided with access to mental health services in their homes and community through EPSDT to prevent their unnecessary institutionalization.

Mary's pediatrician referred her for counseling, having determined that this treatment was medically necessary for her. However, the mental health agency charged with connecting her with a mental health provider told her that it would be several months before Mary could be squeezed in for an intake appointment and then turned her away. In Mary's city, as in others, low Medicaid reimbursement rates result in a shortage of children's mental health providers that accept Medicaid.¹⁹⁶ This response was a denial of Mary's rights under Medicaid EPSDT to a medically necessary service that would have helped

Florida Foster Child to Due Process Prior to Being Committed to a Long-Term, Locked Psychiatric Institution, 25 NOVA L. REV. 725, 735 (2001).

190. *Rosie D.*, 410 F. Supp. 2d at 23–24. The court ordered a remedial plan to address these deficiencies. *Rosie D. v. Romney*, 474 F. Supp. 2d 238, 239–41 (D. Mass. 2007).

191. *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078, 1080 (C.D. Cal. 2001).

192. *Id.* at 1080–81.

193. *Id.* at 1083.

194. *Id.* at 1098.

195. *Id.* at 1086–87.

196. See Land, *supra* note 11, at 298–99; Weithorn, *supra* note 36, at 1373–74; see also CHILDREN'S LAW CTR., IMPROVING THE CHILDREN'S MENTAL HEALTH SYSTEM IN THE DISTRICT OF COLUMBIA (2012) [hereinafter CHILDREN'S LAW CTR., IMPROVING THE CHILDREN'S MENTAL HEALTH SYSTEM] (advocating for higher Medicaid reimbursement rates in order to attract more child psychiatrists to the District of Columbia), available at <http://www.childrenslawcenter.org/sites/default/files/clc/Improving%20the%20Children%27s%20Mental%20Health%20System%20%28May%202012E%29.pdf>.

to ameliorate her condition and could have allowed her to remain in the community.

D. *The Juvenile Justice Legal Regime*

Virtually every family member who participated in focus groups discussed the myriad of problem behaviors exhibited by their children before they were arrested and referred to juvenile court. Families described unaddressed learning problems and subsequent social and behavioral problems, undiagnosed mental health needs, experimentation with substance use, and engagement in risk and ill-considered actions. . . . Youth described being scapegoated by school personnel, rather than helped when they were having problems. . . .

Families discussed their frustration and sense of hopelessness when told nothing could be done to help their child. Rather than finding “No Wrong Door,” they found “All Wrong Doors.”¹⁹⁷

The federal statutory scheme¹⁹⁸ regulating juvenile delinquency prevention and juvenile justice programs explicitly promotes community-based mental health treatment and seeks to avoid confinement in juvenile correction facilities and institutionalization in RTCs whenever possible.¹⁹⁹ The Juvenile Justice Delinquency Prevention Act,

197. MODELS FOR CHANGE, FAMILY INVOLVEMENT IN PENNSYLVANIA'S JUVENILE JUSTICE SYSTEM 9 (2009).

198. While this Article focuses on statutory and regulatory provisions, youth who are incarcerated or otherwise considered “in state custody,” including youth who are committed to an RTC by a juvenile justice agency, may also have substantive due process rights under the Fourteenth Amendment similar to those of prisoners, which include the right to medical care. However, a substantive due process right to mental health services has rarely been explicitly recognized. Most of the jurisprudence on the substantive due process rights of individuals confined to an institution has stemmed from the Supreme Court's decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982). In the Third Circuit, a number of cases have cited a substantive due process right of incarcerated individuals, including youth, to mental health services. In *A.M. v. Luzerne County Juvenile Detention Center*, a youth named A.M. saw a doctor at the very beginning of his detention and was never again treated for his mental health needs. *A.M. v. Luzerne Cnty. Juvenile Detention Ctr.*, 372 F.3d 572, 576 (3d Cir. 2004). The court adopted a “deliberate indifference” standard for determining when a facility had violated an inmate's or detainee's due process rights and found that the medical staff was deliberately indifferent to A.M.'s mental health needs. 372 F.3d at 584–85. In *D.W. v. Rogers*, a case involving the civil commitment of a juvenile to a mental health facility, the Eleventh Circuit recognized a substantive due process right to mental health treatment. 113 F.3d 1214, 1217, 1219 (11th Cir. 1997). However, both the First and Fifth Circuits have expressed doubts about a Fourteenth Amendment right to treatment for juveniles. *Santana v. Collazo*, 714 F.2d 1172, 1176–77 (1st Cir. 1983); *Morales v. Turman*, 562 F.2d 993, 998 (5th Cir. 1977).

199. The statute is structured as a funding statute, vesting enforcement of its provisions with the Department of Justice. Although an analysis as to its enforceability is outside the scope of this Article, it is unlikely that the statute is privately enforceable. See, e.g., *Cruz v. Collazo*, 84 F.R.D. 307 (D.P.R. 1979) (noting that although 42 U.S.C. § 5602 clearly evinces the intention to implement the “least restrictive alternative” in regard to rehabilitation of juvenile delinquents, there is no evidence that a private cause of action was created by Congress so as to give standing

the leading federal statute governing state juvenile justice systems that receive federal funding, requires states to meet certain requirements that reflect these and other congressional intentions.²⁰⁰ The statute promotes the identification of youth with unmet mental health and learning needs, including those struggling in school, with an explicit intention of preventing unwarranted suspensions and expulsions and disrupting the school-to-prison pipeline that entangles many children with mental health disorders.²⁰¹ States are also required to promote community-based mental health treatment as a means to prevent the entry of children into the juvenile justice system. Specifically, states must provide counseling, training, and mentoring programs to youth who are at particularly high risk, including those residing in low-income and high-crime areas and those experiencing educational failure.²⁰² State plans should include assistance for approaches designed to strengthen families, including the involvement of extended family members, through family counseling and other services.²⁰³

The legislation also established an Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the Department of Justice.²⁰⁴ Congress empowered the OJJDP to research and evaluate the need for appropriate mental health services for youth at risk of involvement, or already involved, with the juvenile justice system and provide grants to promote the development of such services.²⁰⁵ Financial assistance from the federal agency is available for projects that provide treatment to youth who are at risk of entry into the juvenile justice system and to their families, as well as to juvenile offenders.²⁰⁶ These programs should include services for youth with serious mental health and emotional disturbances,²⁰⁷ as well as counseling, training, and mentoring to youth who are at highest risk of involvement in the delinquency system, such as those who live in high-crime areas.²⁰⁸

to sue a state or state agencies for not complying with the statute). Many of these principles are embodied in state laws and the need for community-based treatment or freedom from unnecessary confinement or institutionalization can be argued or decided in local or state delinquency proceedings regarding an individual youth.

200. 42 U.S.C. § 5601 (2006).

201. *See id.* § 5651(a)(2)(A)–(F).

202. *Id.* § 5633(a)(9)(G).

203. *Id.* § 5633(a)(16).

204. More than two and a half years into the administration of President Barack Obama, he has yet to nominate anyone to serve as administrator of OJJDP. For an explanation of the impact of the President's failure to appoint a leader for this agency, see Editorial, *Juvenile Justice Adrift*, L.A. TIMES, July 6, 2011, at A10.

205. 42 U.S.C. § 5661(a)(1)(B)(vii), (c).

206. *Id.* § 5651(a)(1).

207. *Id.* § 5651(a)(2)(H).

208. *Id.* § 5651(a)(4).

Despite the intention that children and families be provided with services to prevent delinquency system involvement, many children fall through the cracks without access to needed services and end up in this punitive system. A high percentage of incarcerated youth suffer from a mental health disorder.²⁰⁹ Most youth in the juvenile justice system qualify for at least one mental health diagnosis, and it is not uncommon for eighty percent or more of youth involved with the delinquency system to have a diagnosis of “conduct disorder.”²¹⁰ As many as one out of every five youths in the juvenile justice system has serious mental health problems.²¹¹ Some of these children have mental disorders that are undiagnosed, and the behaviors that led to their criminal offenses are often manifestations of their illness.²¹² Others have received mental health assessments and have been diagnosed, but cannot obtain the treatment they need quickly enough to stabilize and avoid involvement with the delinquency system.²¹³ Sometimes, without the availability of needed mental health services, a parent may call the police when his child is acting aggressively, out of desperation, fear, or hope that the child will finally get the needed attention and services.²¹⁴ Children with mental health disorders, particularly those of color, are often suspended from school as a result of disciplinary problems, a phenomenon that can lead to involvement in the delinquency and criminal justice systems through what has become known as the “school-to-prison pipeline.”²¹⁵

209. Cichon, *supra* note 47, at 12; Marc A. Schindler, *Mental Health Issues Facing Adolescents in the Juvenile Justice System: Part I*, AACAP NEWS, Jan.–Feb. 1999, at 10, 11. An Ohio Department of Mental Health study found that 86% of incarcerated females suffered from significant mental health symptomatology. OHIO TASK FORCE ON MENTAL HEALTH SERVS. TO JUVENILE OFFENDERS, OHIO DEP’T OF MENTAL HEALTH, FINAL REPORT AND RECOMMENDATIONS (Feb. 1998), available at <http://60c839e46aa2b05f44a0545042a9813f1819b245.gripelements.com/what-we-do/provide/forensic-services/task-force-on-juvenile-offenders.php>. A Virginia study revealed that 77% of children in secure detention homes have some type of emotional disorder. POLICY DESIGN TEAM, MENTAL HEALTH NEEDS OF YOUTH IN VIRGINIA’S JUVENILE DETENTION CENTERS 14–15 (1994), available at http://www.ncmhjj.com/resource_kit/pdfs/Prevalence/References/MHNeedVirg.pdf.

210. See Schindler, *supra* note 209, at 11.

211. “[Some] estimates place the rate of serious emotional disturbance among youth in the general population at 9 to 13 percent (much higher than the 0.5- to 5-percent range previously used by State policymakers.” Joseph J. Coccozza & Kathleen R. Skowrya, *Youth with Mental Health Disorders: Issues and Emerging Responses*, in NATIONAL CENTER FOR MENTAL HEALTH AND JUVENILE JUSTICE 1, 4 (2000) (citation omitted). For a discussion and definition of a conduct disorder, see AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 93–99 (4th ed. 2000).

212. Leviton, *supra* note 20, at 24.

213. *Id.*

214. *Id.* at 24 & n.54.

215. Tulman, *supra* note 6, at 404–05.

The delinquency system is simply not equipped to serve the high number of youth in the juvenile justice system that have a diagnosable mental health disorder.²¹⁶ Once children have entered the juvenile justice system, the federal statutory scheme requires that mental health assessment and treatment must be provided. The reality is that the mental health needs of many juvenile offenders go undetected and untreated.²¹⁷ Under the Juvenile Justice and Delinquency Prevention Act, states must have a plan in place for providing needed mental health services to youth in the juvenile justice system and for targeting those youth who are in greatest need of such services.²¹⁸ For incarcerated youth, states must ensure that qualified mental health professionals conduct needed assessments and develop individualized treatment and discharge plans that provide for mental health services.²¹⁹ Youth who are receiving psychotropic medications must be under the care of a licensed mental health professional, and programs must be in place to provide suicide-prevention services for incarcerated youth who will re-enter their communities following incarceration.²²⁰ Even an offender who is considered immediately dangerous must receive an immediate psychological evaluation and follow-up treatment.²²¹

Here and elsewhere, where the Juvenile Justice and Delinquency Prevention Act requires treatment, that treatment is to be broad and comprehensive, and include medical, educational, special education, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services as needed.²²² Children who have been committed as a result of federal criminal activity must also be provided with necessary mental health services, education, and medical care.²²³

Federal juvenile justice law also requires that states allow children to remain in the community and out of incarceration and institutionalization whenever possible. The OJJDP is charged with promoting the development of community-based projects and services intended to allow juvenile offenders to stay in their home and to strengthen their

216. Land, *supra* note 11, at 328 (citing a number of studies that show the prevalence of mental illness and unmet treatment needs among youth in the juvenile justice system).

217. Youth who receive immediate screenings upon entering the juvenile justice system are far more likely to have their problems identified and treated. Screenings also help identify juveniles who may benefit from "multisystemic therapy." SARAH HAMMOND, NAT'L CONFERENCE OF STATE LEGISLATURES, MENTAL HEALTH NEEDS OF JUVENILE OFFENDERS, 2007, at 6.

218. 42 U.S.C. § 5633(a)(7)(B)(iv) (2006).

219. *Id.* §§ 5633(a)(9)(S), 5651(a)(8), 5651(a)(16).

220. *Id.* §§ 5651(a)(16)(D), 5651(a)(21).

221. *Id.* § 5651(a)(24).

222. *Id.* § 5603(15).

223. 18 U.S.C. § 5039.

families.²²⁴ At least seventy-five percent of funds available through that program must be used for community-based alternatives to incarceration and institutionalization in residential placements, including home-based alternatives and a continuum of foster care or group home alternatives.²²⁵ Those funds must also be used to develop community-based programs and services to work with parents and other family members to strengthen families so that juveniles can remain in their home.²²⁶ Programs must be in place to allow nonviolent offenders to remain with their families as an alternative to incarceration or institutionalization.²²⁷ States must have a comprehensive and coordinated system of services that preserves a child's placement with his family or otherwise provides services in the least restrictive environment possible, while still maintaining public safety.²²⁸ If effectively established, these programs would keep children at home in their communities and out of restrictive RTCs whenever possible.

