

Crossing Guards Wanted: Navigating Among the Intersections of Public Mental Health Programs for Youth

By Patrick Gardner

Teenagers can be difficult for adults to understand in the best circumstances. Add mental illness to the interaction, and even great parents with abundant resources and solid social supports are apt to throw up their hands in frustration and despair. When poverty, sexual abuse, violence, homelessness, neglect, drug addiction, and family disorganization are in the mix, the result is a surefire recipe for misery, distrust, and failure.

Every day hundreds of thousands of American families face the challenge of dealing with mental illness in difficult circumstances. Unfortunately in too many cases the outcomes are poor. Absent effective treatment, children and adolescents with mental disorders fail in school, they are bounced among foster homes, and too often they are consigned to juvenile hall to spend their youth in isolated confinement. Poor and minority children are especially at risk of adverse outcomes.

Children's mental illness is one of society's most difficult challenges. The nature of our response may be making the difficult impossible. Not only do we fail to aid every child in need; we tend to isolate them from their families and communities. We build arbitrary constraints that determine which children we help,

in what setting, and for how long; and the services we provide tend to be generic and sporadic. Research shows that health providers have learned effective treatments that can improve the lives of children with mental illness. Experience tells us that we have a long way to go to accomplish this goal.

In this article I seek to (1) highlight the problem of children's mental health and the social failure it causes; (2) outline government's response and its shortcomings; and (3) describe collaborative efforts that advocates are using to improve outcomes for at-risk kids.

I. Unmet Mental Health Needs

Mental health disorders among youth harm individual children and, when aggregated across communities, constitute a serious public health challenge. Among young adults, "mental illness is the most common cause of hospitalization . . . with the exception of childbirth, and is the second leading cause of disability . . ." ¹ Unmet psychiatric treatment needs cause widespread failure in family relationships and child-serving institutions. Poor outcomes, however, are not preordained. A better understanding of mental health and a more informed view

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¹ SERENA CLAYTON ET AL., INVESTING IN ADOLESCENT HEALTH: A SOCIAL IMPERATIVE FOR CALIFORNIA'S FUTURE 50 (2000), available at <http://youth.ucsf.edu/nahic>.

of how mental disorders affect families and institutions yield useful tools for effecting change and securing improved outcomes.

A. Dire Needs

Mental health needs among youth are more extensive than generally recognized. About one child in five in the United States has a diagnosable mental health disorder that causes at least minimal impairment.² About four million youth nationwide, or 11 percent, suffer from major mental illness that significantly impairs functioning; and the most extreme cases of mental disorders occur in about 5 percent of children.³

Dealing effectively with mental health needs of children and adolescents requires greater understanding of the nature of youthful mental disorders. Unlike somatic illness or injury, psychological disorders involve both the individual and society: “A mental disorder results from the interaction of a child and her environment. Thus mental illness often does not lie with the child alone. [Conceptually] the mental disorder is an ‘emergent property’ of a transaction with the environment.”⁴ Psychological disorders, therefore, are defined by dysfunctional interactions with family, friends, teachers, or the daily tasks of living.

Children’s mental health has the added dimension of occurring within the context of ongoing psychosocial development: “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.”⁵ A mental illness arises where a child deviates from normal developmental processes. This means, in effect, that the mental health of a child is a moving target and that the difference between health and illness is often a matter of degree. It also means that behaviors that might consti-

Children’s mental illness is one of society’s most difficult challenges. However, society’s dismal response is part of the problem. Another problem lies in governmental shortcomings.

tute a disorder at one stage of development, such as crying spells or aggressive outbursts, may be normal for a child at another stage. A developmental context for child and adolescent mental health helps explain the emphasis on degree of impairment and the consideration of children as being not simply “little adults.”⁶

Children in out-of-home placements disproportionately suffer mental health disorders:⁷ “Experts estimate that between 30 and 85 percent of youngsters in out-of-home care have significant emotional disturbances. Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders than those living with their own families.”⁸ The circumstances among detained youth are no better: “It is estimated that 60 percent of the teenagers in juvenile detention have behavioral disorders and approximately 20 percent experience serious emotional disturbance In addition, some

² U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 123–24, 179 (1999).

³ *Id.*

⁴ *Id.* at 136.

⁵ *Id.* at 123.

⁶ *Id.* at 123–28.

⁷ *Id.* at 185.

⁸ ELLEN BATTISTELLI, CHILD WELFARE LEAGUE OF AM., FACTSHEET: THE HEALTH OF CHILDREN IN OUT-OF-HOME CARE, www.cwla.org/programs/health/healthcarewfact.htm (last visited May 17, 2001).

50 to 75 percent have serious substance abuse problems.”⁹

B. Adverse Outcomes

According to Dr. Steven Hyman, director of the National Institute of Mental Health, “Children with unrecognized or untreated cognitive and emotional disorders cannot learn adequately at school . . . [and] are at heightened risk for school failure and drop out, drug use, risk behaviors for HIV [human immunodeficiency virus] transmission, and many other difficulties.”¹⁰ Mental health problems also may lead to increased family stress and disorganization, domestic violence, and child abuse or neglect. Evidence is strong that over 90 percent of the approximately 5,000 children and adolescents who commit suicide each year have a mental disorder.¹¹ Suicide is the third leading cause of death among teens.¹²

Mental health disorders often engender incorrigible or defiant behavior. Undiagnosed and untreated, these behaviors can lead to school suspensions and expulsions, delinquency adjudication, and detention with the attendant labeling, sanctions, segregation, and hopelessness. Public school statistics tell a chilling story: “National data indicate that 20 percent of students with serious emotional disorders are arrested at least once before leaving

high school; 50 percent drop out of high school; and almost 75 percent of those that drop out are arrested within five years of leaving school.”¹³

