Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth

Lois A. Weithorn
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I. INTRODUCTION

Plus ça change, plus c’est la même chose.¹

The French proverb according to which the more something changes the more it remains the same is more than a witticism. It is a wonderfully concise expression of the puzzling and paradoxical relationship between persistence and change. It appeals more immediately to experience than the most sophisticated theories that have been put forth by philosophers, mathematicians, and logicians, and implicitly makes a basic point often neglected: that persistence and change need to be considered together, in spite of their apparently opposite nature. This is not an abstruse idea, but a specific instance of

the general principle that all perception and thought is relative, operating by comparison and contrast.\textsuperscript{2}

In 2003, the Government Accountability Office ("GAO")\textsuperscript{3} reported that in the year 2001, parents across the nation relinquished custody of over 12,700 children to the child welfare or juvenile justice systems when they could not access or afford the mental health services they sought for their children.\textsuperscript{4} The U.S. Senate Governmental Affairs Committee subsequently held hearings,\textsuperscript{5} and the House Committee on Government Reform embarked upon its own investigation. After a year-long study, the House Committee reported even more alarming numbers: During the \textit{six-month period} from January 1 to June 30, 2003 "nearly 15,000 incarcerated youth waited for community mental health services" in juvenile detention facilities because of the unavailability or unaffordability of appropriate community-based mental health services.\textsuperscript{6} A second set of Congressional hearings took place in July 2004.\textsuperscript{7}

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3. Effective July 7, 2004, after eighty-three years, the GAO changed its name. See GAO'S \textit{Name Change and Other Provisions of the GAO Human Capital Reform Act of 2004}, at http://www.gao.gov/about/namechange.html (last visited Aug. 23, 2005). According to the Comptroller General of the United States, the new name more accurately reflects the mission of the GAO, an independent, nonpartisan federal agency charged with "measuring the government's performance and holding it accountable for results." David M. Walker, GAO Answers the Question: \textit{What's in a Name?}, at http://www.gao.gov/about/rollcall07192004.pdf (last visited Aug. 23, 2005). In the text of this Article, the agency will be referred to by its new name, or as the "GAO." In footnotes, however, the agency's name will be cited exactly as it appears on each document.

4. Specifically, the GAO reported: "State child welfare officials in 19 states and county juvenile justice officials in 30 counties ... estimated that in fiscal year 2001 parents in their jurisdictions placed over 12,700 children—mostly adolescent males—into the child welfare or juvenile justice systems so that these children could receive mental health services." U.S. GEN. ACCT. OFFICE, GAO-03-397, \textit{CHILD WELFARE AND JUVENILE JUSTICE: FEDERAL AGENCIES COULD PLAY A STRONGER ROLE IN HELPING STATES REDUCE THE NUMBER OF CHILDREN PLACED SOLELY TO OBTAIN MENTAL HEALTH SERVICES} 4 (2003), \textit{available at} http://www.gao.gov/new/items/d03397.pdf [hereinafter GAO, 2003]. The GAO asserted that these numbers were likely to be an underestimate of the scope of the problem because officials in several states ("including officials of 5 states with the largest populations of children") did not respond to the GAO survey. \textit{Id}.

5. \textit{See Nowhere to Turn: Must Parents Relinquish Custody in Order to Secure Mental Health Services for Their Children?: Hearings Before the Senate Comm. on Governmental Affairs, 108th Cong. (2003).}

6. \textit{SPECIAL INVESTIGATIONS DIV., MINORITY STAFF OF HOUSE COMM. ON GOV'T REFORM, 108TH CONG., \textit{INCARCERATION OF YOUTH WHO ARE WAITING FOR COMMUNITY MENTAL HEALTH SERVICES IN THE UNITED STATES II} (Comm. Print 2004) [hereinafter INCARCERATION OF YOUTH].} Specifically, the investigation surveyed administrators of juvenile detention centers and asked them to identify the numbers of youth incarcerated in their facilities with "mental illness," "who do not need to be in detention," who are waiting for community-based mental health services, and who can leave "detention ... as soon as appropriate treatment services become available." \textit{Id} at 3. The...
There are many other signs that large numbers of families have been unable to access mental health care for their children and turn elsewhere when they or others in the community reach their breaking points. Many children in emotional crisis end up in hospital emergency rooms. They remain there, or are transferred to non-psychiatric medical wards, where they wait—sometimes for hours, sometimes for days—until the recommended services become available. Their appearances in these settings are sufficiently frequent that writers have coined a phrase to describe them: “boarder kids.” The stream of prospective patients in emotional crisis into emergency rooms has taken its toll on the hospitals. In July 2004, officials in Clark County, Nevada declared a state of emergency because persons (children and adults) with symptoms of mental disorders were flooding hospital emergency rooms. In response, the Governor of Nevada released $100,000 in emergency funds to divert these psychiatric patients to other treatment resources. The increase in emergency-room use by those with mental health problems is a national problem that affects significant numbers of children.

Reportedly, the wait for community-based mental health services for children is months-long. Beds in psychiatric hospitals and residential treatment centers for emotionally disturbed children are in short supply. Furthermore, many children admitted to inpatient survey included admission to a mental health treatment facility among those services for which the youth waited. Id. The limitations of the survey data are discussed in note 310 supra.


8. See infra Part IV.B.

9. See, e.g., Alice Dembner, Acutely Mentally Ill Children Face Delay of Care, Study Finds, BOSTON GLOBE, July 12, 2003, at B1; Kristen Lombardi, Boarder Patrol, WORCESTER PHOENIX, July 7-14, 2000 (on file with author); Abigail Trafford, Boarder Kids, On The Edge, WASH. POST, June 27, 2000, at Z05.


11. See infra Part IV.B.


psychiatric units or in residential treatment centers for emotionally disturbed children cannot go home—despite professional recommendations that they are ready for discharge—because of inadequate mental health services in the community. Despite all of the reported difficulties families and children have getting in and out of such facilities, rates of admission of children to inpatient and residential mental health facilities continue to “skyrocket,” revealing an exceedingly high demand for out-of-home placements for these youth. And, there is one more place where troubled and troublesome youth seem go to in large numbers: away. Hundreds of thousands of troubled youth run away from home or from foster care or are “thrown away” by their families. These statistics constitute further evidence that existing service systems are failing to address the serious problems experienced by many of today’s American families.

Yet, these signs of crisis are only the tip of the iceberg. Every year hundreds of thousands of children experience an out-of-home placement under the auspices of one of three primary child service and intervention systems (that is, the mental health, child welfare, or juvenile justice system). In fact, despite decades of policy initiatives aimed at reducing use of institutions and other out-of-home placements for troubled and troublesome youth, more per capita episodes of out-of-home placements were experienced by children in the last decade of the twentieth century than at any time since comprehensive data were first available (that is, since the 1920s).

14. ISSUE BRIEF, supra note 12, at 5.
17. See infra Part III.A.
This Article examines and challenges our legal system's conventional patterns of response to troubled and troublesome youth. At the close of this Introduction, Part II provides a brief overview of five modern child service and intervention systems: the health and mental health care systems, the child welfare system, the juvenile justice system, and the educational system. Part III introduces the population of interest—"troubled and troublesome youth"—a highly-diverse group of young persons who have been removed from their homes or who are at risk of such removal because of their own emotional difficulties, their troublesome conduct, or their parents' challenges in maintaining a safe or adequate home environment. While the term troubled emphasizes the inner emotional distress experienced by these youth, the term troublesome highlights the difficulties that their conduct creates for their families, schools, and communities. Part III examines these youth "through the lens" of each of the health, mental health, child welfare, juvenile justice, and educational systems. Despite the many legal distinctions among these systems, ranging from independent statutes authorizing state intervention to separate streams of governmental funding, neither legal policy nor practice confront the overlap in the populations of troubled and troublesome youth served. There is a core group of children whose conduct and family circumstances could satisfy the legal criteria required to trigger the intervention in multiple systems. Part III deconstructs the rigid system-specific constructions of these children, contending that these characterizations lead to exceedingly narrow and frequently inappropriate intervention approaches that do not meet the needs of troubled and troublesome youth, their families, and their communities.