Federal law also serves to prevent unnecessary institutionalization and confinement for juveniles who are accused of committing crimes in violation of federal law.²²⁹ Under this system, the magistrate judge has a basic duty to release a juvenile to his parents unless detention is required for safety or to ensure future appearances in court.²³⁰ If a juvenile is to be detained prior to disposition, that detention should occur in his home or community whenever possible.²³¹ When commitment is necessary, wherever possible, "the Attorney General shall commit a juvenile to a foster home or community-based facility located in or near his home community."²³² A "comprehensive and coordinated system of services" must reflect congressional "goals of preserving families and providing appropriate services in the least restrictive environment" possible.²³³

224. 42 U.S.C. § 5651(a)(5).

225. *Id.* § 5633(a)(9)(A).

226. *Id.* §§ 5633(a)(9)(B), (M).

227. *Id.* § 5633(a)(9)(F)(i).

228. *Id.* § 5603(19)(A).

229. 18 U.S.C. § 5035 ("Whenever possible, detention shall be in a foster home or community based facility located in or near his home community."); *id.* § 5039 ("Whenever possible, the Attorney General shall commit a juvenile to a foster home or community-based facility located in or near his home community."); *id.* § 5031 (defining juvenile delinquency as "the violation of a law of the United States committed by a person prior to his eighteenth birthday which would have been a crime if committed by an adult").

230. *Id.* § 5034.

231. *Id.* § 5035.

232. *Id.* § 5039.

233. 42 U.S.C. § 5603(19)(A).

Finally, federal law also embodies an explicit intention for juvenile justice agencies to coordinate with other child-serving agencies regarding prevention programming, as well as the treatment of youth who do become involved in the delinquency system. To receive formula grants under the Juvenile Justice and Delinquency Prevention Act, states must submit a plan showing that the state is coordinating preventative efforts with other child-serving agencies. For example, state plans must provide for the coordination and maximum utilization of related programs operated by private and public agencies, such as education, special education, health and welfare programs.²³⁴ States must also form an advisory group that includes representatives of other public agencies concerned with delinquency prevention and treatment.²³⁵ Recognizing that many offenders will also have involvement with the child welfare system and that those youth require mental health treatment to promote their stability and prevent recidivism, the statute requires that states develop programs that provide treatment to those juvenile offenders who have also been victims of abuse and neglect and to their families.²³⁶ The OJJDP is specifically empowered to provide grants to states to develop "comprehensive juvenile justice and delinquency prevention projects that meet the needs of juveniles through the collaboration of the many local service systems juveniles encounter."²³⁷ These grants should be used to "develop locally coordinated policies and programs among education, juvenile justice, and social service agencies,"²³⁸ which could serve to prevent confusion resulting from differing eligibility criteria and bureaucratic buck-passing.

Despite the system's intention that children receive preventive treatment in the community and remain out of detention and incarceration, many children with mental health disorders, like Mary, end up in restrictive juvenile correction facilities or RTCs and stay there longer than needed, awaiting the availability of community-based mental health services.²³⁹ A small percentage of youth are directed into diversion programs, and most youth receive no services as they

234. *Id.* § 5633(a)(8).

235. *Id.* § 5633(a)(3)(A)(ii)(III); *see also id.* § 5633(a)(9)(C).

236. *Id.* § 5633(a)(9)(D).

237. *Id.* § 5651(a)(10).

238. *Id.* § 5651(a)(2)(G).

239. In the six months between January and June of 2003, as a result of the unavailability of necessary mental health services in their communities, "nearly 15,000 incarcerated youth waited for community mental health services" in juvenile detention facilities. U.S. HOUSE OF REPS. COMM. ON GOV'T REFORM, SPECIAL INVESTIGATIONS DIV., INCARCERATION OF YOUTH WHO ARE WAITING FOR COMMUNITY MENTAL HEALTH SERVICES IN THE UNITED STATES, at ii (2004); *see also* Scaparotti, *supra* note 36, at 194.

wait months for court appearances.²⁴⁰ Community-based mental health service options are lacking, resulting in the funneling of more youth into the juvenile justice system.²⁴¹ Successful programs are frequently short-lived, as community-based programs are often not prioritized in state funding, despite the intentions of the federal legal regime. For example, the Maryland Case Management Advocacy Project provided counseling and daily visits by caseworkers to 135 children and their families. In its first year, only twelve of those children were rearrested.²⁴² Despite this high success rate, the program was terminated.²⁴³

Rather than promoting community-based programs, state juvenile justice agencies and juvenile court judges frequently order that youth requiring mental health treatment be placed in RTCs or correctional facilities,²⁴⁴ even though they are often very restrictive and not rehabilitative in nature. While juvenile detention centers and jails have “become surrogate mental hospitals,”²⁴⁵ they are not equipped to address mental health needs.²⁴⁶ These correctional facilities are not designed as treatment facilities, do not offer the ongoing intensive mental health treatment these youth require, and lack staff trained to provide these youth the care they need.²⁴⁷ Children like Mary end up spending weeks, months, or even years in juvenile correction facilities without necessary treatment or educational services. These facilities are also overcrowded and perform initial screenings and assessments quickly and “en mass,” and sometimes staff “misinterpret symptoms of illness and forcibly restrain, overmedicate, or beat youths.”²⁴⁸ In California, a sixteen-year-old with diagnoses of bipolar disorder and conduct disorder was placed in a juvenile detention center, where she was regularly held in isolation and restrained with handcuffs.²⁴⁹ These

240. Stacey Gurian-Sherman, *Back to the Future: Returning Treatment to Juvenile Justice*, 15 CRIM. JUST. 30, 34 (2000).

241. *See id.* at 31, 34.

242. *Id.* at 36.

243. *Id.*

244. Cichon, *supra* note 47, at 22.

245. Coccozza & Skowrya, *supra* note 211, at 4; *see also* Leviton, *supra* note 20, at 24.

246. Cichon, *supra* note 47, at 12; POLICY DESIGN TEAM, *supra* note 209, at 18 (“Most secure detention home staff do not have the training or professional support available to manage effectively youth with severe or urgent mental health problems.”).

247. The 2010 Survey of Youth in Residential Placement found that eighty-eight percent of youth are in facilities where some or all counselors were not mental health professionals. ANDREA J. SEDLAK & KARLA S. MCPHERSON, OJJDP, *YOUTH'S NEEDS AND SERVICES: FINDINGS FROM THE SURVEY OF YOUTH IN RESIDENTIAL PLACEMENT 3* (2010).

248. Leviton, *supra* note 20, at 30.

249. SUE BURRELL & ALICE BUSSIÈRE, “DIFFICULT TO PLACE”: YOUTH WITH MENTAL HEALTH NEEDS IN CALIFORNIA JUVENILE JUSTICE 1 (2005).

attempts to calm her simply exacerbated her mental health problems.²⁵⁰ With such counterproductive, punitive interventions and without appropriate mental health treatment, an average of 17,000 incidents of suicidal behavior occur in U.S. juvenile correction centers each year,²⁵¹ providing further evidence of the inadequate mental health care offered at these facilities. Seventy-five percent of juvenile detention centers fail to meet even basic suicide prevention guidelines.²⁵²

Juvenile justice systems also fail to adequately address the mental health needs of youth re-entering their communities, as the necessary planning and provision of aftercare services rarely occurs.²⁵³ Barriers to addressing the mental health needs of youth in the delinquency system in the community, in detention facilities, and after release from detention facilities reflect the broader problems plaguing the children's mental health system, including inadequate screening and assessment; a dearth of training, staffing, and programs necessary to deliver mental health services; the lack of funding and clear funding streams to support mental health services; and confusion as to which child-serving system is responsible for providing services to these youth.²⁵⁴ Due to the difficulty of securing community-based mental health services and, for some children, the perception that they cannot safely live in an unsecured setting in the community, youth in the delinquency system with mental health disorders might be sent by the state juvenile justice agency to correctional facilities or long-term RTCs, where they will experience unnecessary institutionalization, and after which they are highly likely to recidivate and end up back in detention or another RTC.²⁵⁵

Mary's situation is illustrative of the school-to-prison pipeline phenomenon, as her unaddressed anger and difficulty relating to other children led to her fighting at school and, ultimately, to her arrest and detention in a juvenile correction facility. Despite her cries for help and suicidal ideations, incarceration became the solution to Mary's problems, without needed mental health services. While in a juvenile

250. *Id.* at 2. For juveniles with mental health disorders, detention can bring about "a heightened sense of trauma and acute feelings of depression, anxiety and the possibility of suicidal behavior." HAMMOND, *supra* note 217, at 7.

251. Leviton, *supra* note 20, at 13.

252. COAL. FOR JUVENILE JUSTICE, HANDLE WITH CARE: SERVING THE MENTAL HEALTH NEEDS OF YOUNG OFFENDERS 18 (2000).

253. Leviton, *supra* note 20, at 31.

254. Coccozza & Skowyra, *supra* note 211, at 7.

255. D.C. BEHAVIORAL HEALTH ASS'N, THE UNMET PROMISE: THE UNTAPPED RESOURCE OF MENTAL HEALTH TREATMENT FOR YOUTH IN JUVENILE JUSTICE SYSTEM 4 (2010) [hereinafter THE UNMET PROMISE].

correction facility, Mary received no treatment and the juvenile justice agency did not arrange for mental health services for her in the community upon discharge. Although the federal legal regime prioritizes coordination with other systems, as was the case for Mary, state and local juvenile justice agencies responsible for the “rehabilitation” of youth offenders often fail to coordinate effectively with special education, mental health, and health care agencies to ensure that adequate educational services and community-based mental health services are provided for youth involved with the delinquency system. Instead, despite the explicit goals of the federal juvenile justice statutory scheme to prevent recidivism through the provision of mental health services to juvenile offenders, Mary received no treatment while in the juvenile detention facility, received no treatment in the community, was needlessly confined in a RTC, and subsequently recidivated. If the vision that Congress promoted in the development of the federal statutory schemes were carried out, youth like Mary who have mental health needs would receive timely community-based treatment, rather than incarceration and segregation in RTCs.

E. The Disability Rights Legal Regime

The consequences of an erroneous commitment decision are more tragic where children are involved. [C]hildhood is a particularly vulnerable time of life and children erroneously institutionalized during their formative years may bear the scars for the rest of their lives.²⁵⁶

In 1990, Congress passed the Americans with Disabilities Act (ADA) to provide states with a “clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”²⁵⁷ The ADA was designed to prevent discrimination in employment and public services offered by both private and public entities.²⁵⁸ The statute seeks to further “equality of opportunity, full participation, independent living, and economic self-sufficiency” for individuals with disabilities.²⁵⁹ Furthermore, Title II of the ADA prohibits discrimination by governmental entities against individuals with disabilities, mandating that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or

256. *Reno v. Flores*, 507 U.S. 292, 318 (1992) (O'Connor, J., concurring) (alteration in original) (quoting *Parham v. J.R.*, 442 U.S. 584, 627–28 (1978) (Brennan, J., dissenting)).

257. 42 U.S.C. § 12101(b)(1) (2006).

258. David Ferleger, *The Constitutional Right to Community Services*, 26 GA. ST. U. L. REV. 763, 768 (2010).

259. 42 U.S.C. § 12101(a)(8).

be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”²⁶⁰

Specifically, the ADA forbids discrimination in the form of unnecessary institutionalization in settings where individuals with disabilities are unable to interact with nondisabled individuals, thereby requiring integration into the broader community. Echoing § 504 of the Rehabilitation Act, which proscribes discrimination against individuals with disabilities by programs receiving federal financial assistance,²⁶¹ the ADA also requires that recipients of federal funds provide services and programs to disabled individuals in the “most integrated setting appropriate to the needs” of the individuals.²⁶² Its prohibition on discrimination covers programs and activities provided by a public entity, requiring that they be administered in a setting that enables individuals with disabilities to interact with nondisabled persons as much as possible.²⁶³ For example, Title II of the ADA requires that public schools provide reasonable accommodations in all aspects of educational programming so that children can remain in integrated school settings, including access to particular services and areas of the school.²⁶⁴

The ADA also explicitly recognizes institutionalization as a form of segregation and discrimination against people with disabilities,²⁶⁵ and it requires that public entities refrain from engaging in discrimination in the form of unjustified segregation.²⁶⁶ In order to comply with the ADA, public entities must make reasonable modifications to policies, practices, and procedures to ensure that individuals can access the services they need in their own communities, unless they can prove that

260. *Id.* § 12132.

261. Section 504 of the Rehabilitation Act of 1973 also prohibits discrimination against persons with disabilities by programs or activities receiving federal funds. 29 U.S.C. § 794(a) (“No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .”).

262. 28 C.F.R. § 41.51(d) (2011).

263. 28 C.F.R. § 35.130(d); *see also* BAZELON CTR. FOR MENTAL HEALTH LAW, MAKING YOUR LIFE YOUR OWN: HOW OLMSTEAD EXPANDS RIGHTS AND OPPORTUNITIES FOR PEOPLE WITH SERIOUS MENTAL ILLNESSES 1 (2011), *available at* <http://www.bazelon.org/LinkClick.aspx?fileticket=HZT-J9kSCZk%3d&tabid=118> [hereinafter MAKING YOUR LIFE YOUR OWN] (explaining that the integration mandate requires that publicly funded services refrain from needlessly segregating persons with disabilities by keeping them away from the mainstream community).

264. LAURA ROTHSTEIN & SCOTT F. JOHNSON, SPECIAL EDUCATION LAW 36–37 (4th ed. 2010).

265. 42 U.S.C. § 12101(a)(2)–(3); *see also* *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999).