Through varying pathways, many disordered children end up in restrictive care—in residential treatment centers, including group homes and halfway houses, juvenile detention, and psychiatric hospitals. Studies suggest that each year child welfare, juvenile justice, and mental health authorities institutionalize more than 700,000 children with diagnosable mental health needs.¹⁴ Although institutional care is necessary for the most severely disordered youth, for others it likely aggravates their condition. A stable link between a caring adult and an at-risk child is a critical element for successful development.¹⁵ Isolating disordered youth from their families, friends, school, and community threatens these links. Moreover, as youth become socialized to institutional life, they become less capable of making the transition back to the families and communities they need for support.¹⁶ Once inside, youth often are subjected to punitive conditions. Paul DeMuro calls it “bizarre treatment”:

In the name of suicide prevention we lock up a depressed, alienated kid for days on end. When a kid doesn't stand in line,

⁹ The Substance Abuse and Mental Health Services Administration defines “serious emotional disturbance” as “a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, and that resulted in functional impairment which substantially interferes with or limits [a] child’s role or functioning in family, school, or community activities” within the past year. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 172. See 58 Fed. Reg. 29422–25 (1993); LEWIN GROUP, NAT’L ASS’N OF PSYCHIATRIC HEALTH SYS., ENHANCING YOUTH SERVICES 3 (2000), at www.naphs.org/youth_services/lewinpaper.html. See also SPECIAL EDUCATION ADVOCACY UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) FOR CHILDREN IN THE JUVENILE DELINQUENCY SYSTEM 1–6 (Joseph B. Tulman & Joyce A. McGee eds., 1998) (“Within the juvenile justice system . . . children and adolescents with disabilities are grossly over-represented and are disproportionately detained and confined.”) [hereinafter SPECIAL EDUCATION ADVOCACY].

¹⁰ *Mental Health of America’s Children Before the House Subcommittee on Labor-DHHS, Education and Related Agencies Committee on Appropriations*, 105th Cong. (Oct. 29, 1997) (statement of Steven E. Hyman, director of the Nat’l Inst. of Mental Health).

¹¹ DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 150.

¹² *Id.*

¹³ CLAYTON ET AL., *supra* note 1, at 51.

¹⁴ DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 180.

¹⁵ *Id.* at 125–26.

¹⁶ *Id.* at 170.

he's a problem. So we restrain him to teach him discipline. But the problem is, that kid can't stand in line. It's part of his illness that he can't stand in line.¹⁷

Punishing youth with mental illness may not be the worst harm they will suffer, but it is a great injustice and not an effective strategy to improve outcomes.

C. Failure in Child-Serving Institutions

J.B. was 3 years old when Washington's child welfare agency removed her from her natural parents' home. As a result of the severe abuse, she acted up in ways that made providing for her very difficult. The foster parents with whom she was placed were untrained and unprepared to deal with her behavioral health needs. The volatile mix of extreme needs and minimal preparation and training resulted in 29 placements in 15 years.

J.B. is a named plaintiff in a class action lawsuit alleging that Washington state has failed to meet its obligations to abused and neglected children because, among other reasons, the state failed to provide permanent placements for hundreds of children in its care. Instead foster children bounced from place to place, unable to establish the stability they so badly needed for trust and development.

According to one expert in the case, [t]here is a direct relationship between the mental health problems of foster care children and the inability of Washington Department of Social and Health Services (DSHS) to provide for permanent placements of children.

When the child's mental health problems manifest themselves in difficult or dangerous behaviors, the foster parents are unprepared and unable to deal

with the child's behaviors. They lack adequate access to professional mental health and case management resources to help the child and assist them with the child's behaviors. When the behaviors become unmanageable, the foster parents demand that the child be removed from their home.

DSHS removes the child from the home but subsequently moves the child to a similar placement. Again, the child's behaviors exceed the foster parent's ability to manage and help the child and the home again asks [that] the child be removed. The cycle repeats itself. With each additional placement, the child is further damaged.¹⁸

Unmet mental health needs also cause failures in our juvenile justice system. One tragic example is Thomas's story as recounted in *Handle with Care*:

For much of his childhood, [Thomas's] mental disorder went undiagnosed and untreated.

When a crisis hit, the family was bounced back and forth between systems. A mental health worker would be involved with the family one week, then absent for years. A well-meaning social worker would rush in with some patchwork services to get the family stabilized, and then disappear.

Eventually, Thomas' trajectory mirrored that of so many youth around the country with unacknowledged and untreated mental health disorders. He reached adolescence and broke the law. Like most youth who wind up in juvenile hall, his crime was not a violent one.¹⁹

¹⁷ COALITION FOR JUVENILE JUSTICE, 2000 ANNUAL REPORT: HANDLE WITH CARE: SERVING THE MENTAL HEALTH NEEDS OF YOUNG OFFENDERS 21, at www.juvjustice.org/publications/annualreport/2000/report.pdf.

¹⁸ Motion to Certify as Class Action Pursuant to CR 23: Declaration of Kathleen Westover, M.A., at 5, Braam v. State of Washington, No. 98 2 01570 1 (Wash. Super. Ct. Wash. Whatcom County filed July 10, 2000).

¹⁹ COALITION FOR JUVENILE JUSTICE, *supra* note 17, at 12–17.