Part IV reviews the various signs of crisis that further betray the inadequacy of modern American legal and social responses to troubled and troublesome youth. In response to unmet service needs, parents, advocates, and litigators have sued to compel provision of appropriate mental health services to these children. Other signs of crisis include influxes of troubled and troublesome children into emergency rooms and as boarders on medical wards, high rates of parental relinquishment of custody of children to the child welfare and juvenile justice systems, large numbers of runaway and thrownaway children, and skyrocketing rates of admission of children to mental hospitals.

Part V argues that our nation's high rates of out-of-home placements are incompatible with core traditions in American law

21. See infra Part III for further discussion of the parameters of the population of interest.
valuing parent-child relationships and family integrity, freedom from unnecessary incarceration, and integration of those who are different into the mainstream of community life. Furthermore, while the removal of troubled and troublesome youth from their homes may provide temporary containment of the immediate crises triggering intervention, there is little evidence that such removals achieve the purposes used to authorize them. In theory, the state’s *parens patriae* and socialization-oriented police power interests in promoting the welfare of our nation’s children justify its intervention in the family and its regulation of children’s lives. Part V contends that modern legal responses to troubled and troublesome youth fail in their mandates to protect these children and to promote their positive development into well adjusted and constructively contributing members of society.

Part VI examines efforts throughout the twentieth century to reform these systems, and in particular, to deinstitutionalize certain populations of children from one set of institutions or another. While the child welfare system and juvenile justice system have each been the focus of federal reforms, many assert that policymakers should now work to transform the mental health system responses to children and families.\(^{22}\) Yet, these reforms have had limited success. Unintentional, unanticipated, and undesired movements of children among systems is the hallmark of these policy reforms, as formal deinstitutionalization policies of one system lead to increased use of alternate systems’ institutions.

Part VII articulates a vision of a coordinated and responsive service system that provides effective and appropriate services to troubled and troublesome youth and their families. In their 1974 book, *Change*, Watzlawick, Weakland, and Fisch distinguish two types of change: “one that occurs within a given system which itself remains unchanged [that

is, “first-order change”], and one whose occurrence changes the system itself [that is, “second-order change.”]. 23 Therefore, as Watzlawick and colleagues point out, “[s]econd-order change is thus change of change...” 24 or, expressed differently, change in the focus of and process by which change occurs.

Clearly, our strategies for achieving change in our responses to troubled and troublesome youth are flawed; more of the same is unlikely to bring us closer to reaching our goals. Not only are these approaches inconsistent with core American legal traditions, but they often exacerbate rather than ameliorate the child’s and family’s difficulties. Furthermore, there is evidence that those policymakers responding to the current crises are recycling the ineffective solutions of the past. For example, the Nevada state legislature “approved the construction of a 150-bed psychiatric hospital in Las Vegas” to alleviate the “clogging” of emergency rooms by “mentally ill people.” 25 Along similar lines, a reporter who detailed the saga of a boarder kid in Massachusetts imagined: “In a perfect world, this young patient would be sent immediately to a psychiatric hospital . . . .” 26 Yet, pumping funds into inpatient mental health services fails to recognize that we’ve already been down that road, and the result was anything but perfect. Expanding the number of inpatient beds offers little more than a temporary quick fix, and proliferates a form of intervention with many shortcomings. 27 These responses constitute first-order change. First-order change may be a necessary first step by policymakers to relieve immediate crises, particularly when there is substantial suffering associated with delays in response. But, first-order change is no more likely to address the underlying problems creating the crises than is the metaphorical finger in the dike.

Thus, Part VII proposes a framework for legal policy reform that seeks to achieve second-order change through altering: (1) the structure

23. See WATZLAWICK ET AL., supra note 2, at 10 (emphasis added).
24. Id. at 11.
27. For a discussion of these shortcomings, see, for example, Weithorn, Skyrocketing Admissions, supra note 16, at 796-98. For a “classic” analysis of the effects of institutionalization, see ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES 4 (1961).
of the intervention systems, and (2) the nature of the interventions provided to troubled and troublesome youth and their families. This model rejects traditions of removal, confinement, and segregation of troubled and troublesome youth in favor of approaches that foster positive adaptation of children within their natural systems, such as families, schools, and communities, and are concordant with our society's valuing of family relationships, liberty, and inclusion. Ironically, as set forth in Part VII, those intervention approaches most faithful to our legal values are also those with the strongest empirical support for efficacy. Part VII proposes the development of "metasystem" capabilities that transcend current system boundaries and coordinate a state's responses to these children and families and allow access to a full range of universally available services at any point of entry. In a truly restructured system, the needs of the particular child and family would determine the components of the intervention rather than which system has first contact with the child, or which of the labels describing the child lead to payment. Thus, Part VII seeks to address the failures of past reforms by emphasizing integrated policymaking and intersystem coordination, and shifts in financial incentives that promote the articulated policy goals.

II. MODERN CHILD SERVICE AND INTERVENTION SYSTEMS THAT RESPOND TO "TROUBLED AND TROUBLESOME" YOUTH

At the beginning of the twenty-first century, five primary systems provide care and service to, or intervene in the lives of, large numbers of troubled and troublesome children in the United States: the health and

28. For examples of the social-ecological models of child development and family functioning, see URIE BRONFENBRENNER, THE ECOLOGY OF HUMAN DEVELOPMENT: EXPERIMENTS BY NATURE AND DESIGN (1979); JAMES GARBARINO, CHILDREN AND FAMILIES IN THE SOCIAL ENVIRONMENT (2d ed. 1992). These authors offer distinct and integrated ways of conceptualizing the needs of troubled and troublesome youth and their families. These perspectives have led to the development of innovative intervention approaches that effectively promote children's adaptive functioning within the systems of relevance to them (that is, family, school, and community) and that work to mobilize and strengthen children's natural support systems. For further discussion of these programs, see infra Part VII.

29. One of the meanings of the prefix "meta" is "beyond, encompassing, transcending." The prefix is used in that manner here, and the term "meta-system" [hereinafter metasystem] is used to connote a governmental entity structured so to transcend the traditional boundaries of the child service and intervention systems discussed within this Article.

30. In other words, whether a child's or family's problems become evident to the child's school, to a pediatrician, to an emergency room physician, to a mental health professional, to child protective services, to juvenile justice authorities, or to the police, the full range of appropriate services should be easily accessed.
mental health care systems, and the child welfare, juvenile justice, and educational systems. The term “system” is used loosely. While a service or intervention system ideally will reflect “a coordinated body of methods or a scheme or plan of procedure,” certain of the systems described herein might be more like “an assemblage or combination of things or parts” that share a general common mission and “form[] a complex or . . . whole,” but do not necessarily operate in coordination. These systems are comprised of various collections of professionals, facilities, agencies, and organizations operating either in the public or private sectors, most typically with some involvement in both sectors. Three of these systems—the mental health, juvenile justice, and child welfare systems—presently maintain, or in the past have maintained, various types of “institutions” providing residential services for a subset of the system’s clients. The concept of institution as used here, is further defined below.

A. The Health Care System

Critical to an understanding of the mental health system in the United States is an understanding of the health care system, because the former is often treated as a component of the latter. More often than not, however, the mental health component is like a “square peg” trying to fit into a “round hole” within a health care system that tends not to be particularly hospitable to its presence.