266. *See* 42 U.S.C. § 12132.

the provision of community-based services would fundamentally change the nature of the program or result in undue burden.²⁶⁷

Both the integration and reasonable-modification provisions of Title II of the ADA aim to prevent the discrimination of individuals with disabilities through isolation,²⁶⁸ and they can be used to challenge the unwarranted institutionalization of children with mental disabilities in RTCs. The standard for determining whether institutionalization constitutes discrimination under Title II of the ADA was announced by the Supreme Court in 1999 in the landmark case *Olmstead v. L.C. ex rel. Zimring*. In *Olmstead*, two women with intellectual disabilities and mental health disorders filed suit in federal court claiming that their continued confinement in an institution, after it was determined that they were able to function in a community-based program, was a violation of the ADA and their constitutional rights under the Due Process Clause of the Fourteenth Amendment.²⁶⁹ Although the Court declined to rule on the constitutional claims, the majority opinion, written by Justice Ginsburg, agreed that unjustified isolation constitutes discrimination based on disability and ruled in favor of the plaintiffs on their claims under Title II of the ADA.²⁷⁰

The Court looked to Congress's intention in enacting the ADA to eliminate the historical segregation and isolation of people with disa-

267. *Id.* § 12182(2)(A).

268. See Ferleger, *supra* note 258, at 769; see also 42 U.S.C. § 12182(2)(A)(ii).

269. 527 U.S. at 588.

270. *Id.* In addition to protections provided under § 504 of the Rehabilitation Act and the ADA, children involuntarily placed in RTCs by public agencies may also be entitled to constitutional protections under the Due Process Clause of the Fourteenth Amendment. See *Parham v. J.R.*, 442 U.S. 584, 585 (1979) (noting that a child retains a constitutional liberty interest through the Due Process Clause of the Fourteenth Amendment to be free from unwarranted and ineffective treatments); *Reno v. Flores*, 507 U.S. 292, 316 (1993) (O'Connor, J., concurring) ("Children, too, have a core liberty interest in remaining free from institutional confinement. In this respect, a child's constitutional '[f]reedom from bodily restraint' is no narrower than an adult's." (alteration in original)). Although the Supreme Court found in *Parham v. J.R.* that "a child has a protectible interest . . . in being free from unnecessary bodily restraints," it declined to provide extensive due process protections to a child whose parent committed him or her to a state mental institution, relying heavily on parental autonomy in allowing for parents to commit their child against the child's will. 442 U.S. at 585, 601. The Court explained that the determination of a doctor employed by that facility as to the need for treatment would protect a child from the "risk of error inherent in the parental decision to have a child institutionalized for mental health care." *Id.* at 606-08. Similarly, the Supreme Court of Alabama upheld the broad authority of parents over their children in *R.J.D. v. Vaughan Clinic* and further asserted that "health care providers should be able to rely on a parent's consent when admitting a minor child into their care." 572 So. 2d 1225, 1228 (Ala. 1990) (holding that the mere fact that the plaintiff did not consent to the placement does not abrogate the mother's authority over custody and care of the plaintiff and that it is the parents' legal right to determine what is best for the child); see also Weithorn, *supra* note 36, at 1414.

bilities through intentional exclusion and failures to modify existing facilities and practices.²⁷¹ The Court reasoned that unjustified institutional isolation is a form of discrimination because it perpetuates the unwarranted assumption that people with disabilities must be isolated from the remainder of society and are incapable of being productive members of society.²⁷² Additionally, institutionalization diminishes the everyday lives of individuals with disabilities by excluding them from life activities such as family relations, social contacts, economic independence, and educational advancement.²⁷³ Thus, unnecessary institutionalization forces individuals with disabilities to relinquish their right to a life in the community in order to receive treatment, while those without disabilities can often receive medical services without relinquishing any such right.²⁷⁴

Furthermore, the Court noted that Title II of the ADA “defines ‘the most integrated setting appropriate to the needs of qualified individuals with disabilities’ to ‘mean a setting that enables individuals with disabilities’ to interact with nondisabled persons to the fullest extent possible.’”²⁷⁵ Psychiatric hospitals and RTCs—where all of the residents have mental health disorders and are denied interaction with nondisabled individuals other than staff professionals—fall squarely within the realm of settings that do not allow for integration into the community.²⁷⁶

271. *Olmstead*, 527 U.S. at 588.

272. *Id.* at 600; see also Weithorn, *supra* note 36, at 1431.

273. *Olmstead*, 527 U.S. at 600; see also Weithorn, *supra* note 36, at 1431.

274. *Olmstead*, 527 U.S. at 601; see also MAKING YOUR LIFE YOUR OWN, *supra* note 263, at 1 (“[P]eople with disabilities should not have to move into group settings . . . to obtain the services they need to live and thrive in society like anyone else.”).

275. *Olmstead*, 527 U.S. at 592 (quoting 28 C.F.R. § 35 (1998)).

276. Note that Title II of the ADA prohibits discrimination by *public entities*. 42 U.S.C. § 12132 (2006). While many RTCs that house children are private entities, this Article discusses the plight of children who are placed and funded by public agencies in these facilities. The ADA would similarly prohibit discrimination through unwarranted institutionalization by *public entities* in placing and funding children in these private facilities. See *id.* § 12181(7). In *Helen L. v. DiDario*, the Third Circuit applied the ADA to prohibit discrimination by states that used federal funds to institutionalize individuals with disabilities in private facilities. 46 F.3d 325, 338–39 (3d Cir. 1995). In that case, a 43-year-old woman was paralyzed from the waist down from meningitis and placed in a Philadelphia nursing home. *Id.* at 328. The federal Medicaid program and the state of Pennsylvania funded her nursing home placement despite the availability of an alternative state program that would have allowed her to receive treatments at her home. *Id.* at 329. In ruling that the placement was a violation of Title II of the ADA, the court emphasized that “recipients of federal funds may not engage” in discrimination on the basis of disability. *Id.* at 334 (citing 45 C.F.R. § 84.4(b)(1)). Various public agencies, such as the juvenile justice, child welfare, and education systems, are responsible for the administration of mental health services to children, including residential placement. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 6. These agencies often utilize Medicaid dollars or other federal funds to finance these mental health services. See, e.g., EMBRY HOWELL, URBAN INST., ACCESS TO CHILDREN’S

The majority in *Olmstead* concluded that Title II of the ADA requires states to place people with disabilities in community settings rather than institutions when

the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.²⁷⁷

MENTAL HEALTH SERVICES UNDER MEDICAID AND SCHIP 1 (2004). Thus, these agencies are subject to ADA prohibitions on discriminatory institutionalization because they are recipients of federal funds. As in *Helen L.*, the ADA would similarly apply to prohibit discrimination through unwarranted institutionalization in these private facilities. See 42 U.S.C. § 12181(7). Even where federal funds are not used, if a public agency, such as a state or local child welfare, juvenile justice, or education agency, is placing a child with a disability in a private residential facility, the ADA prohibits discrimination through unnecessary institutionalization. *Id.* § 12101(a)(3). More recently, in *Connecticut Officer of Protection & Advocacy for Persons with Disabilities v. State of Connecticut*, the district court dismissed the defendant's claim that three privately operated nursing homes did not fall under the purview of the ADA because they did not constitute programs provided by a public entity. Ruling on Defendant's Motion to Dismiss and Plaintiffs' Motion for Certification of Class at 11, 41, State of Conn. Office of Prot. and Advocacy for Persons with Disabilities v. Connecticut, No. 3:06CV00179(AWT) (D. Conn. Mar. 31, 2010) (denying the defendant's motion to dismiss). The court rejected this contention based on the ADA mandate requiring states to administer services in the most integrated setting to all qualified individuals. *Id.* at 11–12. Both *Olmstead* and the ADA impose responsibility on the state to provide community-based treatments, and therefore a state's unnecessary institutionalization in private nursing facilities makes it liable under the ADA, whether or not the services are delivered by private entities. *Id.*

277. *Olmstead*, 527 U.S. at 587. When the standard announced by the Court in *Olmstead* is met for a particular child, that child should receive treatment in the community, rather than placement in an RTC. *Id.* However, there is a question as to how a court would treat the second prong, the requirement that transfer to a less restrictive setting not be opposed by the affected individual. Because a parent may consent to the placement by a state agency of her child in an RTC, over the objection of the child, it is not clear whether the court would look to the parent's or the child's view of the institutionalization in determining whether that second prong was satisfied. See *Parham v. J.R.*, 442 U.S. 584, 585 (1979). The deference of courts to parental decisions in committing their children to institutions suggests that a court might look to the parent and not the child to determine consent to transfer to a less restrictive setting. However, the ADA specifically aims to protect the rights of individuals with disabilities. 42 U.S.C. § 12101(b). The statute's focus on individual empowerment is explicitly reflected in the Supreme Court's decision to include in the *Olmstead* standard a requirement that an individual not oppose his transfer to a less restrictive setting. See 527 U.S. at 587. Although under common law, parents have the right and duty to make decisions on behalf of their children, ignoring the view of the child, who is the "affected" individual, in determining whether the transfer to a less restrictive setting is opposed, contradicts the emphasis on the autonomy of individuals with disabilities in the ADA. 42 U.S.C. § 12101(a)(8). Even if the application of this prong of *Olmstead* requires parental consent before a child can be transferred to a less restrictive setting, a parent who initially opposed the transfer of his child back to the community might agree to the transfer if community-based treatment was in fact available. With the inability to secure access to necessary services, parents may be more likely to oppose re-integration of their children. See Weithorn, *supra* note 36, at 1375. If parents were offered effective ways to help, stabilize, and support their children, they could pursue their child's return to the home or community. Parents often initially agree to

These requirements establish the case-by-case analysis for a determination as to whether Title II of the ADA requires states to provide an individual with mental disabilities with community-based treatment.²⁷⁸ While the ADA requires reasonable modification to practices and policies to further avoid discrimination, the Court emphasized in laying out this standard that states may avoid modifications that would significantly alter the state's services and programs.²⁷⁹

Although the Court's rhetoric in the *Olmstead* decision evidenced strong concern about the institutionalization of individuals with disabilities, the institutionalization of children by public agencies in private RTCs has not been explored comprehensively in this light and remains a largely invisible problem. Perhaps the placement of children with disabilities in these facilities is implicitly justified through society's view of the protective *parens patriae* role of the state and of parents,²⁸⁰ or perhaps the issue remains largely unexamined due to the lack of research about the effectiveness of such treatments and the failure to effectively monitor these placements.²⁸¹ When children are out of sight in these facilities, they may also be out of mind, at least to policymakers and scholars.²⁸² Alternatively, the lack of focus on the problem may reflect a reality that as a society, we feel more comfortable trusting to professionals children of whom or for whom we are scared, as our communities have not provided the mechanisms through which these children can achieve health and stability in our midst. For these reasons, and likely others, the placement of children in RTCs has not been viewed with the same concern or association

residential treatment because they are left with no other choice and feel they must send their children away in order for them to receive treatment. See *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1309 (D. Utah 2003) (holding that defendants' failure to provide disabled plaintiffs with the appropriate services put them at direct risk for institutionalization because it forced the plaintiffs to choose between receiving no services, staying in the community, and being institutionalized to receive services, and therefore was a violation of the ADA).

278. See *Olmstead*, 527 U.S. at 607.

279. *Id.* at 603; see also U.S. DEP'T OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD V. L.C. 2* (2011), available at http://www.ada.gov/olmstead/q&a_olmstead.pdf (stressing that states can only be excused from modifications that would "fundamentally alter" the service system).

280. See Weithorn, *supra* note 36, at 1401-03 (discussing the *parens patriae* role of the state in decision making aimed at the protection of children).

281. See UNIV. LEGAL SERVS., INC., *supra* note 56, at 10.

282. See, e.g., NAT'L DISABILITY RIGHTS NETWORK, A DECADE OF LITTLE PROGRESS IMPLEMENTING *OLMSTEAD*, 19 (2009), available at http://www.napas.org/images/Documents/Issues/Community_integration/NDRN_Decade_of_Little_Progress_Implementing_Olmstead.pdf (demonstrating the out-of-sight phenomena through the unnecessarily long placement of a sixteen-year-old girl in a residential facility due to the institution's failure to release her even when she was no longer a risk).

with discrimination as the institutionalization of adults with disabilities.

The promise of the ADA remains unfulfilled for many children who are institutionalized in RTCs. In *Eric L. v. Bird*, for example, the plaintiffs brought action on behalf of children in foster care and those who had been removed from their home by the New Hampshire Division of Children and Youth Services.²⁸³ The claim asserted that the defendants violated federal statutory law and the Constitution by failing to ensure that children were reunited with their families as soon as possible and failing to provide the necessary services to protect children from harm.²⁸⁴ Although the court did not affirm all of the allegations, it allowed the claim that the defendant discriminated against a subset of children with disabilities by “segregating them in institutions which isolate them from non-disabled children, and by denying them services and placement opportunities comparable to those available to non-disabled children.”²⁸⁵ The court concluded that the claim could not be dismissed because a question remained as to whether the state was engaging in discrimination prohibited by § 504 of the Rehabilitation Act and Title II of the ADA by placing children with disabilities in institutions.²⁸⁶ The case ultimately led to a settlement agreement, which the defendants failed to implement, resulting in the appointment of a special master.²⁸⁷

There are steps that states can take to reduce the institutionalization of children with disabilities. In *Olmstead*, the Court suggested that a state can comply with its responsibilities by developing a comprehensive plan “for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated.”²⁸⁸ The development of “*Olmstead* plans” was supported by President George W. Bush in an executive order enforcing the implementation of the ADA in accordance with the *Olmstead* decision.²⁸⁹ Although the Court’s decision did not specifically indicate

283. 848 F. Supp. 303, 306 (D.N.H. 1994).

284. *Id.*

285. *Id.* at 313.

286. *Id.*; see, e.g., *W.R. v. Conn. Dep’t of Children & Families*, No. 3:02CV429 (RNC), 2003 U.S. Dist. LEXIS 5128, at *7–8 (D. Conn. Mar. 24, 2003) (denying the motion to dismiss with regards to the ADA because the minors can recover damages under the ADA if the state’s actions were motivated by animus or ill will inspired by the minors’ disabilities).