Efforts were made to place Thomas in a therapeutic program, but few spaces were available and he was obliged to wait weeks, and then months for a transfer. During this time, Thomas began acting out and was “locked down in his cell more and more often.”²⁰ One day his spirits seemed to rise, and suddenly he was “happy and joking around.”²¹ And then, minutes later, he was discovered “hanging by his neck, his bed sheet ripped and fashioned into a noose.”²²

Although Thomas survived, he “remains on life support, his brain damaged beyond repair.”²³ Tragically Thomas is not alone: “Youth suicide in juvenile detention and correctional facilities is more than four times greater than youth suicide in the general public.”²⁴

When child-serving systems fail, minority children and adolescents are disproportionately harmed. Studies show that

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minority children are less likely to receive preventive services and more likely to be in detention than white children.²⁵ Research suggests that a two-tiered system shows “youth in private facilities and in the health stream...[coming] from more affluent families, on average, than youth confined in public facilities and within justice centers.”²⁶ Differences in personal histories or medical problems cannot account for the discrepancies. According

to one research team, “[V]iolent, disturbed adolescent blacks were incarcerated; violent, disturbed whites were hospitalized. Even when black children were initially considered to be psychiatrically disturbed and were hospitalized, they often subsequently were transferred to corrections.”²⁷ T.M. Lurhman, in her anthropological study of the training of American psychiatrists, put it this way: “Psychiatric illness, like all medical problems but more so, is mired in the ugly realities of the American class structure.”²⁸

II. Government’s Poorly Coordinated Response to Mental Health Needs

One of the defining features of children’s mental health care in the United States is its disaggregated and unplanned character. Government agencies pay for, or directly provide, mental health care, in addition to private health care insurers and providers. Public providers include such agencies as mental health departments, health departments, developmental disability programs, drug and alcohol agencies, public schools, the juvenile justice system, and child welfare bureaus.

A. Balkanized Bureaucracy

According to the surgeon general:

Of those who received services and had both a diagnosis and impaired functioning, about 40 percent received services in the specialty mental health sector, about 70 percent received services from the schools, about 11 percent from the health sector,

²⁰ *Id.* at 17.

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *Id.* at 18.

²⁵ GARY B. MELTON ET AL., NO PLACE TO GO: THE CIVIL COMMITMENT OF MINORS 22–25 (1998), available at www.netstoreusa.com/ljbooks/080/0803230958.shtml; See also DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 181–82; COALITION FOR JUVENILE JUSTICE, *supra* note 17, at 26–31.

²⁶ MELTON ET AL., *supra* note 25, at 23.

²⁷ *Id.* at 23–24 (quoting D.O. Lewis & S.S. Shanok, *Racial Factors Influencing the Diagnosis, Disposition, and Treatment of Deviant Adolescents*, in VULNERABILITY TO DELINQUENCY 295–311 (D.O. Lewis ed., 1981)).

²⁸ T.M. LUHRMANN, OF 2 MINDS: THE GROWING DISORDER IN AMERICAN PSYCHIATRY 157 (2000).

about 6 percent from the child welfare sector, and about 4 percent from the juvenile justice sector. For nearly half the children with serious emotional disturbances who received services, the public school system was the sole provider.²⁹

Which government entity assumes responsibility for a disturbed child's care is often happenstance.³⁰ Very often agencies ping-pong children back and forth.³¹ Consider the case of Sheila M., a 16-year-old who has a dual diagnosis of mental retardation and manic depression. Sheila "has been transferred more than 65 times between children's shelters, group homes, psychiatric hospitals and juvenile jails"³²

The state psychiatric hospital rejected Sheila because "her I.Q. of around 60 is too low to enable her to participate in the therapy."³³ The developmental disability regional center declined to treat Sheila "because she was too mentally ill and therefore too aggressive and dangerous."³⁴ Sheila may well end up in juvenile hall. Against her is a charge of vandalism, a felony for which she could be in detention for years. Allegedly she broke "a pipe in a bathroom at a children's shelter after

being locked in there for punishment."³⁵

Transfers among agencies reflect the reluctance by any one department to accept full responsibility for effectively treating mental health problems. Public schools, for instance, must accept responsibility for mental health needs that constitute a learning disability.³⁶ If a child's disorder affects his behavior but does not qualify as a disability under law, schools may forgo services and respond with sanctions, increasingly suspending or expelling troublesome youth.³⁷ The juvenile justice system is equally wary of accepting ultimate responsibility for adolescents' mental health status. In most cases, medical management and hospitalization in acute cases are the extent of provided services.

Transfers among agencies also reflect the difficulty of coordinating care among multiple bureaus. Without effective coordination, agencies transfer children for selfish reasons, such as to conserve resources or get rid of high-needs or difficult children. Agencies also move children as a result of irrational bureaucratic prerogatives, such as shuttling youth among shelters to avoid occupancy limits. In some cases, agencies move children for presumed beneficial reasons,

²⁹ DEP'T OF HEALTH & HUMAN SERVS., *supra* note 2, at 180.

³⁰ JANE KNITZER, CHILDREN'S DEF. FUND, UNCLAIMED CHILDREN: THE FAILURE OF PUBLIC RESPONSIBILITY TO CHILDREN AND ADOLESCENTS IN NEED OF HEALTH SERVICES 67 (1982) ("Chance often determines whether disturbed children and adolescents become the responsibility of state mental health agencies. They are just as likely, if not more so, to fall under the auspices of state child welfare, juvenile justice, or education agencies, or even public agencies serving mentally retarded persons or alcohol and drug abusers. In part, which system ends up with primary responsibility for a disturbed child rests upon whether the child has an intact, functioning family, or whether the child has been picked up for a status offense or a delinquent act. It may also depend upon the way various state agencies are organized.").