Modern assessments of the American health care system reveal several ironies. While the United States boasts of surpassing other countries in the advanced state of its medical technology, manpower, and resources, it fares poorly in comparison to other developed nations in its ability to deliver these services to its populace, and many

31. It is these five systems to which I refer when speaking of the five “child service and intervention systems.”
32. RANDOM HOUSE WEBSTER’S COLLEGE DICTIONARY 1308 (1997).
33. Id. The language not in quotations was supplied by this author.
34. Because of the functions that the institutions of these three systems serve, they will be referred to collectively as “child care and control institutions.”
35. See infra Part VI.B.
36. This treatment of the mental health care system as a component of the health care system has many dimensions. It is conceptual (i.e., mental health viewed as a component of health), relates to the locus of care (i.e., mental health professionals often perform their functions in health care settings) and to the characterizations of its clients (i.e., those with mental health problems are called “patients”), and the mechanisms of financing (payment for mental health services is often through the same private or public insurance programs as is payment for health services).
Americans do not receive such care. Furthermore, the American population falls below many other industrial nations on a variety of indices of health. One commentator, a member of a committee issuing a 2001 Institute of Medicine report, asserted that “[t]he American health care system offers the sophistication of a space station delivered with the efficiency of a third-world post office.” The Institute report concluded that: “Health care today harms too frequently and routinely fails to deliver its potential benefits.” It cited “strong evidence” that Americans do not reliably receive care “that meets their needs and is based on the best scientific knowledge.”

While the Institute of Medicine grounded its findings on decades of empirical research conducted in the United States by governmental agencies and independent scientists, international studies have reached similar conclusions. For example, life expectancy is lower and infant mortality rates higher in the United States than in many other industrialized nations, and yet we spend far more on health care. A year 2000 report published by the World Health Organization (“WHO”) examined the health care systems of 191 nations. Examining indices relating to the health of the nation’s population, disparities and inequities in receipt of health care services within the population, and health care system responsiveness, the report ranked the United States 37th among the other nations on an aggregate measure of “overall health system performance.” The study also revealed that the United States ranks first in per capita spending on health care, suggesting a substantial discrepancy between investment and result. Although the WHO report

40. CROSSING THE QUALITY CHASM, supra note 38, at 1.
41. Id.
44. Id. at 144, 152-55. The U.S. trailed almost all industrialized nations, including most European nations, as well as countries such as Israel (28th), Canada (30th), and Australia (32nd). Id at 152-55.
45. Id.
has been criticized by some, others suggest we view these findings as a wake-up call.\(^{46}\) This latter conclusion is reinforced by the Institute of Medicine's warning that the American health care delivery system is in need of "fundamental change."\(^{47}\) Further complicating the path to reform: health care costs have risen dramatically and health expenditures exceed the growth of our gross domestic product by greater margins every year;\(^{48}\) substantial proportions of our populace have no health insurance at least some of the time;\(^{49}\) and the market-oriented structure of the American health care system with its attendant political interests makes reform exceedingly difficult.\(^{50}\) All of these problems affect access to adequate and appropriate mental health services for children, since the health care system is a primary gatekeeper of access to mental health services in the United States today.

The modern health care system in the United States consists of two primary components that, until recently, operated relatively independently: the providers (that is, professionals, hospitals, clinics, and other organizations) and payors (that is, third-party insurers, employers, the government, and patients and their families). In recent decades, there has been some consolidation of these two components, primarily in the private sector, and most notably by Health Maintenance Organizations ("HMOs").\(^{51}\) For much of the twentieth century, however, the primary providers of medical services—physicians—enjoyed substantial decisional autonomy in the delivery of health care services, much political clout, and freedom from concerns about the costs of medical services.\(^{52}\) A network of private third-party insurers developed throughout the century, with health insurance benefit packages increasingly dispensed through employers. Private insurers, together with employers and patients, bore the costs of the services. "The


\(^{47}\) \textit{Crossing the Quality Chasm}, supra note 38, at 1.


\(^{49}\) \textit{Inst. of Med., Insuring America's Health: Principles and Recommendations} (2004) (reporting an increase in the rate of uninsured persons under the age of 65 from 29.5\% of this population to 43.3\% between the years of 1987 to 2002); Lawrence O. Gostin, \textit{Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America}, 39 \textit{St. Louis U. L.J.} 7, 18 (1994).

\(^{50}\) Gostin, \textit{supra} note 49, at 18; Pollack, \textit{supra} note 48, at 420-21.


\(^{52}\) \textit{See Kenneth R. Wing et al., The Law and American Health Care} 12-43 (1998).
result... was a uniquely American form of health service financing. Unlike virtually every other industrialized country, Americans relied predominantly on private employment-based, insurance-type financing schemes that largely divorced the financing of services from their delivery.\textsuperscript{53} Thus, the modern American health care system is not the result of coordinated and comprehensive national policymaking. Rather, it simply evolved throughout the twentieth century, shaped by a range of social, economic, and political forces. The resulting system operates to the disadvantage of many, such as those not employed, those not eligible for employer-sponsored benefits, those whose employers do not offer them health insurance benefits, and those whose insurance plans provide coverage that does not adequately meet their health care needs.

Among the economic forces influencing modern health care delivery is the rising cost of such care. This rise led many insurers to adopt cost containment measures, referred to as forms of “managed care.”\textsuperscript{54} Increasingly, for-profit corporations have acquired ownership of various segments of the health care delivery market.\textsuperscript{55} This phenomenon, together with the application of managed care principles guided by profit-making incentives, has led to practices that many claim seriously compromise patient care.\textsuperscript{56} While the future of managed care policies implemented by insurers and HMOs is unclear in light of conflicting

\textsuperscript{53.} Id. at 17.

\textsuperscript{54.} WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 517 (5th ed. 1998).

Managed care is a term that applies broadly to a wide variety of arrangements that restrict the generosity of traditional health insurance. Managed care (1) restricts choice of physicians through networks and gatekeepers, (2) alters discrete treatment decisions through utilization review and prior authorization requirements, and (3) creates cost-constrained financial incentives through capitation payments and risk-sharing pools.

\textsuperscript{55.} See PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 55-56 (2002); Arnold S. Relman, The New Medical-Industrial Complex, 303 NEW ENG. J. MED. 963, 963 (1980); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 420-49 (1982); see also INST. OF MED., supra note 49. In some cases, for-profit corporations have acquired or created facilities that provide health care services. In other cases, certain entities, particularly HMOs, have melded the provider and insurer roles.

\textsuperscript{56.} See, e.g., Thomas R. McLean & Edward P. Richards, Health Care’s “Thirty Years War”: The Origins and Dissolution of Managed Care, 60 N.Y.U. ANN. SURV. AM. L. 283, 316-28 (2004); Linda Peeno, The Second Coming of Managed Care, 40-MAY TRIAL 18, 18 (2004); Clark C. Havighurst, Consumers v. Managed Care: The New Class Actions, 20 HEALTH AFFAIRS 8, 11 (2001). For thoughtful analyses of the challenges, achievements, and future of managed care, see Clark C. Havighurst, How the Health Care Revolution Fell Short, 65 L. & CONTEMP. PROBS. 55 (2002); Clark C. Havighurst, Managed Care—Work in Progress or Stalled Experiment?, 35 HOUS. L. REV. 1385 (1999). Health care providers and patients now assert that the ethics that require practitioners to place patients’ welfare above other values have been compromised because of economic factors and the intrusion of third parties into matters previously reserved for professional judgment.
assessments, lawsuits, and prospective governmental regulation, these policies and their application by medical corporations have implications for the delivery of mental health services to children.