287. See *Eric L. et al. v. Comm’r of the N.H. Dep’t of Health & Human Servs.*, No. 81-376-M, 2003 U.S. Dist. LEXIS 17323, at *6–7 (D.N.H. Sept. 30, 2003).

288. See *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 606 (Ginsburg, J., concurring).

289. Exec. Order No. 13,217, 3 C.F.R. 774–76 (2002); see also Weithorn, *supra* note 36, at 1433.

what would constitute a “comprehensive effectively working plan,” the U.S. Department of Health and Human Services issued a letter to state Medicaid directors in 2000 providing guidance to the states regarding their creation of *Olmstead* plans.²⁹⁰

The letter indicated that plans must be created to provide services to eligible individuals in community-based settings and that individuals with disabilities and their representatives must be provided an opportunity to participate in the development of such plans.²⁹¹ Furthermore, the plans should address ways to correct unjustified institutionalization and ensure availability of community-based services.²⁹² Moreover, individuals and their families must be given the opportunity to choose how to best meet the individual’s needs, whether through community programs or institutions.²⁹³ Lastly, the plans must indicate steps toward quality improvement and support throughout implementation.²⁹⁴

The ultimate goals of such plans are to remove all qualified persons from unnecessary institutionalization, to allow them to return to their communities with appropriate services, and to prevent future discriminatory placements.²⁹⁵ The unnecessary placement of children with mental health disorders in detention facilities, psychiatric hospitals, and residential treatment facilities shows that the *Olmstead* planning process could be more effectively used to de-institutionalize youth.²⁹⁶

290. *Letter/Guidance to State Medicaid Directors*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (Jan. 14, 2000), <http://www.acf.hhs.gov/programs/add/otherpublications/olmstead.html#letter> [hereinafter *Letter to State*]; see also BAZELON CTR. FOR MENTAL HEALTH LAW, MERGING SYSTEM OF CARE PRINCIPLES WITH CIVIL RIGHTS LAW: *OLMSTEAD* PLANNING FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE 4 (Nov. 2001), <http://www.bazelon.org/LinkClick.aspx?fileticket=ZQNT7T3LABw%3d&tabid=104> [hereinafter MERGING SYSTEM OF CARE].

291. *Letter to State*, *supra* note 290.

292. See *id.*; see also U.S. DEP’T OF JUSTICE, *supra* note 279, at 7 (“The plan should include commitments for each group of persons who are unnecessarily segregated . . .”).

293. See *Letter to State*, *supra* note 290; see also MAKING YOUR LIFE YOUR OWN, *supra* note 263, at 2 (emphasizing that people with disabilities have the right to elect where they receive services).

294. *Letter to State*, *supra* note 290.

295. See Weithorn, *supra* note 36, at 1433; see also YOUTH VILLAGES, ALABAMA DEPARTMENT OF HUMAN RESOURCES’ ASSESSMENT OF SERIOUSLY EMOTIONALLY DISTURBED YOUTH IN RESIDENTIAL AND THERAPEUTIC FOSTER CARE PLACEMENTS 2 (2004) (noting that many children remain in inappropriate, restrictive long-term placements due to the lack of a full continuum of care in their communities).

296. In 2001, shortly after the Supreme Court’s decision in *Olmstead*, the Bazelon Center for Mental Health Law issued a report on the progress of states in *Olmstead* planning regarding children based on a review of *Olmstead* plans by the National Association of State Protection and Advocacy Systems (NAPAS). MERGING SYSTEM OF CARE, *supra* note 290. Despite the development and implementation of *Olmstead* plans in most states, the NAPAS review indicated that minimal efforts had been made in using *Olmstead* plans for children and little consideration had been given to children in residential facilities. See *id.* at 5. Although there have been re-

Litigation around the country reveals that the *Olmstead* mandate has not yet been fully achieved regarding the provision of appropriate community-based services for individuals with disabilities.²⁹⁷ States should include in their *Olmstead* plans steps they will take to reduce the number of children needlessly placed in segregated settings by public agencies.²⁹⁸

Title II of the ADA and the Court's interpretation of the statute in *Olmstead* can serve as effective legal avenues to protect children with disabilities from unnecessary institutionalization. As described above, unjustified residential placement is exactly the type of discrimination against which the ADA aims to protect. Just like adults with disabilities, children with disabilities are a vulnerable group with a history of disproportionate treatment and segregation.²⁹⁹ Rather than institutionalizing Mary in an RTC, her school should have examined whether such isolation and segregation were in fact warranted. The educational agency should have carried out the intentions of Congress in the ADA by prioritizing her continued placement in the community, with the services necessary to make such continuing integration possible. The effects of institutionalization on a child like Mary are substantially detrimental to the development of the proper skills necessary for her to become a functioning member of both the community and her family.

IV. THE DISJUNCTION BETWEEN THE SHARED GOAL OF COMMUNITY-BASED TREATMENT AND THE REALITY FOR CHILDREN WITH MENTAL HEALTH DISORDERS

The analysis of legal regimes related to child welfare, special education, health care, juvenile justice, and disability rights reveals common goals of early identification, prevention, the provision of community-based services, and avoidance of out-of-home and congregate care placements. Yet local and state agencies frequently fail to ensure that children timely receive the mental health treatment they require and continue to place children from low-income families in RTCs, to the detriment of those children and at high cost to taxpayers. What are

views of state *Olmstead* plans since that time, no review has specifically focused on the extent to which state plans address the needs of children. See NAT'L COUNCIL ON DISABILITY, *supra* note 160, at 5.

297. See, e.g., Statement of Interest of the United States at 13, *Troupe v. Barbour*, No. 3:10cv153HTW-LRA (S.D. Miss. Apr. 8, 2011), available at http://www.ada.gov/briefs/troupe_interest_br.pdf; see also Weithorn, *supra* note 36, at 1433.

298. See MERGING SYSTEM OF CARE, *supra* note 290.

299. Cf. *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 127–28 (1984) (Stevens, J., dissenting) (describing abuse of treatment in a 1981 decision).

the reasons for this disjunction between the goals of the relevant federal legal regimes and the continued institutionalization of poor children with emotional and behavioral problems? The stigma surrounding mental illness, the scarcity of providers, delays in gaining access to community-based services, and compartmentalization among child-serving public agencies contribute to this disconnect between the “law on the books” and the reality for children.³⁰⁰

A. *The Stigma of Mental Illness*

Without effective community education and outreach by state agencies, parents and children may go without necessary services due to the stigma associated with mental illness and involvement in mental health treatment.³⁰¹ Stigma can lead to a failure to identify, diagnose, and treat children’s mental health needs, which can be particularly problematic in communities of color and those without financial resources,³⁰² where a lack of education, outreach programs, and culturally competent mental health providers and materials exacerbates the problem.³⁰³ A child and her parents may be hesitant to acknowledge her emotional struggles or ask for help as a result of the stigma attached to mental illness. Even the Supreme Court has acknowledged the powerful effect of stigma on the individual, emphasizing that “[o]ne who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma.”³⁰⁴

300. See Larke Huang et al., *Transforming Mental Health Care for Children and Their Families*, 60 AM. PSYCHOLOGIST 615, 620 (2005) (highlighting that multiple barriers, including stigma, fragmentation of services, lack of availability, and cost, contribute to all populations not receiving appropriate services).

301. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 25; MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 180, 188; see also ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY 2–3 (1986).

302. See Leviton, *supra* note 20, at 19.

303. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 28. Stigma contributes directly to missed opportunities for prevention and early identification. *Id.* at 15. “Cultural competence is the ability to work effectively and sensitively within various cultural contexts,” including the “ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services.” *Cultural Competence in Mental Health Care*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Cultural_Competence/Cultural_Competence.htm (last visited Sept. 17, 2011) (“For consumers of color, access to mental health services and the quality of the services they receive are negatively affected by the lack of cultural competence in service delivery. Many research studies have shown that because of the lack of cultural competence, people of color may not seek services in the formal system, cannot access treatment, drop out of care, are misdiagnosed, or seek care only when their illness is at an advanced stage.”).

304. See *Addington v. Texas*, 441 U.S. 418, 429 (1979).

In addition to its effects on the individual with a mental health disorder, stigma can also leave families feeling at fault for their child's mental health problems.³⁰⁵ "Parents are fearful about bringing the social and emotional difficulties of their children to the attention of medical professionals, perhaps afraid they may be blamed."³⁰⁶ This fear can be compounded for low-income parents, who may be more likely to feel disrespected or misunderstood by health care providers.³⁰⁷ Many parents do not recognize the necessity of mental health services, "linking use of services to a lack of toughness."³⁰⁸ Some parents may have themselves experienced trauma or abuse and feel that they survived without mental health services and that their children should be able to do the same.³⁰⁹ Teachers, public agency officials, courts, attorneys, mental health professionals, and others sometimes contribute to the problem of stigma by demonizing children and painting them as violent superpredators.³¹⁰ Discussions in courtrooms and evaluation reports sometimes paint a picture of a dangerous villain, rather than reflecting images of a child who has suffered trauma or a child with a disability who is crying out for help.

The stigma associated with mental illness may have prevented Mary's foster mother from meaningfully connecting Mary's behaviors with a mental health need. Frustrated by Mary's behavior, embarrassed by the chatter in the neighborhood that Mary was "crazy," and lacking access to information about mental health disorders and the available types of treatment, her foster mother was not empowered to advocate for services that could have helped both her and Mary to achieve stability. The various child-serving agencies that were involved in the lives of Mary and her foster mother failed to help them understand her diagnoses and potential treatments, leaving the stigma associated with mental health disorders—as well as the stigma associated with being a victim of rape—unaddressed.

305. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 30.

306. *Id.* at 15.

307. *Id.* at 30.

308. ANITA CHANDRA ET AL., HEALTH AND HEALTH CARE AMONG DISTRICT OF COLUMBIA YOUTH 112 (2009), available at http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR751.pdf.

309. *Id.* Children also can be directly stigmatized by their classmates. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 15.

310. See, e.g., PETER ELIKANN, SUPERPREDATORS: THE DEMONIZATION OF OUR CHILDREN BY THE LAW (1999).

B. Scarcity of Providers and Delays in Receiving Services

While the mental health needs of many children go unidentified altogether, those children who are identified and referred for mental health services still often face significant barriers to actual receipt of those services, including lack of available specialists, insurance restrictions, and appointment delays. A low-income family seeking a mental health service may find a long wait to gain access to that service,³¹¹ or may find that the service is not available to low-income individuals covered by Medicaid or not available in the geographic region whatsoever.³¹² Finding a provider can be especially difficult if the child does not have insurance or if the child's insurance does not provide for extensive mental health coverage.³¹³ Even for children covered by Medicaid, some Medicaid managed care organizations, for example, will only authorize a limited number of visits for treatment that is often insufficient to meet a child's mental health needs.³¹⁴ In part because Medicaid reimbursements are sometimes too low for mental health providers to remain economically viable, there are often few providers in a given Medicaid network available to provide intensive mental health care.³¹⁵ Moreover, parents do not have ready access to case-management services that can help them navigate various bureaucratic hurdles to obtain needed care.³¹⁶

Delays in gaining access to services contribute significantly to the failure of children to receive needed community-based mental health treatment. More than two thirds of primary care physicians who refer children for mental health services report appointment delays, with

311. For example, a Children's National Medical Center psychiatrist testified before the District of Columbia City Council that there is a ten-week wait for a child served by Medicaid to see a psychiatrist at the hospital's outpatient clinic. *Budget Cuts Mean Shrinking Access to Mental Health Services for DC's Children*, D.C. BEHAVIORAL HEALTH ASS'N (June 6, 2011), <http://www.dcfpi.org/budget-cuts-mean-shrinking-access-to-mental-health-services-for-dc%e2%80%99s-children#respond>.

312. In the District of Columbia, for example, because Medicaid reimbursement rates for mental health services are often very low and the process of obtaining reimbursement can involve significant bureaucratic obstacles, many mental health providers choose not to accept Medicaid insurance, meaning that some mental health services simply are not available in the city at all. *Id.*

313. CHANDRA ET AL., *supra* note 308, at 112.

314. *Id.*; see also MAKING SENSE OF MEDICAID, *supra* note 23, at 15 ("Most managed health care plans, such as HMOs, contract to provide only a short-term acute mental health benefit. However, the state remains responsible under the law for providing care to children who have serious disorders and who require services the HMO does not provide. States should inform families of their child's right to all medically necessary services, but few provide clear explanations. As a result, families, unaware that their child has such a right, do not know how to claim additional services if the HMO benefit is inadequate.").

315. See MAKING SENSE OF MEDICAID, *supra* note 23, at 15.

316. CHANDRA ET AL., *supra* note 308, at 112.

average wait time for an appointment with a specialist being three to four months.³¹⁷ If a referral is not made for a child to receive specialty mental health services until that child is already “spiraling out of control,” a delay of several weeks is too long to wait.³¹⁸ As in Mary’s situation, when a child who is in crisis must wait for mental health services, the child’s stability, and even his safety or life, could be at risk.

Designing and implementing a strong community-based mental health treatment plan for a child presenting with such complex needs is sometimes more difficult than sending the child away, where he will no longer be stressing and stretching the capacities of his family, school, neighborhood, or public agencies. In describing the phenomenon of a failed community-based mental health system in the District of Columbia and the resulting high rates of RTC placement, a city administrator explained, “The issue is lazy bureaucracy It’s much more difficult to design a detailed wraparound plan than it is just to stick a youth in a facility.”³¹⁹ A city juvenile justice agency worker reported that caseworkers simply turn to residential treatment placements “because they run out of ideas. I don’t think they know how to create a plan to help a young person . . . so they resort to the most extreme measure. You are talking about taking away their liberty to help them.”³²⁰

C. *Compartmentalization and Fragmentation Among Child-Serving Agencies*

The limited mental health services that are available for children from low-income families are often funded by a number of public

317. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 19.