³¹ MELTON ET AL., *supra* note 25, at 10.

³² Fox Butterfield, *Concern Rising Over Use of Juvenile Prisons to "Warehouse" the Mentally Ill*, N.Y. TIMES, Dec. 5, 2000, at A14.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ Schools have a duty to provide a free and appropriate education under the Individuals with Disabilities Education Act. 20 U.S.C. §§ 1412 *et seq.* See *infra* text accompanying note 73.

³⁷ KIM BROOKS ET AL., SCHOOL HOUSE HYPE: TWO YEARS LATER 15 (2000), at www.jjic.org/pdf/shh2.pdf.

including transfers in the hope of securing more appropriate services.³⁸

In virtually every state, five or more agencies are involved in providing care to disordered children. Each agency has its own mission, organizational culture, institutional procedures, eligibility rules, and funding streams. Understanding one agency's eligibility and procedural rules and funding options can be a full-time job. Coordinating among programs requires an even greater effort. Nancy Young and Sydney Gardner expressed their frustration in an article on cooperation among Child Protective Services, Temporary Assistance for Needy Families (TANF), and Alcohol and Other Drug prevention programs:

The full range of funding options for agencies working across the [Child Protective Services] and [Alcohol and Other Drug] systems is truly bewildering: a Los Angeles program serving pregnant and parenting mothers with [Alcohol and Other Drug] problems, for example, has woven together 40 different funding sources. In working on these issues, we have found no one who understands all the available categorical funding sources in the three systems, and no state or county has yet developed a comprehensive inventory of the three systems' funding sources and updated it on an annual basis.³⁹

The proliferation of programs and funding sources for mental health needs engenders deep frustration on the part of advocates for, and parents of, children in need. It also makes holding government accountable for duties owed to at-risk kids

much more difficult because obtaining services from one agency often requires enforcing a duty that another owes. This crossover care situation commonly occurs for foster children seeking mental health care and for juvenile offenders seeking special education services.

B. Insufficient Access to Services or Individualized Care

Mental health care typically begins with a referral and then a mental health screen. The referral may come from any number of sources, including a teacher, social worker, probation officer, crisis counselor, guardian *ad litem*, or a parent. If the initial screen indicates the need for a diagnosis, such a diagnosis forms the basis for a treatment plan. Services follow, with periodic adjustments to the treatment plan as the child progresses toward a hoped-for outcome of improved health and functioning. Typical mental health services include inpatient treatment, residential treatment, therapeutic foster care or group home placement, outpatient treatment, partial hospitalization or day treatment, community-based care, counseling, medical management, case management, and crisis services.⁴⁰

Although many children receive mental health care each year in the United States, the response to troubled youth oftentimes is no response at all. One study determined that only 11 percent of children at risk receive services in a mental health setting and identified less than 1 percent of school children nationally as having mental health problems.⁴¹ The U.S. Office of Technology Assessment reported in 1986 that "approximately 70 percent of children and adolescents in need of treatment do not receive mental health treatment."⁴² The recent surgeon general's report similarly concluded that

³⁸ Instability is a key risk factor for mental health disorders. Physically transferring a child to secure appropriate services is a symptom of the breakdown in coordinating care.

³⁹ Nancy K. Young & Sidney L. Gardner, *Children at the Crossroads*, 56 PUB. WELFARE 3, 6 (1998).

⁴⁰ DEP'T OF HEALTH & HUMAN SERVS., *supra* note 2, at 168–79.

⁴¹ LEWIN GROUP, *supra* note 9, at 11; DEP'T OF HEALTH & HUMAN SERVS., *supra* note 2, at 179–81.

⁴² DEP'T OF HEALTH & HUMAN SERVS., *supra* note 2, at 180.

“a high proportion of young people with a diagnosable mental disorder do not receive any mental health services at all.”⁴³

Even children in state custody routinely fail to receive needed mental health treatment: “Approximately 60 percent of all children in out-of-home care have moderate to severe mental health problems [and yet] . . . less than one-third of children in the child protective system are receiving mental health services.”⁴⁴

The gap between need and services arises, in part, because states fail to provide adequate resources to support necessary services. As a result, reimbursement rates are too low, arbitrary “utilization” restrictions are on services, and too few providers are available to meet youth’s needs.⁴⁵ Society stigmatizes mental health disorders. People and politicians do not understand mental illness and are afraid of its consequences:

In our society, we usually see people with cancer, heart disease, or a broken leg as innocent sufferers, and we usually feel that they have some claim to our help In psychiatric illness there is no such clarity. We often find it difficult to respond to psychiatric patients as innocent sufferers, because taking an overdose seems deliberate and

chosen in away that having cancer does not. We sometimes even find it difficult to respond to them as people, because when a [person] is psychotic he loses the ability to behave like a person among people. That makes it difficult to empathize with madness and hard to know how to respond appropriately.”⁴⁶

Social stigma and poor understanding of mental health issues also contribute to insufficient access to care through avoided mental health screens. Poor data collection aggravates the situation as consumers and decision makers alike remain uninformed about the extent and nature of mental health needs. As recently as twenty years ago, the best estimates about mental health problems among children were just guesses.⁴⁷ Information gathering is improving, but slowly.

Children are also underserved in the manner in which they receive services. Public entitlement to services often depends upon whether a child has a formal diagnosis.⁴⁸ Services have an order of priority for severe cases.⁴⁹ Thus preventive services are usually unavailable. Moreover, offered services depend upon the agency providing them, and all agencies tend to provide categorical services without sufficient regard to individual or family needs. For example, a mental health department

⁴³ *Id.*

⁴⁴ BATTISTELLI, *supra* note 8.