B. The Mental Health “System”

Of the five systems discussed here, the term “system” is perhaps least descriptive of the highly fragmented and uncoordinated array of services targeting what have been referred to as mental disorders, illnesses, or disabilities, mental health or psychological problems, emotional disturbances, social maladjustments, and so on. Many troubled and troublesome youth are, or have at one time been, viewed as falling into one of these or related categories. Complicating legal and societal responses to these children and their needs is the fact that most of the services delivered to children in this diverse group are provided under the fiscal umbrella of, or by professionals or facilities within, one of the other four systems. Despite this reality, there is typically little or no coordination or organization of these cross-system services. Thus, whatever criticisms may be lodged at the American health care system pale in comparison to those directed at the mental health system. According to the first-ever Report on Mental Health developed by the Office of the United States Surgeon General and published in 1999:

Over the past three centuries, the complex patchwork of mental health services in the United States has become so fragmented that it is referred to as the de facto mental health system . . . . Its shape has been determined by many heterogeneous factors rather than by a single guiding set of organizing principles.

Political scientist David Rochefort has gone a step farther and characterized this diverse and loosely-connected array of professionals, services, facilities, and policies as the “mental health ‘nonsystem.’” In its Final Report, in 2003, the President’s New Freedom Commission on Mental Health asserted:

57. SURGEON GENERAL’S REPORT, supra note 22, at 73-80, 179-85 (1999). Most of the financing of mental health interventions occurs through sources such as private and public health insurance and educational system budgets. Id.
58. Id. at 73 (citation omitted).
59. DAVID A. ROCHEFORT, FROM POORHOUSES TO HOMELESSNESS: POLICY ANALYSIS AND MENTAL HEALTH CARE 5 (2d ed. 1997). For purposes of efficiency, I continue to use the term “system” throughout this manuscript to refer to the myriad of organized and disorganized mental health services, professionals, and facilities, despite recognition that the word “system” is a misnomer when used in this context.
"[T]he mental health delivery system is fragmented and in disarray... leading to unnecessary and costly disability, homelessness, school failure and incarceration." The... unmet needs and barriers to care [include]:

- Fragmentation and gaps in care for children,
- Fragmentation and gaps in care for adults with serious mental illnesses,
- High unemployment and disability for people with serious mental illnesses,
- Lack of care for older adults with mental illness, and
- Lack of national priority for mental health and suicide prevention.\(^6^0\)

The Surgeon General’s Report characterized the “de facto mental health system” as having four sectors: specialty mental health, general medical/primary care, human services, and voluntary support networks.\(^6^1\) The specialty mental health sector includes services provided by those professionals who, by training or affiliation, focus their work in the field of mental health. By contrast, the medical/primary care sector provides a range of general health care services. The mental health-related expertise of its “family physicians, nurse practitioners, internists, pediatricians” and related professionals\(^6^2\) varies dramatically. Yet, a substantial proportion of mental health problems that come to professional attention first present themselves to these professionals.\(^6^3\) The human services sector includes a range of public and private professionals and agencies such as: child and social welfare, juvenile and criminal justice, and education. Finally, voluntary and consumer-oriented programs and supports provide a range of services as well. This sector has grown in the past several decades, and is comprised of advocacy groups such as the National Mental Health Association\(^6^4\) and the National Alliance for the Mentally Ill.\(^6^5\)

\(^6^0\) President’s New Freedom Comm’n on Mental Health, supra note 22, at 3 (quoting language from its Interim Report to the President).

\(^6^1\) Surgeon General’s Report, supra note 22, at 73.

\(^6^2\) Id. at 73.

\(^6^3\) For example, the proportion of adults in the United States population who receive mental health treatment from general medical professionals in a given year (5%) is only slightly below the proportion who receive such services from mental health specialists (6%). Id. at 76.

\(^6^4\) The National Mental Health Association (“NMHA”) “is the country’s oldest and largest nonprofit organization addressing all aspects of mental health and mental illness.” See Nat’l Mental Health Ass’n, More About NMHA, at http://www.nmha.org/about/index.cfm. “NMHA was established in 1909 by former psychiatric patient Clifford W. Beers” who, “[d]uring his stays in public and private institutions,... witnessed and was subjected to horrible abuse.... Beers set into motion a reform movement that took shape as the National Mental Health Association.” Id. The
For children, to a greater extent than for adults, the human service sector is involved in responding to mental health issues. Of those children in the U.S. population who receive mental health services in a given year, the largest proportion receive these services through the schools. Yet "there is a severe paucity of programs that focus on . . . . the most severely impaired group of students in the schools and those most in need of comprehensive services." Research reveals that many children processed through the child welfare and juvenile justice systems meet diagnostic criteria for mental disorders, yet most of them do not receive appropriate services.

Mental health care delivery in the United States suffers from all of the problems of the health care system discussed above, given its primary affiliation with that system. There exist dramatic inequities across society in the degree to which those who require mental health services can access and afford them. Many consumers are unable to benefit from the advances in knowledge and expertise that have occurred in the field. Complicating the mental health service delivery process even more is the degree to which mental health services rely on other service systems to provide them with a home and financing. Within each system, mental health services and mental health needs are generally given low priority. The models underlying the structure and philosophy of service provision of the other systems may work for mental health services in some instances, but not in others. Indeed, as the mental health care delivery system in the United States suffers from all of the problems of the health care system discussed above, given its primary affiliation with that system. There exist dramatic inequities across society in the degree to which those who require mental health services can access and afford them. Many consumers are unable to benefit from the advances in knowledge and expertise that have occurred in the field. Complicating the mental health service delivery process even more is the degree to which mental health services rely on other service systems to provide them with a home and financing. Within each system, mental health services and mental health needs are generally given low priority. The models underlying the structure and philosophy of service provision of the other systems may work for mental health services in some instances, but not in others.
health system seeks to find its place within the health, education, social service, and juvenile justice and criminal justice systems, it is like a square peg trying to squeeze into a round hole, rejected at every turn by the host system or those who finance that system. Third-party insurers subject mental health treatment to far more scrutiny, restrictions, and limitations than they do general health care;\(^7\) schools seek to exclude children with certain types of emotional problems from the entitlements of the Individuals with Disabilities Education Act [hereinafter IDEA];\(^7\) the child welfare system fails miserably in addressing the predictable mental health needs of foster children;\(^7\) the juvenile justice system no longer professes to offer treatment and rehabilitation to wards and is ill-equipped to deal with serious mental health conditions;\(^7\) and the criminal justice system likewise has disclaimed a rehabilitative purpose, except in certain limited circumstances.\(^7\) Only those components of the mental health system funded directly through state and federal budgets, such as the federal Substance Abuse and Mental Health Services...
Administration ("SMHSA") within the Department of Health and Human Services ("DHHS"), or a state department of mental health, seem to have their own home, but those homes have become smaller and smaller in recent years.\(^7^5\) Thus, it is fair to say that the problems encountered in the delivery of mental health services are wider and deeper than those attendant to delivery of general medical care. The splintered and haphazard nature of mental health service delivery in the United States contributes significantly to the overuse and inappropriate use of institutional interventions with troubled and troublesome youth.\(^7^6\)

C. The Child Welfare System

The juvenile court's dependency jurisdiction authorizes state intervention in families when deemed necessary to protect a child from abuse, neglect, or other forms of maltreatment perpetrated by parents, legal guardians, or others who stand in a legally recognized parent-like relationship with the child. In defining the grounds for dependency jurisdiction, state statutes must identify what types of parental conduct, living situations, or harm experienced by a child constitute maltreatment. These determinations are necessarily \textit{policy} decisions infused with social values as to what constitutes adequate parenting.\(^7^7\) Because maltreatment statutes authorize state intervention in the family, the statutes and the courts that interpret and apply them must delicately balance parental rights to discretion in childrearing\(^7^8\) with the state's \textit{pares patriae} interests in protecting children from harm and its police power interests in promoting the constructive socialization of children.\(^7^9\) The modern child welfare system reflects current social ambivalence about state

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76. See infra Part III.B.5.