Of those patients who were referred, 59% had zero visits to the specialist; only 13% averaged one or more visits a month in the follow-up period of six months. In short, an increasing number of problems (15–30%) are being identified by primary care providers, but rates of recognition (48–57%) are still low and connections to mental health specialists are difficult.

Id.

Eighty-five percent of “drop-out rates” for mental health services can be attributed to operational failures, such as delays in the provision of services. NAT’L COUNCIL FOR CMY. BEHAVIORAL HEALTH CARE, ENHANCED ACCESS AND ENGAGEMENT QUALITY IMPROVEMENT INITIATIVE: STRATEGIES TO INCREASE THERAPY ADHERENCE 1 (2010), *available at* <http://www.thenationalcouncil.org/galleries/policy-file/EnhancedAccessReport%20FINAL.pdf>.

318. THE UNMET PROMISE, *supra* note 255, at 5.

319. Jason Cherkis, *Outsourcing Troubled Kids*, WASH. CITY PAPER (Jan. 7, 2011), <http://www.washingtoncitypaper.com/articles/40237/outsourcing-troubled-dc-kids/full> (quoting a former District of Columbia administrator).

320. *Id.* (alteration in original) (quoting a Department of Youth Rehabilitation Services official).

agencies, meaning that responsibility for mental health care is dispersed among multiple settings,³²¹ particularly for low-income children with mental health disorders.³²² While these children often have several public agencies involved in their lives because they present with multiple problems,³²³ those agencies rarely work together.³²⁴ This fragmentation is evident in the differing entry points, eligibility criteria, financial structures, service offerings, service delivery structures, and procedures that a family must navigate to secure treatment through various child-serving agencies.³²⁵ “There are a plethora of programs, laws, regulations, federal and state mandates, but many have conflicting or rigid rules . . . and arbitrary eligibility requirements”³²⁶ For example, the requirement by some agencies that a child

321. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 14.

322. See Cichon, *supra* note 47, at 9.

323. Cichon, *supra* note 47.

324. STROUL, *supra* note 27; see also BAZELON CTR. FOR MENTAL HEALTH LAW, STILL WAITING, *supra* note 25, at 9 (“Several federal agencies are key [in implementing the Olmstead decision], including HUD, the Justice Department, the Education Department, the Department of Health and Human Services and its agencies (among them SAMHSA and the Administration on Children, Youth and Families), Social Security Administration and CMS.”).

325. For example, in the District of Columbia, this fragmentation is evident at a number of levels. Medicaid-eligible children are provided services through two funding mechanisms—Medicaid managed care organizations (MCO) or Medicaid fee-for-services for children in the custody of the foster care or juvenile justice systems. D.C. BEHAVIORAL HEALTH ASS’N, TOWARDS A TRUE SYSTEM OF CARE: IMPROVING CHILDREN’S BEHAVIORAL HEALTH SERVICES IN THE DISTRICT OF COLUMBIA (PART 1 OF 2), at 3, 8 (2009), available at <http://www.dcbehavioralhealth.org>. Although MCOs are responsible for the delivery of services, the burden shifts to the Department of Mental Health if the child has severe mental health issues. *Id.* at 5. However, MCOs are still responsible for delivering developmental services and schools remain responsible for early intervention services. *Id.* at 10. Both MCOs and fee-for-service Medicaid diffuse the responsibility over various local agencies, resulting in confusion for both parents and providers regarding the acceptance of services through the different Medicaid systems. CHILDREN’S LAW CTR., IMPROVING THE CHILDREN’S MENTAL HEALTH SYSTEM, *supra* note 196, at 19. Furthermore, different MCOs might have varying requirements for eligibility criteria for different services, or may not even have any providers within network that provide the necessary service. D.C. BEHAVIORAL HEALTH ASS’N, *supra*, at 8. With different entry points for mental health service provision through the local school, child welfare, juvenile justice, mental health, and health care agencies, “there are many payment structures and providers, and often parents are unable to find anyone who has an accurate and comprehensive understanding of all the service and treatment options available for their child. . . . A child’s condition deteriorates during the time the family waits to find appropriate, consistent treatment.” CHILDREN’S LAW CTR., IMPROVING THE CHILDREN’S MENTAL HEALTH SYSTEM, *supra* note 196, at 19. Many children do not receive needed services due to this complexity and fragmentation of the system. CHILDREN’S LAW CTR., MEDICAID AND CHILDREN’S MENTAL HEALTH CARE IN THE DISTRICT OF COLUMBIA 13, 19 (2011), available at <http://www.childrenslawcenter.org/sites/default/files/clc/Medicaid%20Mental%20Health%20101.pdf>. For a discussion of some of the problems plaguing the children’s mental health system in the District of Columbia, see D.C. BEHAVIORAL HEALTH ASS’N, *supra*; CHILDREN’S LAW CTR., MEDICAID AND CHILDREN’S MENTAL HEALTH CARE, *supra*.

326. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 18.

have a diagnosis that falls into a particular category makes it difficult for a child to receive immediate services if she has not yet been assessed or diagnosed with a specific disorder. Delays in obtaining needed assessments can mean that a child in crisis could wait months or longer before receiving an evaluation that would provide her with the necessary diagnosis.³²⁷ In the end, if a parent cannot produce the necessary documentation to satisfy relevant eligibility criteria, an agency might be altogether precluded from serving the child or family.³²⁸

Sometimes a public agency asserts that services should be provided by other agencies, rather than coordinating efforts with those agencies to ensure that children get the services they require.³²⁹ In order to save limited resources, the agency—which is likely understaffed and underfunded—might disclaim responsibility for providing the needed care and attempt to shift the responsibility to another agency.³³⁰ When a child is referred from the first agency to a second, the second agency could also respond similarly, referring the family to yet another agency.³³¹ Mary encountered this responsibility shifting. Such buck-passing shows that “the public mental health system for children is anything but a ‘system.’”³³²

327. See, e.g., CHILDREN'S LAW CTR., IMPROVING THE CHILDREN'S MENTAL HEALTH SYSTEM, *supra* note 196, at 17 (recommending that the District of Columbia ensure that children who are in crisis have access to mental health services quickly without first requiring that children receive a specific type of diagnosis through a lengthy evaluation process); *Budget Cuts Mean Shrinking Access to Mental Health Services for D.C.'s Children*, *supra* note 311 (describing the average ten-week delay to receive an initial psychiatric evaluation appointment at one of the largest Medicaid psychiatric providers in D.C.).

328. See Cichon, *supra* note 47, at 10.

329. Land, *supra* note 11, at 281; see also Rebecca A. Clay, *Coordinating Care for Children with Serious Mental Health Challenges*, SAMHSA NEWS, July–Aug. 2009, at 1, 2, available at http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_4/CoordinatingCare.aspx (“The different child-serving systems, such as child welfare, juvenile justice, and education, need to speak to each other . . .”) (quoting Gary M. Blau, Chief of the Child, Adolescent, and Family Branch at Community Mental Health Services).

330. Cichon, *supra* note 47, at 10; see also Leviton, *supra* note 20, at 19. The United States General Accounting Office has reported on coordination issues between special education and Medicaid systems at federal, state, and local levels, indicating coordination challenges in “determining which IDEA-related services Medicaid will cover, identifying children who are eligible for both programs, and managing the documentation required for submitting Medicaid claims.” U.S. GEN. ACCOUNTING OFFICE, MEDICAID AND SPECIAL EDUCATION: COORDINATION OF SERVICES FOR CHILDREN WITH DISABILITIES IS EVOLVING 3 (1999), available at <http://www.gao.gov/new.items/he00020.pdf>.

331. Cichon, *supra* note 47, at 571; see, e.g., Huang et al., *supra* note 300, at 622 (“The confusion that results from the involvement of so many agencies creates often insurmountable systemic barriers to effective and comprehensive service delivery.”).

332. Cichon, *supra* note 47.

Confusion at both the policy and practice levels as to which agency is responsible for providing services to a particular child, especially when delivery of multiple services is needed, can provide a significant barrier to addressing the needs of children with mental health disorders.³³³ When an agency does finally accept responsibility for serving a child, it may not have the resources or expertise to serve the child and family with the full array of required services,³³⁴ or there may be significant delays in the provision of the necessary services.³³⁵ It frequently is so difficult to timely gain access to the range of needed services that many children go without needed services.³³⁶

In Mary's case, the child welfare, health care, juvenile justice, and special education systems all failed individually to meet her needs or coordinate and communicate among each other and instead passed the buck to one another.³³⁷ Her situation illustrates the fragmentation, compartmentalization, and lack of coordination that plagues the children's mental health system as agencies try to separate responsibility and point the finger at one another. As one federal judge opined:

It may be possible in some situations to ascertain and determine whether the social, emotional, medical, or educational problems are dominant and to assign responsibility for placement and treatment to the agency operating in the area of that problem. In this case, all

333. Coccozza & Skowrya, *supra* note 211, at 7. Even courts have struggled to determine which legal system has responsibility for certain types of mental health treatment for youth. *See, e.g.,* Cnty. of San Diego v. Cal. Special Educ. Hearing Office, 93 F.3d 1458, 1468 (9th Cir. 1996) (discussing legal standards set by courts for determining whether the special education system or mental health system is responsible for funding the cost of a child's residential treatment program).

334. Cichon, *supra* note 47, at 10.

335. CHILDREN'S LAW CTR., IMPROVING THE CHILDREN'S MENTAL HEALTH, *supra* note 196, at 35 (highlighting that, despite District of Columbia regulations requiring mental health agencies to provide services within seven days of a referral, only 26% of children in the community actually receive services within seven days and only 50% within a month).

336. Leviton, *supra* note 20, at 17.

337. This phenomenon of buck-passing is illustrated in *North v. District of Columbia Board of Education*, 471 F. Supp. 136, 139-41 (D.D.C. 1979). In that case, the defendant argued that the emotional well-being of a child with significant health problems, as well as emotional disturbance, was the responsibility of the D.C. Department of Human Resources and that it adequately discharged its duty to provide educational services with a school placement, even though the child could not be stable with that placement. *Id.* at 139. The defendant argued that it "should not be saddled with the responsibility of providing him with living arrangements not strictly of an educational nature" and argued this was the responsibility of social services agencies. *Id.* at 140. Instead, the D.C. Board of Education urged the parents to resort to commitment schemes "pertaining to children who are delinquent, neglected, or in need of supervision." *Id.* In response, the Court expressed concern that two agencies of the District of Columbia that have responsibility to care for the child were "seeking to shift the responsibility to each other." *Id.* at 141. The Court explained, "Presently, in many States, responsibility is divided, depending upon the age of the handicapped child, sources of funding, and type of services delivered. . . . [T]he responsibility must remain in a central agency" *Id.* at 139.

of these needs are so intimately intertwined that realistically it is not possible for the Court to perform the Solomon-like task of separating them.³³⁸

Because the local and state agencies responsible for providing services to children frequently do not coordinate with one another, they often fail to comply with their clear federal statutory and regulatory mandates.³³⁹

V. COORDINATION AMONG PUBLIC AGENCIES TOWARD THE PROVISION OF EVIDENCE-BASED PRACTICES TO CHILDREN WITH MENTAL HEALTH DISORDERS

Various federal legal regimes have intersecting goals of providing children with mental health disorders treatment in the community and preventing their institutionalization. Research developments in other disciplines, such as health policy, psychiatry, psychology, and social work, provide the tools needed for the realization of this shared vision. First, researchers with the National Institute of Mental Health developed a framework for the delivery of children's mental health services that can help agencies overcome fragmentation and achieve meaningful collaboration to maintain the placement of children in the least restrictive environment. Known as the "system of care" approach to children's mental health, this service-delivery model requires coordination among stakeholder agencies, as well as policies and structures that support family-centered, holistic case management and treatment.³⁴⁰

In addition to using this coordinated approach, public agencies can make it possible for children to achieve stability and mental health in their communities without institutionalization by offering children and families services that are grounded in research that supports their efficacy. "Evidence-based practices" to mental health treatment are standardized services that have been researched through controlled studies showing that they achieve positive outcomes for children.³⁴¹

338. *North*, 471 F. Supp. at 141; *see also* *Kruelle v. New Castle Cnty. Sch. Dist.*, 642 F.2d 687, 698 (3d Cir. 1981) (finding that the parents were forced to engage in buck-passing because the local district and state agency were pointing to each other to provide the funding needed for services to the youth and determining that the Developmentally Disabled Act was made to supplement the Education Act and neither removes responsibility of funding from the Education Act nor confines options for funding).

339. *Land*, *supra* note 11, at 281.

340. *See* STROUL, *supra* note 27, at 3–4.