⁴⁵ DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 138. Insufficient funding is not unique to children’s mental health services as all child-serving institutions are obliged to get by with too little money. But mental health is particularly vulnerable because at-risk children, especially impoverished adolescents, are politically unpopular and virtually powerless.

⁴⁶ LURHMAN, *supra* note 28, at 271.

⁴⁷ *Id.* at 224 (“In 1978, the President’s Commission on Mental Health reported that 15 [percent] of the population needed some form of mental health services at any one time—and then, astonishingly, mentioned in a footnote that this estimate had no data to support it. . . .The estimate, in other words, was a guess.”).

⁴⁸ Medicaid is the largest funder of children’s mental health in the United States. See DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 183; see also MELTON ET AL., *supra* note 25, at 16. Under Medicaid, access to care is limited to medically necessary services, often necessitating a formal diagnosis and disorder. See CHRIS KOYANAGI ET AL., BAZELON CTR. FOR MENTAL HEALTH LAW, DEFINING MEDICALLY NECESSARY SERVICES TO PROTECT CHILDREN (1998), www.bazelon.org/paper5.pdf.

⁴⁹ DEP’T OF HEALTH & HUMAN SERVS., *supra* note 2, at 169–72, 179–86.

may provide residential care but no urgent response capability; day treatment services but no respite care; or outpatient counseling but only for six or eight sessions.

Social stigma and poor understanding of mental health issues also contribute to insufficient access to care through avoided mental health screens. Poor data collection aggravates the situation.

Although the department may offer a child a full array of services that an agency funds, those services may be a poor fit for the child's needs.

Other common barriers to getting health care also impede access. Such barriers include lack of health insurance, complex eligibility rules, and burdensome application procedures for public health insurance; poor understanding of mental health needs and the availability of subsidized care; difficulty navigating the public benefits maze; limited outreach; cultural and language barriers; and lack of trust in government programs and providers.

C. Overreliance on Institutional Care

Most of the children who do receive mental health care get low-level services such as counseling or medical management. As many as an estimated 5 percent to 10 percent of children and families in the United States annually seek outpatient psychotherapy.⁵⁰ Most expenditures on the costs of care, however, are on residential treatment and hospitalization. Residential treatment centers account for

about a fourth of all mental health expenditures on children each year.⁵¹ Inpatient hospitalization constitutes an additional 50 percent of the total cost of children's care in the United States.⁵² Lopsided spending on the most restrictive and expensive care reflects an institutional bias based on historic treatment methods and funding, the present emphasis on treating high-needs children, and the political and economic power of institutions.⁵³

Excessive use of institutional care not only soaks up resources otherwise for less restrictive interventions but also can be harmful to the intended beneficiaries.⁵⁴ Unnecessary institutionalization, whether in a mental health hospital, a residential care facility, or a juvenile correctional facility, isolates youth from their families, friends, schools, and communities. According to Justice Ruth Bader Ginsberg, writing for the majority in *Olmstead v. L.C.*, "[U]njustified institutional isolation . . . is a form of discrimination . . . [that] severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."⁵⁵

Most children, even those from disordered families, want to live at home. Inappropriately restrictive care spurns that desire and violates a child's sense of autonomy and privacy. To make matters worse, placements are often far from home, thereby making family visits rare or nonexistent, adding to the feelings of abandonment. Moreover, treatment that does not deal with the child's home environment is unlikely to resolve behavioral health problems.⁵⁶

⁵⁰ *Id.* at 168.

⁵¹ *Id.* at 169.

⁵² *Id.* at 171.

⁵³ Gary B. Sutnick, "Reasonable Efforts" Revisited: Reforming Federal Financing of Children's Mental Health Services, 68 N.Y.U. L. REV. 136 (1993). See also Lois A. Weithorn, Note, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773 (1988); LITTLE HOOVER COMM'N, BEING THERE: MAKING A COMMITMENT TO MENTAL HEALTH (2000).

⁵⁴ MELTON ET AL., *supra* note 25, at 52–77; DEP'T OF HEALTH & HUMAN SERVS., *supra* note 2, at 170; Weithorn, *supra* note 53, at 783–98.

⁵⁵ *Olmstead v. L.C.*, 527 U.S. 581, 600–601 (1999) (Clearinghouse No. 52,203).

⁵⁶ MELTON ET AL., *supra* note 25, at 52–77.

Youth who spend even short periods in restricted facilities often become socialized to the institution. This is especially problematic for disordered youth in detention. Correctional camps and juvenile halls are criminogenic institutions that “create criminals or exacerbate criminal behavior.” Warehousing disordered youth in these facilities has little chance of turning adolescent lives around. Indeed, “virtually every study examining recidivism among youth sentenced to juvenile training schools in the past three decades has found that at least 50 to 70 percent of offenders were re-arrested within one or two years after release”⁵⁷

Some children need and benefit from restrictive care. Others land there because no alternatives would allow a child to receive services while remaining at home. When Jane Knitzer wrote *Unclaimed Children* in 1982, developing a system of care that provided a continuum of services to children in the community was a new idea.⁵⁸ Today most states have a system of care policies in place. Yet, while many excellent local programs demonstrate that community care can work, no jurisdiction has a statewide system of care that eliminates unnecessarily restrictive placements.⁵⁹

Still other children are in institutional care because, ironically, their parents cannot afford treatment for them. Relinquishing custody of a child can gain access to needed care because children in state custody are usually eligible for Medicaid benefits.⁶⁰ Forcing families to make a choice between health and custody, however, is cruelly shortsighted and counterproductive. But, according to a

National Alliance for the Mentally Ill survey in 1999,

36 percent of survey respondents said their children were in the juvenile justice system because mental health services outside of the system were unavailable to them; 23 percent of parents were told that they would have to relinquish custody of their children to get needed services; and 20 percent said that they actually relinquished custody to get services.⁶¹

The pain a parent must go through to have the state arrest a severely disturbed child, or have the state place the child in foster care, in order to secure appropriate mental health care is beyond imagining.