79. For an analysis of these state interests, see infra Part V.B.
intervention in the family.\textsuperscript{80} The system is criticized for casting its net too broadly and for overreaching in children’s and families’ lives, and at the same time for failure to adequately protect children.\textsuperscript{81} Critics also cite child welfare workers’ misunderstandings of, and disrespect for, the cultural traditions of non-white segments of the population, and for bias against racial and ethnic minorities and those in poverty.\textsuperscript{82} Furthermore, there is no clear evidence that the child welfare system’s interventions, even under the best of circumstances, are effective in remediating those circumstances leading to its involvement, in keeping children safe, or in promoting children’s short- and long-term social and emotional well-being.\textsuperscript{83} Furthermore, evidence exists that out-of-home placements

\textsuperscript{80} See Weithorn, Protecting Children, supra note 77, at 53-60 (discussing the modern child welfare system).

\textsuperscript{81} See, e.g., DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189 (1989).

\textsuperscript{82} During hearings in the 1970s, Congress considered data indicating “that 25 to 35% of all Indian children had been separated from their families and placed in adoptive families, foster care, or institutions,” as a result of the intervention of state child welfare authorities. See Mississippi Band of Choctaw Indians v. Holyfield, 490 U.S. 30, 32 (1989) (citing Problems That American Indian Families Face in Raising Their Children and How These Problems are Affected by Federal Action or Inaction. Hearings Before the Senate Subcomm. on Indian Affairs of the Comm. on Interior and Insular Affairs, 99th Cong. (1974) (statement of William Byler)). Furthermore, the evidence revealed that the “adoption rate of Indian children was eight times that of non-Indian children. Approximately 90% of the Indian placements were in non-Indian homes.” Id. at 33. Congress enacted the Indian Child Welfare Act in 1978, 25 U.S.C. §§ 1901-1963 (2000), in an attempt to shield Indian parents from the intervention of child protection workers who are unfamiliar with Indian culture and childrearing traditions. Id. at 34-35. The statute’s goal was to promote tribal sovereignty in decisionmaking over the welfare of Indian children. Id.

\textsuperscript{83} Unfortunately, a century of child welfare intervention has been accompanied by very little outcome research. Existing studies are plagued by methodological problems. Useful research must be clear in specifying the intervention evaluated in a manner that allows others to replicate the intervention outside of the experimental setting. Other methodological limitations include a failure to use measures that are related to the initial purpose of state intervention. Thus, for example, while parental reports of satisfaction with the intervention provide one type of information, it must be supplemented by outcome measures that are more closely tied with the reason for state intervention, such as whether the child was re-abused within a six-month period after return to her parents. Good research also employs control groups comparable to the treatment group on important variables and examines the changes over time in one group relative to the other. Much child welfare research fails to provide such generalizable and criterion-relevant data that incorporate use of control groups. For a discussion of the challenges in assessing the efficacy of child protection interventions, see Michael S. Wald et al., Protecting Abused and Neglected Children 181-200 (1988); Geraldine Macdonald, Effective Interventions for Child Abuse and Neglect: An Evidence-Based Approach to Planning and Evaluating Interventions 19-24 (2001).

Many experts have bemoaned the lack of good child welfare research, and most remain unconvinced that conventional forms of intervention by child protective services make a difference in the lives of children and families, or that one approach used by child protection agencies is superior to another. See, e.g., U.S. Advisory Bd. on Child Abuse & Neglect, U.S. Dep’t of Health & Human Servs., Child Abuse and Neglect: Critical First Steps in Response to a National Emergency xii-xv (1999); Gary B. Melton et al., Empirical Research on Child Maltreatment and the Law, 24 J. Clinical Child Psychol. 47 (1995); Ross A. Thompson & Brian
expose children to further risk of maltreatment by staff or other residents. 84

The earliest incarnations of the child welfare system led to the removal of large numbers of children from their homes, and the placement of most of those children in institutional settings. 85 Today, it is far more likely that a child who is removed from her home will be placed in a foster home than in an institution or other residential facility, 86 although older minors, and those who cross system boundaries (that is, those exhibiting conduct consistent with that of juvenile offenders or the symptoms of serious emotional difficulties) are more likely to be placed in facilities rather than foster homes.

While significant attention has been paid to the coercive intervention of the state in families under the authority of child welfare statutes, there has been little emphasis on those families who avail themselves of the services of their states' dependency systems "voluntarily." I use the term "voluntarily" gingerly. While some parents may sign "voluntary placement agreements" and temporarily surrender custody of their children to the child welfare system, they often do so with the threat that dependency proceedings against them will be commenced if they do not so agree. 87 Recent evidence suggests that others may relinquish custody solely to access otherwise unaffordable mental health services for their children. 88 National statistics as to the


85. See infra notes 622-32 and accompanying text.

86. See infra notes 633-46 and accompanying text.

87. See, e.g., Dorothy E. Roberts, Kinship Care and the Price of State Support for Children, 76 CHI.-KENT L. REV. 1619, 1629-31 (2001) [hereinafter Roberts, Kinship Care]; Amy Sinden, "Why Won't Mom Cooperate?": A Critique of Informality in Child Welfare Proceedings, 11 YALE J.L. & FEMINISM 339, 345 & nn.24-25 (1999); Katherine C. Pearson, Cooperate or We'll Take Your Child: The Parents' Fictional Voluntary Separation Decision and a Proposal for Change, 65 TENN. L. REV. 835 (1998); Robert H. Mnookin, Foster Care—In Whose Best Interest? 43 HARV. EDUC. REV. 599, 601 (1973) (stating that "[i]f one were to use the legal standards of voluntariness and informed consent applied in the criminal law to confessions and to the waiver of important legal rights, many cases of relinquishment . . .might not be considered voluntary.").

88. See GAO, 2003, supra note 4; BAZELON CENTER FOR MENTAL HEALTH LAW, RELINQUISHING CUSTODY: THE TRAGIC RESULT OF FAILURE TO MEET CHILDREN'S MENTAL HEALTH NEEDS (2000); see infra notes 307-08.
The proportion of cases initiated “voluntarily” are not available, and there appears to be substantial variability from state to state. 89

D. The Juvenile Justice System

The modern juvenile justice system has broad discretionary latitude to intervene in the lives of minors who violate criminal statutes (i.e., “delinquents”) or who commit any of a series of infractions collectively referred to as “status offenses.” The range and variety of criminal offenses is great, encompassing misdemeanors and less serious felonies as well as serious or violent felonies. Many cases are handled informally by police 90 or diverted from the court system, 91 while others are formally processed, leading to a dismissal of charges or an adjudication of delinquency.

A juvenile adjudicated as delinquent is subject to a wide range of dispositions, such as probation, suspended sentence, referral or commitment to a mental health or substance abuse program, payment of fines or restitution, commitment to a juvenile correctional facility, or participation in any of the many innovative programs in existence in various locations. 92 Increasingly, however, minors alleged to have

89. Studies conducted in the late 1960s and early 1970s in California and New York City found that approximately 50% and 58% of children in foster care in those respective jurisdictions followed voluntary placement agreements. Mnookin, supra note 87, at 601. National data on the proportion of cases that are grounded in “voluntary” versus coercive removals are not collected routinely. See, e.g., ADMIN. FOR CHILD. & FAMILIES, U.S. DEP’T OF HEALTH AND HUMAN SERVS., CHILD WELFARE OUTCOMES 2000: ANNUAL REPORT (failing to include this as a variable tracked in an over 300-page report of national data on child welfare placements and outcomes).

90. For example, one 1999 study indicates that police will typically use informal means (e.g., advising, commanding, threatening) in encounters with juveniles, arresting in only a small percentage (13.1%) of cases. NAT’L RES. COUNCIL & INST. OF MED., JUVENILE CRIME: JUVENILE JUSTICE 163-64 (2001) (hereinafter NRC, JUVENILE JUSTICE).