341. ASS'N FOR CHILDREN'S MENTAL HEALTH, EVIDENCE BASED PRACTICE BELIEFS, DEFINITION, SUGGESTIONS FOR FAMILIES 4 (2004), available at http://www.acmh-mi.org/41447_ACMH_Booklet.pdf; *see also* *Mullen*, *supra* note 14, at 205–06 (explaining four selection criteria that have been used to determine whether a practice is evidence-based, including whether "the treat-

Wraparound services, multisystemic therapy (MST), functional family therapy, and therapeutic foster care (also known as “multidimensional treatment foster care”) are examples of evidence-based practices that could be provided to children through a coordinated system of care. The intentions of legal regimes that affect children with mental health disorders can be realized if evidence-based practices are delivered in a coordinated manner, reflecting system of care principles. For example, the integration mandate required under *Olmstead* to reduce unnecessary institutionalization of children can be fulfilled if states develop systems of care for children’s mental health that incorporate the use of evidence-based practices.³⁴²

A. *Coordination and Collaboration Among Child-Serving Agencies*

Although an individual agency can improve the care and treatment of youth with mental health disorders, the needs of these children “cannot be placed at the doorstep of any single agency or system. . . . [E]ffective solutions require that multiple relevant agencies coordinate and integrate strategies and services.”³⁴³ For example, collaboration among agencies “can include coordinated strategic planning, multiagency budget submissions, implementation of comprehensive screening and assessment centers, cross-training of staff, and team approaches to assessment and case management.”³⁴⁴

In order to identify those children in need of evidence-based mental health services in the community, public agencies should coordinate to provide mental health screenings to children who are at high risk for requiring mental health treatment, such as children living in high-poverty and high-crime neighborhoods, children in special education, and those who have had some contact with the child welfare or juve-

ment practices had been standardized through manuals or guidelines; the practices had been evaluated with controlled research designs; through the use of objective measures, important outcomes were demonstrated; and the research was conducted by different research teams”).

342. See BAZELON CTR. FOR MENTAL HEALTH LAW, STILL WAITING, *supra* note 25, at 2 (“The current system is broken in many ways. The continuing failure to provide the community services envisioned in the *Olmstead* ruling wastes public resources. Multiple studies of alternative approaches find that institutional care is more expensive than early and consistent community options. . . . Systems of care for children reduce inpatient hospital days Multisystemic therapy for high-risk youth saves more than \$31,661 in subsequent costs to the criminal justice system, while multidimensional treatment foster care for troubled youth saves \$43.70 in residential treatment costs for every dollar spent.”).

343. Coccozza & Skowrya, *supra* note 211, at 7.

344. *Id.* at 8; see also Huang et al., *supra* note 300, at 622 (“Collaborative efforts to deliver community-based services and supports, revision of rules that impede service delivery, and alignment of financing to support prevention and treatment should be integral aspects of this effort.”).

nile justice systems.³⁴⁵ When the screenings flag a potential unmet need, those children should be assessed more comprehensively for specific disorders and treatment needs.³⁴⁶ Public agencies should communicate about the needs of youth with serious mental health disorders to ensure they are diverted from RTCs and from the juvenile justice and child welfare systems, whenever possible, and instead provided with appropriate community-based services.³⁴⁷ The provision of community-based treatment is not only immediately less expensive than more costly interventions like residential treatment, but “[l]ower recidivism for juvenile offenders, reduced rates of psychiatric hospitalization, less need for child welfare intervention, fewer emergency room visits, fewer disruptive crises in the school,” and other long-term positive effects also result in substantial cost savings.³⁴⁸

Agencies and courts should hesitate before placing children in RTCs and should instead coordinate to explore all of the available community-based treatment options whenever possible. The American Bar Association’s Youth at Risk Initiative encourages juvenile probation officers, attorneys, judges, and other professionals to be vigilant in placing children at RTCs and to engage youth and parents in a discussion regarding better alternatives.³⁴⁹ When a child is at risk of entering residential treatment, different child-serving agencies should mobilize these various professionals and work together to assess the child’s needs, overcome any eligibility or financial barriers, and deliver community-based services immediately to prevent residential placement. Children who end up incarcerated or in RTCs should receive effective mental health treatment and monitoring in placement. Effective planning prior to discharge to arrange for services to be provided immediately upon return to the community can prevent the cycling of those children back into emergency rooms, psychiatric

345. See Huang et al., *supra* note 300, at 616 (emphasizing the ineffectiveness of the current system of treatment for children due to the use of excessively restrictive settings, the lack of availability of community-based options, and the weakness of the coordination among agencies, but finding an effective resolution in the use of evidenced-based practices within a system of care).

346. Coccozza & Skowrya, *supra* note 211, at 9.

347. *Id.* at 8–9 (noting that for some youth, “penetration into the juvenile justice system and placement into juvenile detention and correctional facilities will [only] further increase the number of mentally ill youth in the Nation’s juvenile facilities who are receiving inadequate mental health services”).

348. Weithorn, *supra* note 36, at 1503; see also WASH. STATE INST. FOR PUB. POL’Y, WATCHING THE BOTTOM LINE: COST-EFFECTIVE INTERVENTIONS FOR REDUCING CRIME IN WASHINGTON 6 (1998) (estimating that the use of multisystemic therapy could save crime victims about \$13,982 in future out-of-pocket costs).

349. Behar et al., *supra* note 33, at 411–12.

hospitalizations, residential treatment placements, and juvenile correction facilities.³⁵⁰

Public agencies should take steps to meaningfully incorporate the system of care approach by developing structures and policies for the early identification of children with mental health disorders, the delivery of necessary services in the community, and the timely and well-planned discharge of children who are placed out of the home. The system of care framework was developed to facilitate such reform in the children's mental health system³⁵¹ through meaningful improvement of the delivery of services to children and families across different agencies.³⁵² While most states report that they have adopted a system of care approach, a much smaller number can actually point to any policies, regulations, laws, or practices that have been developed to make the system of care operational.³⁵³ Public agencies should implement the system of care approach by developing comprehensive, community-based systems of supports and services emphasizing individualized care, full participation of families, coordination among child-serving agencies, cultural competence (defined as the ability to work effectively and sensitively within various cultural contexts), and the placement of children in the least restrictive environment.³⁵⁴

These core principles involve the restructuring of local systems and policies to provide a broad range of treatment services.³⁵⁵ A system of care is not a specific service, but rather a holistic, coordinated approach that a public agency or network of public agencies can use to allow for all aspects of a child's life to be considered in his treatment, in contrast to the isolation of individual mental health services and compartmentalization on the part of public agencies responsible for the provision of those services.³⁵⁶ Systems of care incorporate a wide range of services that emphasize the importance of early identification and intervention, as well as partnerships with youth and their families.³⁵⁷ Families receive all of the necessary treatments to serve the

350. See, e.g., SEDLAK & MCPHERSON, *supra* note 247, at 8–9 (noting that one-third of juveniles in residential treatment have no idea what will happen when they leave the facility).

351. STROUL, *supra* note 27, at 1.

352. See STROUL, *supra* note 27, at 1; see also Huang et al., *supra* note 300, at 616.

353. COOPER ET AL., *supra* note 13, at 6.

354. BETH A. STROUL ET AL., *UPDATING THE SYSTEM OF CARE CONCEPT AND PHILOSOPHY 1* (2010).

355. *Id.* at 7.

356. *Id.* at 5 (“[The system of care concept] is not intended to refer to a single ‘program’ that operates according to this philosophy, but rather to a coordinated network of services and supports across agencies to meet the multiple and complex needs of any given population.”); see also Clay, *supra* note 329.

357. STROUL ET AL., *supra* note 354, at 4.

multiple needs and problems that are occurring simultaneously within the family unit, such as counseling, educational services, and substance abuse services.³⁵⁸ Within a system of care, families and children receive services from relevant agencies in a cohesive manner, and intervention occurs on various different levels.³⁵⁹

The holistic approach and complexity creates difficulties in assessing the effectiveness of systems of care through research. Because no uniform system exists and because this approach is constantly evolving, there are limitations on the assessment of positive outcomes. Furthermore, most studies have not been performed with control groups to compare systematic results,³⁶⁰ but the existing research has demonstrated promising reductions in residential treatments and out-of-home placements generally, as well as increased parent satisfaction with the accessibility of services.³⁶¹ The public agencies charged with serving Mary could have achieved her stability and maintained her placement in the community if they had collaborated through a system of care approach that both reflected cultural competency to address issues of stigma and involved coordinated identification of the range of services necessary to address her intensive needs.

B. Use of Evidence-Based Practices in Mental Health Treatment

Recent research has shown that the use of evidence-based practices delivered within a system of care significantly improves outcome results.³⁶² While the system of care provides a coordinated approach to service *delivery*, effective services themselves must be available in the form of evidence-based practices. By delivering evidence-based practices through a systems of care approach, public agencies can ensure that each child has an effective treatment plan that is individualized to

358. See *id.* at 3 fig.1; see also Huang et al., *supra* note 300, at 623 (emphasizing the need for the implementation of preventative measures and early intervention).

359. STROUL, *supra* note 27, at 7. Moreover, because systems of care treat a range of issues, the concept is flexible and uses existing services, as well as evidence-based practices to effectively serve the various needs of children. *Id.* Even though the core concepts are the same, systems of care generally vary across the country, as they have been adapted by particular public agencies in some states to address the needs of their individual communities. *Id.* at 7–8. Systems of care do not produce identical policies or methodologies, but instead reflect a “cluster of organizational change strategies that are based on a set of values and principles that are intended to shape policies, regulations, funding mechanisms, services and supports.” *Id.* at 6–9.

360. See MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 168–69.

361. *Id.* at 191–93.

362. See ROBERT M. FRIEDMAN & DAVID A. DREWS, EVIDENCE-BASED PRACTICES, SYSTEMS OF CARE, & INDIVIDUALIZED CARE 6–7 (2005), available at http://rtckids.fmhi.usf.edu/rtcpubs/EBP_friedman_drews.pdf.

the goals and values of his family.³⁶³ Despite the proven effectiveness of evidence-based practices, as of 2008 only twelve states mandated the use of such practices for children and only eight of those actually promoted, supported, or required them statewide.³⁶⁴ Evidenced-based practices should be mandated and implemented across all states through a system of care philosophy, because such a coordinated approach can be used to effectively overcome stigma, fragmentation of services and persistence of unavailable services to better serve children within the mental health system.³⁶⁵ Through these evidence-based practices, which are culturally competent and community-based, such barriers can be eliminated and the ultimate goals of *Olmstead* and the relevant federal legal regimes can be achieved.

1. Wraparound Programs

Reflecting the principles of the system of care approach, wrap-around treatment is a family-driven program that addresses the various needs of children involved in multiple systems who are at risk for out-of-home placement.³⁶⁶ The wraparound philosophy focuses on the creation of a definable plan that is comprehensive, holistic, and individualized for each child and family.³⁶⁷ The program essentially “wraps” the child and family with services in a manner that allows for cross-system collaboration and blending of funds from various agencies to create more flexibility in treatment.³⁶⁸ A child’s services can be funded from multiple agencies, such as through local child welfare and juvenile justice agency funds, as well as Medicaid dollars,³⁶⁹ rather than requiring the child and family to navigate individual, compartmentalized systems to receive services. A six-year follow-up study of

363. *Id.* at 10. *But see* COOPER ET AL., *supra* note 13, at 6 (noting that while fifty states report they have incorporated a system of care philosophy, only eighteen states can actually point to specific steps to make a system of care operational or embed those principles in regulatory and legislative structures).

364. COOPER ET AL., *supra* note 13, at 7.

365. *See* Huang et al., *supra* note 300, at 620–21 (highlighting the need for “culturally based interventions and alternative care” to reduce barriers, such as stigma, lack of availability, and fragmentation of services, that deter communities of color from receiving necessary services).

366. ERIC BRUNS & JESSE C. SUTER, SUMMARY OF THE WRAPAROUND EVIDENCE BASE: APRIL 2010 UPDATE 1 (2010), available at <http://www.nwi.pdx.edu/publications.shtml>; *see also* STACEY M. CORNETT, HOME-BASED SERVICES FOR HIGH-RISK YOUTH: ASSESSMENT, WRAPAROUND PLANNING AND SERVICE DELIVERY 3-3 (2011).

367. STROUL, *supra* note 27, at 7; *see also* BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 23, at 35 (discussing the several components of wraparound services, including multidisciplinary team meetings, coordinating formal and informal services, implementing an individualized plan, and monitoring specific outcomes).

368. Leviton, *supra* note 20, at 33.

369. *See* Cocozza & Skowyr, *supra* note 211, at 18.

a coordinated case-management program using the wraparound approach, called Child and Youth Intensive Case Management (CY-ICM), found that New York saved almost \$8,000,000 when hospital admissions significantly declined after clients enrolled in CYICM.³⁷⁰ This study demonstrates that wraparound is not only effective in reducing negative outcomes, but also in reducing state costs in supporting youth and families.

Families receiving wraparound services engage in a team-driven and family-centered program that builds on their strengths as a family.³⁷¹ Unlike other services, which are professionally driven and deficit-based, wraparound is an “on the ground” system that is guided by specialized planning to ensure a core system of family values.³⁷² Wraparound programs aim to allow a youth at-risk of residential treatment to instead receive the services that she requires at home and in the community.³⁷³ These programs often provide services for about thirty to ninety days,³⁷⁴ but can last longer. A care coordinator is assigned to a family and is responsible for creating a treatment plan for the child and family that incorporates multiple systems.³⁷⁵ The care coordinator then works with a team consisting of family members, service providers, and community members to ensure the child is receiving the necessary services at home, school, and within the community.³⁷⁶ Wraparound programs are systematic and outcome based,³⁷⁷ and families help develop clearly defined goals and performance measures throughout their engagement in wraparound.³⁷⁸

The Wraparound Milwaukee program is well known as a model of an effective alternative approach to residential treatment and psychiatric hospitalization for children. A collaborative county-operated organization provides comprehensive care to youth referred by the child

370. Mary E. Evans et al., *Child, Family, and System Outcomes of Intensive Case Management in New York State*, 67 *PSYCHIATRIC Q.* 273, 280 (1996).

371. MAGELLAN HEALTH SERVS., *supra* note 40, at 9; *see also* Bruce Kamradt, *Wraparound Milwaukee: Aiding Youth with Mental Health Needs*, 7 *JUV. JUST.* 14, 15 (2000) (describing wraparound as a “[s]trength-based approach to children and families”).