III. Improving Accountability and Outcomes

The public mental health system for children and adolescents in the United States consists of numerous independent agencies pursuing disparate missions in a largely unplanned and uncoordinated effort to “serve children.” The array of programs and providers is dizzying and yet leaves out or underserve many, if not most, children. What can poverty law attorneys do about this?

One is to navigate children and their families through the intersections among agencies. Adolescents who are seeking alternatives in an unresponsive bureaucracy or are “lost in the cracks” between bureaus need crossing guards. Used to dealing with administrative agencies, poverty lawyers can play this role. But,

⁵⁷ COALITION FOR JUVENILE JUSTICE, *supra* note 17, at 24, 47.

⁵⁸ KNITZER, *supra* note 30.

⁵⁹ See, e.g., Bruce Kamradt, *Wraparound Milwaukee: Aiding Youth with Mental Health Needs*, 7 JUV. JUST. J. 14 (2000); a recently proposed settlement in *J.K. v. Eden*, an Early and Periodic Screening, Diagnosis, and Treatment class action case seeking improved behavioral health benefits for Title XIX eligible children in Arizona, seeks to address the disjunction between state policy and practice. For more information on the proposed settlement agreement, see www.bazelon.org/jksettlement.html; *J.K. v. Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993).

⁶⁰ MARY GILBERTI & RHODA SCHULZINGER, BAZELON CTR. FOR MENTAL HEALTH LAW, RELINQUISHING CUSTODY: THE TRAGIC RESULT OF FAILURE TO MEET CHILDREN’S MENTAL HEALTH NEEDS 9–13 (2000).

⁶¹ COALITION FOR JUVENILE JUSTICE, *supra* note 17, at 39–40.

in order to be effective crossing guards, advocates need to adopt a global view by stepping outside of the bureaucratic structure of individual agencies. That means stretching beyond the subject-matter areas in which public interest attorneys specialize. Child welfare advocates may need to develop a better understanding of health law, for instance. Public defenders may need to learn about education law. Securing a right-of-way for youth could go a long way toward increasing accountability, improving access to individualized services, and reducing excessive reliance on restrictive placements.

Admonishing advocates to learn broad new areas of law may not elicit great enthusiasm. However, there is an alternative to spending long weekends with a hornbook. Public defenders, legal services and Protection and Advocacy attorneys, children's advocates, and members of the private bar have pooled their expertise and formed partnerships to cut across bureaucratic boundaries and improve outcomes for at-risk children and adolescents.

A. TeamChild

TeamChild is a collaborative which Columbia Legal Services, the Seattle-King County, and the state of Washington Defender Associations created in 1995. By addressing the underlying problems of delinquent children, the program seeks to overcome the lack of coordination between government programs and services:

Jack, at age 16, already had been in juvenile detention. He came out and got in trouble again: attempted robbery in the first degree. Project TeamChild in Seattle interceded, obtained a psychiatric evaluation and discovered Jack had undiagnosed and untreated mental health issues. The TeamChild attorney presented the judge with a cost-effective alternative to incarceration[,] and

Jack's behavior and progress finally improved with the concentrated medical treatment.⁶²

According to Martha Stone, executive director of the Center for Children's Advocacy Inc., a TeamChild-modeled program in Hartford Connecticut, "We don't care what system he's in. We don't care how old he is. We don't care if he's got truancy problems, abuse and neglect issues, or mental health problems. We offer one-stop shopping with the philosophy 'whatever it takes.'"⁶³

Seattle's project gets referrals primarily from defenders whom TeamChild trains to spot civil legal issues, although probation officers, judges, and others also make referrals. After an assessment, the TeamChild attorney undertakes direct representation of the juvenile to address civil legal matters including gaining access to special education, safe living conditions, mental health services, and medical coverage, among others. TeamChild attorneys are at public defender and legal services offices and collaborate formally on cases, as well as informally through training sessions, consultations, and referrals.

One critical component to success, according to TeamChild's Elizabeth Calvin, is teen-centered outreach and follow-up. Traditional legal services delivery models are not as effective with at-risk teens. Communicating with adolescents turns on trust that comes from understanding their developmental needs and meeting them on their terms. That might mean intake at Burger King; but so be it. Having gained the trust of their clients, TeamChild lawyers have the opportunity to help kids in crisis cross over the criminal/civil boundary to obtain health and social services to which they have entitlement but which the juvenile court system is unable, or unwilling, to provide.

TeamChild is gaining adherents in other states. Gator TeamChild, at the University of Florida Law School, incorporates law students and graduate stu-

⁶² Susan Kellum, *TeamChild: Curbing Delinquency at Its Roots*, 20 A.B.A. CHILD L. PRAC. 28 (2001), www.abanet.org/child/15-12toc.html.

⁶³ *Id.*

dents from the Florida State University School of Social Work into the model. In Connecticut the Center for Children's Advocacy collaborates with the University of Connecticut School of Law as well as with the School of Medicine and the School of Social Work. Interdisciplinary teams address legal, medical, and emotional needs of the children they serve.