91. In the case of first-time and non-violent offenders, law enforcement and prosecutorial personnel may refer the youth to any of a range of community-based programs offering alternative services. Albert R. Roberts, The Emergence and Proliferation of Juvenile Diversion Programs, in JUVENILE JUSTICE SOURCEBOOK: PAST, PRESENT, AND FUTURE 183, 184 (Albert R. Roberts ed., 2004); Franklin E. Zimring, The Common Thread: Diversion in the Jurisprudence of Juvenile Courts, in A CENTURY OF JUVENILE JUSTICE, supra note 20, at 142. These programs represent a type of early intervention, with the goal of interrupting law-violating conduct without the stigmatizing effects of the delinquency label or the deleterious concomitants of incarceration. Diversion programs vary widely, and only some have been subjected to rigorous scientific evaluations of efficacy. Some, however, have demonstrated positive effects, such as reductions in future arrests. For a summary of outcome research, see NRC, JUVENILE JUSTICE, at 169-76. Some of these programs will be discussed in greater detail within. See infra note 696 and accompanying text.

violated criminal statutes are processed as adults in criminal court rather than in the juvenile justice system. These changes reflect the "get tough" attitude toward juvenile offenders that has become more prevalent in the last two decades.

The juvenile court also handles status offense cases. Status offenses are a family of noncriminal infractions so named because the acts that underlie them would not be considered offenses but for the perpetrator's minority status. State statutes vary somewhat in their definitions of the acts or patterns of conduct that fall within this category. Status offenders may include those minors determined to be "beyond the control" of parents or guardians as well as those who violate a curfew established by the city or county, are habitually truant, run away from home, or otherwise appear to be "incorrigible" by certain definitional criteria, which may be quite vague. The single largest category of violations


94. For a discussion of this "get tough" philosophy, see BARRY C. FELD, BAD KIDS: RACE AND THE TRANSFORMATION OF THE JUVENILE COURT 189-244 (1999).

95. See generally Lee Teitelbaum, Status Offenses and Status Offenders, in A CENTURY OF JUVENILE JUSTICE, supra note 20, at 158. Status offenders are sometimes referred to by state statutes as "persons in need of supervision" ("PINS"), or "children in need of supervision" ("CHINS"). See, e.g., NEV. REV. ST. § 62B.320 (2004); 10 OKLA. STAT. ANN. § 7301-1.3(6) (2004). For a more extensive discussion of the juvenile court's jurisdiction over status offenders, see infra Part III.B.3.

96. See, e.g., CAL. WELF. & INST. CODE § 601(a) (2004) (also referring to this category of minors as habitually disobedient); ARIZ. REV. STAT. ANN. § 8-201(15)(a) (2004); FLA. STAT. ANN. § 984.03(9)(c) (2005) ("To have persistently disobeyed the reasonable and lawful demands of the child's parents or legal custodians, and to be beyond their control despite efforts by the child's parents or legal custodians and appropriate agencies to remedy the conditions contributing to the behavior.").


98. See, e.g., CAL. WELF. & INST. CODE § 601(b) (2004) (defining habitual truancy as "four or more truancies within one school year" or per the determination of a "school attendance review board or probation officer"); ARIZ. REV. STAT. ANN. § 8-201(15)(b) (2004).

99. ARIZ. REV. STAT. ANN. § 8-201(15)(c) (2004); FLA. ST. ANN. § 984.03(9)(a) (2005) ("[t]o have persistently run away from the child's parents or legal custodians").

100. See, e.g., ARIZ. REV. STAT. ANN. § 8-201(15)(d) (2004) (offering as one alternative definition of an "incorrigible child" one who "[h]abitually behaves in such a manner as to injure or endanger the morals or health of self or others." Status offenders may also be those minors who engage in underage drinking, or use of drugs. HOWARD N. SNYDER & MELISSA SICKMUND, OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, U.S. DEP'T OF JUSTICE, JUVENILE OFFENDERS
bringing status offenders before the court is illegal use of alcohol and drugs by persons under the age of 21, even though those statutes authorizing juvenile court jurisdiction over status offenders typically do not address minors' use of such substances.\textsuperscript{101}

From its inception in 1899, the juvenile court defined its mission as benevolent, grounded in the state's \textit{parens patriae} authority to assist those "wayward" children whose own parents, for whatever reason, had been unable to keep them out of trouble or provide adequate care.\textsuperscript{102} It espoused a "treatment" or rehabilitative philosophy, emphasizing the needs of the individual child rather than the circumstances or acts that triggered the court's intervention.\textsuperscript{103} Indeed, at its founding, the juvenile court perceived its role as that of a sort of a "superparent."\textsuperscript{104} Consistent with that "child-saving" mandate, intervention in the lives of minors who had not committed crimes—status offenders—made sense to the extent that it gave the court the opportunity to support parental authority and victims: 1999 national report 207 (1999). For general discussion of the juvenile court's status offender jurisdiction, its history and evolution, see Feld, supra note 94, at 166-88; Teitelbaum, supra note 95, at 158-75.

\textsuperscript{101} Snyder & Sickmund, supra note 100, at 166. For example, in 1996, juvenile courts in the United States formally processed 162,000 status offense cases. Of those, 27.7% were grounded in violations of liquor laws, 24.3% were truancy cases, 15.9% were runaway cases, 12.4% were cases of unmanageability (i.e., beyond parental control/habitual disobedience). The remaining percentage included the residual categories, such as "curfew violations, smoking tobacco and violation of a valid court order." Id. This finding is consistent with other data indicating that a substantial proportion of juveniles in juvenile correctional facilities meet the DSM-IV criteria for a substance use disorder. See, e.g., Gail A. Wasserman et al., Assessing the Mental Health Status of Youth in Juvenile Justice Settings, OJJDP Juvenile Justice Bull., Aug. 2004, at 3-4, available at http://www.ncjrs.org/pdffiles1/ojjdp/202713.pdf. In addition, many of these individuals are diagnosed with co-occurring mental health disorders, a phenomenon that is not limited to those individuals who come in contact with the justice systems. Id. at 3-4; see, e.g., Nat'l Mental Health Ass'n, Fact Sheet: Substance Abuse—Dual Diagnosis, available at http://www.nmha.org/infoctr/factsheets/03.cfm (noting that "[t]hirty-seven percent of alcohol abusers and fifty-three percent of drug abusers also have at least one serious mental illness" and that "[o]f all people diagnosed as mentally ill, 29 percent abuse either alcohol or drugs.").


\textsuperscript{104} LaMar T. Empey, Introduction: The Social Construction of Childhood and Juvenile Justice, in The Future of Childhood and Juvenile Justice 1, 1-34 (LaMar T. Empey ed., 1979); Mack, supra note 102, at 107.
or to substitute itself for parents perceived to ineffective in controlling their children, particularly where it was believed that failure to do so would lead to an escalation of the minor’s norm-violating conduct. As such, the basis for juvenile court intervention in the case of status offenders straddles delinquency and dependency jurisdiction. While the court’s dependency jurisdiction is grounded in state disapproval of parental conduct, and its delinquency jurisdiction is grounded in the minor’s violation of a criminal statute, status offense jurisdiction combines censure of the minors’ misbehavior with the implication of parental inefficacy that accompanies the court’s involvement. Not surprisingly, the lines dividing the three categories of juvenile court jurisdiction can, at times, become blurred. Thus, at various points in the history of the twentieth century juvenile court, minors falling into any of these three general categories could be treated similarly and/or housed together in system facilities.