372. BRUNS & SUTER, *supra* note 366, at 1.

373. Leviton, *supra* note 20, at 33.

374. LYNNE MARSENICH, *EVIDENCE-BASED PRACTICES IN MENTAL HEALTH SERVICES FOR FOSTER YOUTH* 35 (2002).

375. *OJJDP, Model Programs Guide: Wraparound/Case Management*, available at <http://www.ojjdp.gov/mpg/programTypesDescriptions.aspx>.

376. *Id.*

377. *Id.*; *see also* CORNETT, *supra* note 366, at 3-9.

378. *OJJDP, supra* note 375; *see also* Kamradt, *supra* note 371, at 16 (explaining wraparound services as an outcome-focused approach that sets clear goals for youth and families that are continuously measured).

welfare and juvenile justice systems.³⁷⁹ Studies of the Milwaukee program report a 60% reduction in recidivism and residential treatment,³⁸⁰ and an 80% reduction in hospitalization.³⁸¹

The Fostering Individualized Assistance Program (FIAP), developed at the University of Southern Florida, has also achieved positive results by providing wraparound services and supports for children and their families to help develop greater permanency in foster placements and reinforce natural family supports.³⁸² A random-assignment study compared children receiving standard services to children receiving FIAP services and found that children involved with FIAP were significantly less likely to change placements, boys were less likely to be delinquent or externalize behaviors, and children who had a history of incarceration or running away were less likely than children receiving standard services to repeat these behaviors.³⁸³ Additionally, in Ohio, several state agencies contribute to a program called the Linkages Project, which supports the collaboration of local agencies in providing services to youth to facilitate a reduction in crime and improvement in mental health services.³⁸⁴ Similar home-based family intervention programs in Washington and Maine have also been shown to effectively reduce the possibility of future out-of-home placement.³⁸⁵

As of 2002, various studies demonstrated that wraparound programs were effective in decreasing the cost of care, rates of delinquency, and placement in restrictive settings, as well as improving social and community functioning.³⁸⁶ In 2009, a meta-analytic review of the seven controlled studies on wraparound treatment revealed significant results for outcome assessments, including improvements in “youth behavior, youth functioning, and youth community adjust-

379. See Coccozza & Skowrya, *supra* note 211, at 8.

380. MAGELLAN HEALTH SERVS., *supra* note 40, at 9.

381. COMMONWEALTH OF PA. OFFICE OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., *supra* note 42, at 19; *see also* OJJDP, *supra* note 375; MAGELLAN HEALTH SERVS., *supra* note 40, at 9.

382. Marsenich, *supra* note 374, at 33.

383. *Id.* at 35; *see also* MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 174.

384. Coccozza & Skowrya, *supra* note 211, at 8.

385. Edward C. Hinckley & W. Frank Ellis, *An Effective Alternative to Residential Placement: Home-Based Services*, 14 J. CLINICAL CHILD PSYCHOL. 209 (1985); *see also* BRUNS & SUTER, *supra* note 366, at 5 (referencing a study in Washington comparing youth in the Connections program to youth receiving mental health services for less than a two-year period that demonstrated youth in Connections were significantly less likely to recidivate and functioned substantially better at home, school, and in the community).

386. MAGELLAN HEALTH SERVS., *supra* note 40, at 9.

ment.”³⁸⁷ Many children with unmet mental health needs are involved in a variety of systems, such as the child welfare, juvenile justice, Medicaid, and special education systems. Wraparound yields positive outcomes because it requires coordination of these systems (just as the federal legal regimes described herein require coordination), employing mechanisms that take into account the complexity and overlapping needs of families and children involved in multiple systems.³⁸⁸ This approach can also help to reduce stigma and ensure long-term results through family engagement and an emphasis on problem solving, teamwork, hope, and social support.³⁸⁹

Participation on Mary's part in a wraparound program could have brought key professionals from all of the agencies that affected Mary's life to the table to develop an effective plan for her treatment. A wraparound caseworker could have managed her treatment by securing the input and involvement of the necessary stakeholders in her service delivery. In allowing for blended funding streams, any financial barriers to the provision of community-based mental health services, such as the counseling that her pediatrician recommended, could have been removed. By giving both Mary and her foster mother an opportunity to discuss their values and goals, the team's development of a wraparound program could have been responsive to her foster mother's concerns regarding stigma and could have been individualized to fit Mary's unique needs as a child in foster care, a victim of rape, and a student with learning and emotional disabilities.

2. *Multisystemic Therapy*

Multisystemic therapy is one of the most researched evidence-based practices for troubled youth and their families.³⁹⁰ Youth who participate in MST receive intensive, short-term, in-home treatment with their families.³⁹¹ MST aims to improve the family's ability to overcome risk factors that lead to delinquency and helps reinforce protective factors.³⁹² It also tries to enhance monitoring techniques used by

387. BRUNS & SUTER, *supra* note 366, at 2. However, more research is needed to expand upon the existing studies and examine the contexts in which wraparound is most effective.

388. *Id.*

389. *Id.*

390. Johanna K. P. Greeson et al., *Contributions of Therapist Characteristics and Stability to Intensive In-Home Therapy Youth Outcomes*, 19 RESEARCH ON SOC. WORK PRAC. 239, 240 (2009).

391. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 175; see also COOPER ET AL., *supra* note 13, at 44 (“The treatment is delivered in natural settings and is designed in collaboration with family members.”).

392. Judy L. Estren & Kristin Winokur, *Community-Based Solutions for Delinquent Youth: A Guide for Advocates*, 29 A.B.A. CHILD L. PRAC. 49, 57 (2010).

parents and replace negative relationships with positive social relationships.³⁹³ The home setting is used to foster a healthier environment in which the family feels empowered and capable.³⁹⁴ The program reflects the importance of coordination among various agencies through direct intervention in multiple facets of a youth's life, including family, school, and peer relationships, and gives youth and families the tools needed to resolve common problematic situations.³⁹⁵ MST is an example of a service that could make up one component of a wraparound program.

Typically, MST programs involve home-based services that last approximately four months.³⁹⁶ MST therapists must have a high level of clinical training and receive intensive supervision, which distinguishes MST from other alternative services.³⁹⁷ During the three to five months of treatment, MST teams provide consistent therapy and assistance to the family, which usually involves multiple contacts throughout the week.³⁹⁸ Because caseloads are usually very low, ranging from four to six families, MST teams are available twenty-fours a day to address family needs,³⁹⁹ allowing for intervention short of hospitalization or residential treatment when a child is escalating towards a crisis. Therapists focus on identifying family strengths and developing healthy support systems,⁴⁰⁰ and addressing various risk factors that disrupt the family dynamic, such as parental substance abuse.⁴⁰¹ Furthermore, therapists use empirically supported therapies, like pragmatic family and cognitive behavioral therapies, to advance family functioning and cohesion.⁴⁰²

393. WASH. STATE INST. FOR PUB. POL'Y, *MULTISYSTEMIC THERAPY OUTCOMES IN AN EVIDENCE-BASED PRACTICE PILOT 2* (2011), available at www.wsipp.wa.gov/rptfiles/11-04-3901.pdf; see also COMMONWEALTH OF PA. OFFICE OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., *supra* note 42, at 18 ("MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with 'prosocial' peers and reducing association with 'deviant' peers, primarily through parental mediation.").

394. *Multisystemic Therapy (MST) for Juvenile Offenders*, NREPP (2007), <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=26> [hereinafter *National Registry*].

395. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 175-76; see also Leviton, *supra* note 20, at 32.

396. *National Registry*, *supra* note 394.

397. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 176.

398. MAGELLAN HEALTH SERVS., *supra* note 40, at 9.

399. *Id.*; Estren & Winokur, *supra* note 392, at 57.

400. *Model Programs Guide: Multisystemic Therapy (MST)*, OJJDP, <http://www.ojjdp.gov/mpg/mpgProgramDetails.aspx> (last visited Jan. 25, 2011).

401. *Id.*

402. *National Registry*, *supra* note 394.

In a recent study published by the Washington State Institute for Public Policy in April 2011, 215 youth who enrolled in MST in 2007 were examined on the basis of various characteristics and outcomes.⁴⁰³ The population included youth between the ages of twelve and seventeen who were exhibiting behavioral issues, were at high risk for out-of-home placement, and had an available family support structure.⁴⁰⁴ All youth and families were referred by the mental health, juvenile justice, child welfare, or education systems.⁴⁰⁵ Youth who received MST were compared to youth in analogous circumstances in the mental health system.⁴⁰⁶ Although the results were not statistically significant, youth receiving MST were less likely to be involved in any crimes after a twelve-month period.⁴⁰⁷ Furthermore, youth involved in MST had significantly higher rates of utilization of mental health services during the following year.⁴⁰⁸

The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices also examined the statistical effectiveness of MST through several different studies that evaluated post-treatment arrests, long-term arrests, long-term incarceration rates, self-reported criminal activity, alcohol and drug use, perceived family functioning and cohesion, and peer aggression.⁴⁰⁹ Overall, youth involved in MST recidivated 42% of the time, in contrast with the 62% recidivism rate for youth receiving other typical services.⁴¹⁰ Over a four-year period, only 22% of MST-involved youth recidivated, compared with 71% of youth who completed another service.⁴¹¹ Furthermore, approximately 13 years later, youth who had completed MST treatment had significantly lower rates of recidivism and improved family cohesion in relation to comparable youth who participated only in more standard treatment programs, such as individual therapy.⁴¹² In addition to positive outcomes associated with recidivism, psychiatric symptomatology, and re-

403. WASH. STATE INST. FOR PUB. POL'Y, *supra* note 393, at 1.

404. *Id.* at 2.

405. *Id.*

406. *Id.* at 4.

407. *Id.* at 4 & exhibit 5.

408. *Id.* at 6.

409. *National Registry*, *supra* note 394. Each study was an experimental study with a control group. For example, one long-term study compared youth who received MST to youth who only received individual therapy over a thirteen-year period in Baltimore, Maryland.

410. *Id.*

411. *Id.*

412. *Id.*; *see also* OJJDP, *supra* note 4 (describing a 1992 study in South Carolina comparing outcomes for juvenile offenders receiving MST to outcomes for those receiving only typical treatment revealed that family cohesion was significantly higher with families receiving MST).

duced drug use, MST also serves as a cost-effective clinical alternative to residential placement.⁴¹³

Although more research is needed to assess the effectiveness of MST on specific populations, the initial results are promising in comparison to more restrictive treatments like psychiatric hospitalization and residential treatment.⁴¹⁴ By maintaining family contact and a stable environment with accessible services, youth and families are given the tools to develop social skills to build healthier relationships and avoid risk factors.

MST could have supported Mary and her foster mother in a very intensive program with multiple meetings per week, ensuring that Mary did not experience an emotional crisis without immediate intervention from a highly trained mental health professional. This treatment would have addressed Mary's social, emotional, and behavioral challenges in her home, school, and community and addressed her problems holistically to allow her to learn positive behaviors and appropriate social skills in those settings.

3. *Functional Family Therapy*

Functional family therapy (FFT) is a program for at-risk youth that focuses on developing protective factors and assisting the family in reducing risk factors.⁴¹⁵ This research-based program targets youth who are already exhibiting delinquent behaviors, violence, substance abuse, or emotional disorders.⁴¹⁶ FFT developed out of the need to serve an at-risk population of adolescents and families who were neglected and did not have the resources to gain treatment.⁴¹⁷ Because many families entered into the system angry and frustrated, FFT was created to facilitate treatment for underserved populations, as well as provide culturally competent treatments to discouraged families.⁴¹⁸ This treatment primarily focuses on developing family alliances, com-

413. Cocozza & Skowrya, *supra* note 211, at 10; *see also* WASH. STATE INST. FOR PUB. POL'Y, *supra* note 393, at 6; WASH. STATE INST. FOR PUB. POL'Y, *supra* note 348, at 1 (noting that MST is also very cost-efficient, saving taxpayers a net gain of \$7,881 for every high-risk juvenile in the program).

414. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 176.

415. Estren & Winokur, *Community-Based Solutions*, *supra* note 392, at 57.

416. MAGELLAN HEALTH SERVS., *supra* note 40, at 9.

417. JAMES ALEXANDER ET AL., FUNCTIONAL FAMILY THERAPY: BLUEPRINTS FOR VIOLENCE PREVENTION, BOOK THREE (1998), available at http://www.colorado.edu/cspv/blueprints/model_programs/FFT.html.

418. *Id.*; *see also* COMMONWEALTH OF PA. OFFICE OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., *supra* note 42, at 18 ("The treatment model is deliberately respectful of individual differences, cultures and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on risk and protective factors.").

munication skills, problem solving, and parenting skills to reduce behavioral problems.⁴¹⁹

FFT is a short-term, outcome-driven intervention targeting youth aged 11–18.⁴²⁰ Participating families typically receive 8–12 one-hour sessions for approximately 90 days,⁴²¹ while more severe cases might require 26–30 hours of direct services to the family unit.⁴²² FFT sessions are usually administered in either a community or home-based setting to reinforce the importance of the family in the youth's treatment.⁴²³ Similar to other multifaceted programs, FFT uses a wide-range of professionals to serve the family throughout the program, such as mental health professionals, mental health technicians, and probation officers.⁴²⁴

FFT uses a phased program to accomplish its goals.⁴²⁵ Although all FFT programs are individualized based on the family unit, each family plan uses a build-up program to accomplish specific goals.⁴²⁶ In the engagement phase, the therapist concentrates on creating a trusting environment and emphasizes the factors that will help the family complete the plan.⁴²⁷ Subsequently, the motivation phase focuses on changing maladaptive behaviors and reinforcing motivation and faith.⁴²⁸ Thereafter, the assessment phase clarifies the function of interpersonal relationships within the families and focuses on how the relationships can influence changes in behavior.⁴²⁹ During the next step, individualized techniques are developed to promote appropriate behaviors.⁴³⁰ In the last phase, the case management explores community restraints and resources that may either help or hinder the family's functional needs.⁴³¹ Although the phases are separate, they

419. MAGELLAN HEALTH SERVS., *supra* note 40, at 9; *see also* COMMONWEALTH OF PA. OFFICE OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., *supra* note 42, at 18 (2008) (“FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation . . . , and quality assurance and improvement.”).