B. Los Angeles's Informal Coalition

California law empowers the juvenile court adjudging an abused or neglected child as dependent to "make any and all reasonable orders for the care, supervision, custody, conduct, maintenance, and support of the child, including medical support . . ."⁶⁴ The statute also provides: "To facilitate coordination and cooperation among government agencies or private service providers, or both, the court may, after giving notice and an opportunity to be heard, join in the juvenile court proceedings any agency or private service provider that the court determines has failed to meet a legal obligation to provide services to the child."⁶⁵ Taken together, these provisions create an extraordinary opportunity to bridge bureaucratic boundaries and secure mandated services for at-risk youth.

Public interest law advocates and Dependency Court Legal Services in Los Angeles have teamed up to do just that.⁶⁶ Focusing on mandatory duties owed disabled children, including, for example, the Individuals with Disabilities Education Act, advocates have been petitioning Los Angeles's juvenile courts to join local education and mental health authorities in dependency cases.⁶⁷ The Act entitles children with serious emotional disturbance to an individual evaluation, the development of an individualized education program, and special education and related

services that enable the child to benefit from special education.⁶⁸ The Act's mandate provides the necessary "legal obligation to provide services" that allows the court to join the agencies as parties. Once an agency is before the court, lawyers can secure an order mandating appropriate services. In many cases the threat of joinder can get recalcitrant departments to act.⁶⁹ In cases where multiple agencies are responsible for overlapping duties, the court can oblige them to sort out their respective responsibilities and hold them accountable for delivering treatment.

The partnership between Dependency Court Legal Services and the public interest lawyers was born out of a concern that the nation's largest juvenile court system was failing to provide individualized mental health services that could prevent disordered minors from languishing in restrictive care settings. The problem, according to James Preis, executive director of Mental Health and Advocacy Services Inc., was an unaccountable balkanized bureaucracy:

One of the major bureaucratic barriers to individualized services for children is the lack of interagency collaboration. Cooperation between different agencies is one of the fundamental principles in systems-of-care. Everybody agrees. However, in practice interagency cooperation has come to mean that every agency serving children will develop its own interagency cooperative. As a result, child welfare departments have a program called Family Preservation. The Department of Mental Health has something similar called Systems of Care. The

⁶⁴ CAL. WELF. & INST. CODE § 362(a) (2000).

⁶⁵ *Id.*

⁶⁶ Partners include Public Counsel Inc., Mental Health and Advocacy Services Inc., and Protection and Advocacy Inc.

⁶⁷ Individuals with Disabilities Education Act, 20 U.S.C. §§ 1412 *et seq.* (2000) (West, WESTLAW through P.L. 106-274).

⁶⁸ 20 U.S.C. § 1401(8); *Bd. of Educ. v. Rowley*, 458 U.S. 176 (1982). *See also* SPECIAL EDUCATION ADVOCACY, *supra* note 9, ch. 6.

⁶⁹ CAL. WELF. & INST. CODE § 362(a) (2000).

Department of Probation in Los Angeles has its own interagency program called Mary C., which is a demonstration project to help children who are at risk of ending up in the juvenile justice system. In addition, schools have their Healthy Start programs.

Each initiative requires all of the other agencies [to] participate. However, while each agency discusses cooperation, they are only talking about it within their own sphere. For example, there are a lot of discussions at the Los Angeles County Department of Children and Family Services about developing cooperative interagency efforts. There are similar discussions at the Department of Mental Health. Unfortunately, they are not talking effectively with each other, even though they are talking about the same things.⁷⁰

Section 362(a) offers the opportunity for the cooperating attorneys to hold agencies accountable.

Clearly litigation is undesirable if children can receive the wraparound services they need without requiring a lawsuit. However, because the bureaucratic barriers that separate services for children are so ingrained in the system, real change will likely require a court order to force individual bureaucracies to cooperate.⁷¹

The Los Angeles collaborative works informally together and with defenders in much the same way as do TeamChild advocates. At times attorneys cocounsel individual cases. They also share expertise and advice and coordinate training ses-

sions that cut across the traditional boundaries between juvenile court and health and welfare matters. The team has prepared, as a part of the project, model pleadings to join other agencies in dependency proceedings.⁷²

C. The Threat of a Huge Damages Award

A new innovation in partnering has child advocates teaming up with personal injury attorneys. One case in Florida involves two children who, in 1986, were abandoned in a Miami park at ages 2 and 4. According to *New York Times* reporter Nina Bernstein, “[O]ver the next 14 years the sisters were shuttled through more than 30 foster homes and institutions, beaten, raped, and repeatedly separated from each other while a stream of caseworkers overlooked such obvious evidence of abuse as the diagnosis of syphilis in the older girl when she was 9.”⁷³ A year ago a Florida jury awarded the girls \$4.4 million in damages. Sizable verdicts like that “have encouraged advocates for foster children and personal injury lawyers to join forces . . . in two-track litigation. Their lawsuits ask the courts to change the system, while separately seeking damages on behalf of children already harmed.”⁷⁴

Attorneys with the National Center for Youth Law and Brett & Dugert L.L.P. in Washington state have joined a demand for damages with class action claims for injunctive relief.⁷⁵ The complaint, filed on behalf of children who are in state custody and have emotional, behavioral, mental or physical handicaps or disabilities, includes state claims of negligence and discrimination and federal claims under the Americans with Disabilities Act,

⁷⁰ James Preis, *Advocacy for the Mental Health Needs of Children in California*, 31 LOY. L.A. L. REV. 937, 943–44 (1998).

⁷¹ *Id.* at 944.