The juvenile justice system has been the focus of substantial criticism over the years. Many commentators challenged the unbridled discretion of the court and the notion that the alleged parens patriae mission renders traditional due process protections unnecessary. Ultimately, in a series of landmark cases beginning in 1967, the U.S. Supreme Court extended a range of constitutional protections to defendants in juvenile court, a trend referred to by some as the “criminalization” or constitutionalization of the juvenile justice system. Critics have also claimed that the juvenile justice system fails to effect positive changes in the conduct or welfare of the minors with whom it intervenes. Thus, for example, studies have failed to demonstrate that incarceration in juvenile justice facilities has positive effects on offender recidivism. Rather, observers express concern that

105. Teitelbaum, supra note 95, at 162.
106. Some states reconceptualized some status offenses, most typically “incorrigibility,” which is sometimes defined as being “beyond parental control,” as subcategory of neglect, thus removing these minors from classification as offenders, labeling them instead as dependent. JOHN R. SUTTON, STUBBORN CHILDREN: CONTROLLING DELINQUENCY IN THE UNITED STATES, 1640-1981, at 216-17 (1988).
107. LERMAN, DEINSTITUTIONALIZATION, supra note 20, at 112-14.
108. For a summary and discussion of these critiques, see FELD, supra note 94, at 79-108.
109. See infra notes 443-46 and accompanying text.
time spent in juvenile correctional facilities only worsens juvenile offenders' prospects for adaptive functioning after release because it "leads to exposure to and victimization by older serious delinquent offenders and further fuels criminogenic propensities in child delinquents." Part VII below discusses findings of the efficacy of innovative alternative interventions.

E. The Educational System

The service and intervention system that clearly reaches more children than any other is the educational system. The components of this network of public (federally-, state-, and locally-financed) and private facilities have in common their general mission to educate (i.e., impart knowledge, develop skills, offer instruction to) our nation's youth in order to prepare these individuals for meaningful and productive participation as adults. Because all states in the nation mandate that children attend school beginning at ages five to seven through ages sixteen to eighteen, this system has the potential to touch the lives of most American children. Thus, many advocate for expansion of school-based health and mental health services so as to have the greatest likelihood of reaching more of those who need such services.

Because of a series of federal enactments culminating with the Individuals with Disabilities Education Act ("IDEA"), public schools are obligated to provide services to children with disabilities. IDEA defines "disabilities" broadly enough to include a range of emotional and learning problems experienced by many troubled and troublesome children, although critics argue that the definitions exclude a substantial proportion of children who could benefit from mental health services.


111. LOEBER & FARRINGTON, supra note 110, at xxvii.

112. See infra Part VII.

113. For an analysis of the state's and students' interests in obtaining a formal education, see Wisconsin v. Yoder, 406 U.S. 205 (1972).


116. See infra notes 218-22 and accompanying text for a discussion of the Individuals with Disabilities Education Act ("IDEA") and its relevant provisions.
delivered under the auspices of the school system. These statutes and their application to the needs of troubled and troublesome youth and their families is examined below.117

III. DECONSTRUCTING SYSTEM-SPECIFIC CHARACTERIZATIONS OF TROUBLED AND TROUBLING YOUTH

Teenagers can be difficult for adults to understand in the best circumstances.... 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.... 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.118

A. Who Are “Troubled and Troublesome” Youth?

In this Article, I refer generically to the young persons that are the focus of my discussions as “troubled” or “troublesome.” These terms direct attention to two different and potentially salient dimensions of these children’s experiences or conduct: “troubled” emphasizes the inner emotional distress experienced by these youth; “troublesome” highlights the difficulties that their conduct creates for their families, schools, and communities.119 Some of these children may appear more troubled than troublesome (for example, young persons who report being depressed or anxious), while others may appear to be more troublesome than troubled (for example, those who are truant, disobey their parents, and stay out later than permitted). The use of lay terms to describe these youth at this juncture is intentional. The distinct system-specific nomenclatures typically employed to describe these children obscure the substantial overlap among the children who fall within these systems’

117. See infra notes 218-40 and accompanying text.
119. One could also refer to these youngsters as “troubling,” in that their distress or conduct often disturbs, worries, or perhaps even alarms their families and those in their communities. Other authors have used these terms or variations on them to refer to the children who are the focus of this Article, or some subgroup thereof. See, e.g., HOME-BASED SERVICES FOR TROUBLED CHILDREN (Ira M. Schwartz & Philip AuClaire eds., 1995); CHERYL L. MAXSON & MALCOLM W. KLEIN, RESPONDING TO TROUBLED YOUTH (1997); UNDERSTANDING TROUBLED AND TROUBLING YOUTH (Peter E. Leone ed., 1990); Paul Lerman, Counting Youth in Trouble in Institutions: Bringing the United States Up to Date, 37 CRIME & DELINQ. 465 (1991).
mandates. Many of the youth served by one system satisfy the legal criteria required to trigger the intervention of the others. This point is critical, because key failures in public policies result from the lack of coordination among these systems and the fragmented nature of the resulting service delivery picture.

There have been continual increases in the use of institutional or other out-of-home placements for troubled and troublesome youth in America over this century, despite certain formal deinstitutionalization policies. Because this Article seeks to understand the phenomena contributing to this preference and to propose alternatives to it, of greatest interest are those troubled and troublesome youth who are: (1) at risk for institutionalization or out-of-home placement, and (2) appropriate candidates for community-based alternatives.

The first criterion focuses on children whose emotional distress, behavior problems, norm-violating behavior, or family difficulties place them at risk for institutional or other out-of-home placement. I am excluding from my working definition youth whose difficulties do not rise to a level that would trigger an out-of-home placement. There is no question that the line between the included and excluded according to this criterion is somewhat blurry, since many factors other than the child's own emotional experiences and conduct affect whether that child is at risk for an out-of-home placement. That blurriness, however, is not of concern here, because I do not propose that my criteria of inclusion and exclusion take on any formal legal significance. They simply highlight the characteristics of the population for which the analyses and conclusions set forth in this Article are most relevant.

As used here, the terms "troubled and troublesome youth" include only those youth appropriate for community-based alternatives. Specifically, the terms do not include juveniles who have engaged in serious criminal offenses, such as homicide, aggravated assault, rape, robbery, carjacking, kidnapping, and other serious felonies or attempts thereof. The term "troublesome" is a wholly inappropriate descriptor for conduct that causes, or risks causing, substantial harm to others, in that it connotes behavior that is burdensome or bothersome, but not highly

120. The term institution is defined infra Part VI.B and includes admissions to hospitals or residential treatment centers for the purpose of receiving intensive mental health treatment, residency in a juvenile detention or correctional facility or other residential options used by juvenile justice authorities, placement in child welfare or foster care institutions or other group settings. Out-of-home placements include institutional placements as well as placements in foster homes. Implicit in the use of the term "at risk for" out-of-home placement is the inclusion of children who have already been placed outside of their home under the auspices of one of the service and intervention systems discussed in this Article.
dangerous. Identification of precisely which crimes should fall within the category of "serious" will not be resolved here; I am merely sketching the general parameters that define our group of interest. This exclusion is important, however, because it relates to the underlying legal basis for the child's removal from the home and community. My focus here is on youth for whom state intervention is justified primarily on *parens patriae* or "socialization-oriented" police power grounds, not those whose incarceration is grounded in "public safety-oriented" police power grounds. In other words, the basis for removal from the home and community for troubled and troublesome youth is either the promotion of the youth's own welfare for his or her own sake or the promotion of the youth's welfare for the sake of society-at-large, which has an interest in fostering "the healthy, well-rounded growth of young people into full maturity as citizens . . ." Recognizing that *parens patriae* and police power goals typically converge in the legal regulation of children and families, I define my target group as those for whom the cited purposes serve as the primary—even if not sole—justifications for state intervention. Thus, this group includes nonoffenders, status offenders, and offenders committing "minor" criminal offenses.