420. *Functional Family Therapy*, OJJDP, <http://www.ojjdp.gov/mpg/mpgProgramDetails.aspx> (last visited Jan. 22, 2012).

421. *Id.*

422. ALEXANDER ET AL., *supra* note 417.

423. *Functional Family Therapy*, *supra* note 420.

424. ALEXANDER ET AL., *supra* note 417.

425. *Functional Family Therapy*, *supra* note 420.

426. ALEXANDER ET AL., *supra* note 417; *see also* COOPER ET AL., *supra* note 13, at 44 (“The FFT clinical model organizes the intervention around specific phases.”).

427. ALEXANDER ET AL., *supra* note 417.

428. *Id.*

429. *Id.*

430. *Id.*

431. *Id.*

build on one another, creating reassessment throughout the entire process.⁴³²

Since 1969, several studies have been conducted on the effectiveness of FFT.⁴³³ Multiple studies have shown that in comparison to standard juvenile probation services, residential facilities, and other approaches, FFT reduces re-arrests up to 60% more effectively and significantly reduces recidivism and the cost of treatment.⁴³⁴ In 2009, a meta-analytic study of Washington State's evidence-based programs showed that FFT can reduce a youth's chance of recidivism by 18.1%.⁴³⁵ Furthermore, a 13-year follow-up revealed that children who did not participate in FFT had a 70% chance of recidivating, in contrast with those who received FFT, who only had a 57% chance of recidivating.⁴³⁶ FFT has also proven to be very successful in reducing violence, drug abuse, conduct disorder, and family conflicts, as well as the number of youth in out-of-home placements and juvenile detention.⁴³⁷ As one of the oldest forms of alternative treatment, FFT has evolved into an effective treatment that should be used to help stabilize children with mental health disorders and their families, and to prevent more costly outcomes.

FFT could have provided Mary and her foster mother with an opportunity to learn communication strategies in an individualized program. Mary could have developed appropriate behaviors and effective coping strategies with the support of a trained professional in a structured program, rather than expressing anger and frustration in unsafe ways.

4. *Therapeutic Foster Care*

Therapeutic foster care (TFC), also known as multidimensional treatment foster care, is another alternative to residential treatment and detention for children with mental health problems.⁴³⁸ While the federal legal regimes described herein favor maintenance of the family

432. *Id.*

433. ALEXANDER ET AL., *supra* note 417.

434. *Functional Family Therapy*, *supra* note 420.

435. ELIZABETH K. DRAKE ET AL., EVIDENCE-BASED PUBLIC POLICY OPTIONS TO REDUCE CRIME AND CRIMINAL JUSTICE COSTS: IMPLICATIONS IN WASHINGTON STATE 191 (2009), available at <http://www.wsipp.wa.gov/pub.asp?docid=09-00-1201>; see also THOMAS L. SEXTON & JAMES F. ALEXANDER, OJJDP, *Functional Family Therapy* 1, 6 (2000), available at <http://www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf> ("Of those who completed [FFT], only 19.8 percent committed an offense during the year following completion, compared with 36 percent of the treatment-as-usual comparison group.").

436. DRAKE ET AL., *supra* note 435, at 191.

437. MAGELLAN HEALTH SERVS., *supra* note 40, at 10.

438. Estren & Winokur, *Community-Based Solutions*, *supra* note 392, at 57.

unit and intend for children to remain in their homes whenever possible, some children, such as those who would be unsafe there as a result of abuse or neglect by a parent, must be removed from their homes. For those who require an out-of-home placement, TFC may be the least restrictive alternative for children who have an emotional disturbance or delinquency system involvement.⁴³⁹ The goal of TFC programs is to place high-risk children in therapeutic settings that mimic a nurturing home.⁴⁴⁰ These programs reflect the preference of the child welfare legal regime for children to be placed in family-like settings, rather than congregate care settings.

Although there are several types of TFC, all programs share similar core qualities,⁴⁴¹ using specially trained foster parents as the primary intervention.⁴⁴² Children are usually placed in TFC for about six to nine months, and the TFC parents join a group of professionals who engage in a collaborative individualized plan for the juvenile.⁴⁴³ Throughout the placement, children and TFC parents receive consistent support from clinicians and other mental health professionals.⁴⁴⁴ The families are provided with counseling every week and receive daily contact regarding the child's progress.⁴⁴⁵ An individualized plan allows each youth and family to have clear expectations throughout the program.⁴⁴⁶ Additionally, the biological family is involved in the therapeutic treatments.⁴⁴⁷ Biological parents are given parent training and family counseling to help prepare them for the child's return home.⁴⁴⁸ Furthermore, TFC is a highly structured program that provides consistent monitoring of the child to ensure that the child does

439. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 176.

440. *Id.*; see also *Multidimensional Treatment Foster Care (MTFC)*, NREPP (2009), <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=48> ("Youths are individually placed with highly trained and supervised foster parents and are provided with intensive support and treatment in a setting that closely mirrors normative life.").

441. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 176.

442. MARSENICH, *supra* note 374, at 36.

443. *Multidimensional Treatment Foster Care*, OJJDP, <http://www.ojjdp.gov/mpg/mpgProgramDetails.aspxManagement> (last visited Jan. 25, 2012).

444. MARSENICH, *supra* note 374, at 36; see also COMMONWEALTH OF PA. OFFICE OF MENTAL HEALTH & SUBSTANCE ABUSE SERVS., *supra* note 42, at 19 (2008) ("Intervention is multifaceted and occurs in multiple settings.").

445. *Multidimensional Treatment Foster Care*, *supra* note 443; see also PATRICIA CHAMBERLAIN & SHARON F. MIHALIC, *MULTIDIMENSIONAL TREATMENT FOSTER CARE: BLUEPRINTS FOR VIOLENCE PREVENTION, BOOK EIGHT* (1998), available at <http://www.colorado.edu/cspv/blueprints/modelprograms/MTFC.html>.

446. CHAMBERLAIN & MIHALIC, *supra* note 445; see also *Multidimensional Treatment Foster Care (MTFC)*, *supra* note 440 (noting that youth are provided with a daily structure throughout the program that encompasses clear limits and expectations).

447. *Multidimensional Treatment Foster Care*, *supra* note 443.

448. See *id.*

not interact with negative influences and that she instead begins participating in pro-social activities.⁴⁴⁹ Youth are also provided with skill training, school-based intervention, and academic support.⁴⁵⁰

A study performed by the Oregon Social Learning Center focused on three different populations of youth: (1) chronic delinquents referred by the juvenile justice system; (2) severely emotionally disturbed youth referred by the mental health department; and (3) children with behavioral problems in the child welfare system.⁴⁵¹ TFC was initiated in response to the overwhelming evidence that parent-management training contributed to significant successes in improving problem behaviors.⁴⁵² Results from studies conducted by the National Institute of Mental Health reveal that TFC significantly reduced crime rates for boys a year after completion, in comparison to boys in group homes.⁴⁵³ After two years, boys were more likely to have legitimate jobs, to not use drugs, to have positive relationships with their parents, and to not have engaged in unprotected sex.⁴⁵⁴ Studies of TFC also show that the program facilitated better school attendance and homework completion.⁴⁵⁵ Additionally, youth were more likely to spend fewer days in incarceration and were placed in community placements faster than youth in more restrictive settings.⁴⁵⁶

A Surgeon General's report from 1999 also indicated that TFC led to better outcomes at lower costs than more restrictive placements.⁴⁵⁷ According to the report, TFC lowered the percentage of youth re-institutionalized and reduced the number of criminal referrals, run-aways, and detained youth, in comparison to those placed in group care.⁴⁵⁸ Various controlled studies reveal that youth who participated in TFC "made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior."⁴⁵⁹ Seventy percent of youth in TFC remained in less restrictive environments for a significant amount of time after their treatment.⁴⁶⁰ Similar to other alternative placements, more controlled studies are needed to help

449. See CHAMBERLAIN & MIHALIC, *supra* note 445.

450. *Multidimensional Treatment Foster Care*, *supra* note 443.

451. MARSENICH, *supra* note 374, at 35.

452. *Id.*

453. *Id.* at 36.

454. *Id.*

455. MAGELLAN HEALTH SERVS., *supra* note 40, at 8.

456. *Id.*; see also *Multidimensional Treatment Foster Care (MTFC)*, *supra* note 440 (all three studies referenced involved randomized youth and control groups).

457. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, *supra* note 15, at 177.

458. *Id.*

459. *Id.*

460. *Id.*

distinguish exactly which aspects of TFC benefit youth. However, there is substantial evidence that TFC can effectively help youth who need to leave their homes, without completely removing them from the community.

TFC could have helped Mary and her foster mother to maintain their family unit. With appropriate parent management training, Mary's foster mother could have learned about Mary's disabilities and needs, and developed strategies for effectively addressing her emotional and behavioral problems. Weekly counseling could have helped Mary and her foster mother process their emotions with a trained professional.

VI. CONCLUSION

Inadequacies in the community mental health system have led to the unnecessary institutionalization of children in RTCs.⁴⁶¹ With growing numbers of children living in poverty in the United States⁴⁶² and the higher likelihood that poor children will develop mental health disorders,⁴⁶³ it is more important than ever that the intentions of federal legal regimes related to child welfare, special education, health care, juvenile justice, and disability rights be fulfilled. Through statutes, regulations, case law, and policies, these federal regimes are explicitly structured to ensure that children from low-income families are provided with mental health and educational services in their communities in a timely manner. However, the reality for these children does not reflect the goals of the law as written, and children from low-income families continue to experience unwarranted institutionalization. With states paying as much as seven hundred dollars per day to institutionalize children with emotional and behavioral disorders in RTCs, youth are leaving these facilities only to cycle back into residential treatment, psychiatric hospitalization, and juvenile detention facilities without achieving stability or mental health.⁴⁶⁴

Instead, they are likely to become "disconnected youth," young adults without any meaningful connection to education or employ-

461. Cichon, *supra* note 47, at 12.

462. U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States: 2010 (Sept. 13, 2011), available at http://www.census.gov/newsroom/releases/archives/income_wealth/cb11-157.html (announcing data showing that the poverty rate increased for children under eighteen in the United States from 20.7% in 2009 to 22.0% in 2010).

463. MENTAL HEALTH: A NATIONAL ACTION AGENDA, *supra* note 1, at 129; see also HOWELL, *supra* note 276, at 1.

464. BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 35.

ment.⁴⁶⁵ As these disconnected youth become impoverished young adults, the broken children's mental health system only serves to further the structural poverty that initially led these children to need—and then go without—necessary mental health treatment. This cycle of crisis and disconnectedness stems from the stigma attached to mental illness, the scarcity of services and delays families experience in securing needed services, and the compartmentalization and fragmentation within the children's mental health system.

Policymakers, public agencies, judges, and attorneys need to be educated about the overuse of RTCs, the ineffectiveness of treatment for children in these “total institutions,” the risks of abuse, isolation, overmedication, and physical restraints, and the high costs to taxpayers. Training for all of these stakeholders should also include a discussion of the strong and common mandates of legal regimes related to child welfare, special education, health care, juvenile justice, and disability rights that children receive preventive, community-based treatment, rather than back-end intervention in the form of institutionalization.⁴⁶⁶

Diversion from institutional settings alone will not suffice; evidence-based treatment practices delivered through a coordinated system of care approach is necessary for children to achieve mental health. Stakeholders at all levels can prevent the disconnectedness that these youth are likely to experience without early intervention through coordination with each other and with recognition of the robust ways that the law “on the books” requires this holistic approach. The disjunction between the reality for children living in poverty and the aims of several legal regimes for the provision of early, preventive community-based treatment for children can be overcome through the use of proven treatments grounded in research regarding best practices in children's mental health care. The meaningful incorporation of a system of care approach into the policies and practices of local and state agencies and the use of proven evidence-based practices will

465. See MICHAEL WALD & TIA MARTINEZ, *CONNECTED BY 25: IMPROVING THE LIFE CHANCES OF THE COUNTRY'S MOST VULNERABLE 14–24 YEAR OLDS* (2003), available at <http://www.hewlett.org/uploads/files/ConnectedBy25.pdf>.

466. With law faculty from the Georgetown University Law Center and the University of the District of Columbia David A. Clarke School of Law, as well as local legal services attorneys, the author has developed and implemented trainings and materials to educate court-appointed attorneys in the Family Court of the District of Columbia Superior Court about the concerns related to institutionalization of children in RTCs and the relevant Medicaid, special education, and local juvenile delinquency statutes that attorneys can use to advocate for community-based services and placements for their clients.

allow for the realization of the goals of these legal regimes and for true stability, mental health, and inclusion for children with mental health disorders.⁴⁶⁷

467. *See, e.g.*, Complaint, H.B. v. Emkes, No. 3:11-cv-00663 (M.D. Tenn. July 11, 2011) (requesting that the court order the state to keep the plaintiffs with their families in “an integrated, non-segregated setting that can be reasonably accommodated” because the plaintiffs are “capable of safely living at home with their families with necessary services” and are “being forced to enter segregated residential settings [but] are qualified to participate in more integrated community programs that meet their needs”).