⁷² Model pleadings are on file with and available from the National Center for Youth Law.

⁷³ Nina Bernstein, *Foster-Child Advocates Gain Allies in Injury Lawyers*, N.Y. TIMES, Oct. 27, 2000, at A18 (quoting Jean Soliz, former head of Washington State’s Department of Social and Health Services).

⁷⁴ *Id.*

⁷⁵ Motion to Certify as Class Action, *Braam*, No. 98 2 01570 1.

Section 504 of the Rehabilitation Act, the Child Welfare and Adoption Assistance Act, and the Fourteenth Amendment.⁷⁶ The gravamen of plaintiffs' suit is that the state breached its duty to provide stable and permanent placements for abused and neglected children. Plaintiffs allege that "[s]ome children have been moved as many as thirty to fifty times."⁷⁷ The instability caused by repeated moves aggravates behavioral problems that can cause placement failures. Plaintiffs are seeking better training of foster parents and improved coordination of behavioral health and disability services to reduce transfers and avoid further harm to children already suffering from the trauma of abuse and abandonment.

Adding personal injury lawyers to the mix heightens the impact of a suit and increases the state's accountability. The threat of a huge damages award may diminish an agency's use of delaying tactics. Also, personal injury lawyers with jury trial experience can be a valuable supplement to the poverty lawyer's administrative expertise. According to Jean Soliz, the former head of Washington's Department of Social and Health Services, "[T]he torts give you the leverage to make [the state] take you seriously . . . ; the torts don't fix anything."⁷⁸ Of course, winning a major damages award helps children who have been twice abused—once by their natural parents and again by an indifferent or ineffective state bureaucracy.

D. Other Approaches, Old and New

Some old-fashioned partnerships also continue to pay dividends. In 1975 three San Francisco attorneys concluded that at-risk youth needed legal representation



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that was more comprehensive in scope than delinquency and status offenses.⁷⁹ Legal Services for Children of San Francisco was born out of the idea that juveniles needed advocates who could cut across legal categories and represent youth in civil proceedings that affected their school, health, home life—and even their freedom. Now in its twenty-sixth year, the organization teams up lawyers and social workers on solution-based advocacy that builds on children's strengths and resilience. The collaboration seeks comprehensive solutions in supportive resources in the community and in everyday legal assistance on matters involving out-of-home placement, school discipline, mental health, and HIV advocacy, among others.

⁷⁶ Americans with Disabilities Act, 42 U.S.C. §§ 12101 *et seq.* (2000) (West, WESTLAW through P.L. 106-274); Section 504 of the Rehabilitation Act, 29 U.S.C. §§ 794 *et seq.* (2000) (West, WESTLAW through P.L. 106-274); Welfare and Adoption Assistance Act, 42 U.S.C. §§ 671 *et seq.* (2000) (West, WESTLAW through P.L. 106-274); U.S. CONST. amend. XIV, § 1.

⁷⁷ Second Amended Complaint at 7, *Braam v. State of Washington*, No. 98 2 01570 1 (Wash. Sup. Ct. Whatcom County filed Apr. 3, 2000).

⁷⁸ Bernstein, *supra* note 73, at A18.

⁷⁹ Legal Services for Children of San Francisco's founders included Peter Bull of the Youth Law Center, John Bush of Huckleberry House, and Carole Brill, an attorney in private practice.

Future partnerships may involve prosecuting attorneys, disability lawyers, and public benefit specialists. In California, for example, two counties are exploring mental health courts for youthful offenders.⁸⁰ They are modeling their efforts after drug courts that divert offenders from detention by using intensive monitoring, treatment, and supportive services.⁸¹ This approach challenges the traditional adversarial relationship between prosecutors and defenders. To be successful, they will need to develop the collaborative means to work together. Another intersection that needs crossing guards involves disabled TANF recipients.⁸² Studies confirm that, after years of declining participation, such recipients often have disabilities that affect their capacity to secure and retain work.⁸³ “The Americans with Disabilities Act . . . has been mentioned as a likely source of protection for TANF clients.”⁸⁴ Using the Act for TANF recipients will likely require

the cooperative efforts of disability advocates and legal services lawyers.⁸⁵

The mental health needs of children and adolescents in America are much greater than most of us understand. Unmet needs cause pain and suffering for tens of thousands of kids, as well as failure in child-serving institutions. A fractured system of care, limited access to individualized treatment, an isolating overreliance on restrictive care, and insufficient resources are causing the vast gap between rendered treatment and children’s needs. Advocates can improve the situation by holding agencies more accountable through partnerships that provide at-risk youth with a right-of-way at agency intersections. Greater agency accountability would mean better program coordination, more individualized services, less restrictive care, and better outcomes for kids who deserve it.

⁸⁰ Craig Anderson, *Novel Program Treats Mentally Ill Offenders*, DAILY J., Feb. 26, 2001, at 1.

⁸¹ Jahna Berry, *Clean Teens: Teens Fight Their Addictions from Pot to Alcoholism*, RECORDER (S.F.), Mar. 30, 2001, at 1.

⁸² The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished Aid to Families with Dependent Children and created the Temporary Assistance for Needy Families (TANF) program. Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 7, 29, 42 U.S.C.).

⁸³ Cary LaCheen, *Using Title II of the Americans with Disabilities Act on Behalf of Clients in TANF Programs*, 8 Geo. J. on Poverty L. & Pol’y. 1, 8 (2001).

⁸⁴ *Id.* at 9.

⁸⁵ *See id.* at 10 (Cary Lacheen’s manual on using the Americans with Disabilities Act for TANF clients anticipates that partnership).