**B. Viewing Troubled and Troublesome Youth Through the Lenses of the Mental Health/Health Care, Child Welfare, Juvenile Justice, and Educational Systems**

The title of a 1986 Florida study—"Mad, Bad, Sad, Can't Add"—alludes to the overlap in populations of youth served by the mental health, child welfare, juvenile justice, and educational systems. 

121. For further discussion of this distinction in police power justifications for minors' incarceration, see discussion in *infra* Part V.B. Generally, however, once a juvenile commits a serious offense threatening public safety, decisions about the individual's sentence are influenced primarily by the factors presently guiding punishment in our criminal justice system: the need to protect the public through incapacitation of offenders; the potential deterrent effects of certain sanctions; the community's desire for retribution; and the goal of educating the public as to the parameters of law-abiding conduct through denunciation of the criminal violations. See KATE E. BLOCH & KEVIN C. MCMUNIGAL, CRIMINAL LAW: A CONTEMPORARY APPROACH (2005).


123. I do not place the dividing line for inclusion versus exclusion between felonies and misdemeanors. Some felonies (such as those related to substance abuse, larceny committed in nonviolent circumstances) are likely to be more appropriate for *parens patriae* or socialization-oriented police power intervention than punitive criminal intervention. A more nuanced case-by-case determination which considers the circumstances of the criminal conduct is more useful than bright lines. Juvenile offenders committing many minor offenses still evoke the juvenile justice system's traditional rehabilitation orientation. Furthermore, while the line between minors' commission of non-serious and serious offenses may be blurry at times, research reveals that the lines between status offenders and delinquents who commit minor criminal offenses is even blurrier. See *supra* Part III.A.
health, juvenile justice, child welfare, and educational systems. According to certain strands of sociological thought, the use of different labels to describe identical or similar aspects of human functioning or interaction merely reflect alternative social constructions. Thus, the "same" behavior manifested in different circumstances can be defined in various ways depending upon the system of classification applied by the particular group. These categories are not constant but change according to the dominant modes of thinking. In other words, depending upon the "system of classification applied by the particular group" doing the labeling, troubled and troublesome youth might be viewed in any of several different ways. Lay persons as well as professionals within the major service and intervention systems may view the same troubled and troublesome behavior of a young person in very different ways.

The use of one set of labels or another may serve a range of purposes. At a very basic level, the labels help us organize and give meaning to our observations. As human beings, we are always trying to make sense of our world, and conceptual frameworks assist in this process. According to sociologists, deviance designations also serve important social goals, such as maintaining social control, enabling


126. ALLAN V. HORWITZ, CREATING MENTAL ILLNESS 7-8 (2002) (interpreting the work of sociologists such as Emile Durkheim and Michel Foucault).

127. Id. at 7.

128. For example, the conduct of a hypothetical 15 year-old boy who tries to shoot a live bird with a B.B. gun in his backyard in a residential neighborhood may be viewed differently by several sets of hypothetical parents and/or neighbors. Such behavior might be viewed as: (1) a manifestation of immaturity and poor judgment—but sufficiently within the scope of normal adolescent mistakes to be addressed solely through parental discipline and guidance; (2) a symptom of a mental disorder requiring a formal mental health evaluation; (3) dangerous law-breaking conduct necessitating a call to the police; or (4) a healthy emulation of adult role modeling in a family where the father's hobby is duck-hunting (although the parents may point out to the child that a residential neighborhood is an inappropriate locale for such conduct because of the presence of other people and beloved pets).

129. That is, they provide one "means by which society secures adherence to social norms; specifically, how it minimizes, eliminates, or normalizes deviant behavior." CONRAD & SCHNEIDER, supra note 125, at 7. While informal social control mechanisms operate in a variety of contexts such as ordinary interpersonal interactions (for example, someone who is talking loudly on a cell phone
particular groups or individuals to enhance their status and authority in society, or promoting certain social attitudes and values which may change over time. Deviance designations may be influenced by a range of interrelated legal and economic factors, with alternate constructions used by policymakers or professionals to create eligibility or exclusion from certain services, or to authorize the use of particular social or legal interventions. Or, governmental entities may prefer deviance designations that shift the cost of providing services to others (for example, other individuals, groups, agencies, branches of government, or levels of government).

Regardless of the labels used for troubled and troublesome youth, however, their involvement with one child service and intervention system or another typically signals that someone—whether it is the

in a restaurant may receive a series of disapproving looks from other patrons and may be asked by a restaurant employee or another customer to speak more quietly), formal social control mechanisms operate at a societal level “to secure adherence to a particular set of values and norms.” Id. at 8. “[T]he criminal justice system, with the police, courts, correctional facilities . . . [function as] the major institution of social control. Other institutions such as education, welfare, the mass media, and medicine are also frequently depicted as having social control functions.” Id.

130. Id. at 21. For example, social adoption of the construction of troubled and troublesome youth as “mentally ill” empowers medical professionals: hospitals are created and funded; mental health professionals are authorized to make critical decisions about who receives what types of interventions; psychiatrists are granted substantial influence over decisions about who will be deprived of liberty through involuntary admission to hospitals. “Medicalization” of deviance in this instance, according to Conrad and Schneider’s perspective, allows the psychiatric profession to benefit through prestige, political power, and opportunities for financial gain. Id. at 8-9, 28-37.

131. Deviance designations may, therefore, have “symbolic” implications for society. Gusfield, supra note 125, at 179; JOSEPH R. GUSFIELD, SYMBOLIC CRUSADE: STATUS POLITICS AND THE AMERICAN TEMPERANCE MOVEMENT 180-88 (2d ed. 1986). The dominance of certain humanitarian values, such as benevolent care for those who are “ill” may encourage the “medicalization” of deviance. CONRAD & SCHNEIDER, supra note 125, at 1-16.

132. Changes in social attitudes often lead to shifts in deviance designations. Homosexuality, once viewed as a mental disorder by the American Psychiatric Association, is no longer categorized as such because political opposition to that classification, combined with growing social tolerance of differences in sexual orientation, overpowered the efforts of those who would have preferred that deviance designation to remain unchanged. See, e.g., MARK TAUSIG ET AL., A SOCIOLOGY OF MENTAL ILLNESS 144 (2d ed. 2004). Other types of conduct, once viewed primarily as moral failings, such as “excessive” use of alcohol are now treated primarily as products of mental disease (i.e., alcoholism) or as heinous criminal conduct if occurring while engaged in driving an automobile. See, e.g., JOSEPH R. GUSFIELD, THE CULTURE OF PUBLIC PROBLEMS: DRINKING-DRIVING AND THE SYMBOLIC ORDER (1981).

133. For example, federal aid may serve as a “carrot” to induce state implementation of policies requiring adoption of particular deviance designations. Statutes that tighten or loosen substantive criteria or that inject or reduce procedural requirements necessary for the application of the labels may promote a shift in constructions that enables those applying the law to find a way to avoid the results intended by the policy changes. See, e.g., infra Part VII.

child, her family, or others—perceives a problem and/or is suffering. Thus, the existence of a problem is real.\footnote{135} To the extent that the labels assigned direct us to an appropriate\footnote{136} response to the problem, they are of use. To the extent that they do not, new conceptualizations are needed.

The following is an excerpt from a \textit{Washington Post} story about a particular troubled and troublesome child. No name is provided for him in the article, so I will supply one:

["Donny"] is 9 years old and mentally ill. He suffers from attention deficit disorder, post-traumatic stress disorder (PTSD) and depression [resulting from years of child abuse], a sorry cocktail of problems that afflict some young people. He acts out, getting into fights at school, and one day he threatens the life of another student. The school puts him in an ambulance and sends him to the emergency room at Boston Medical Center. There he is evaluated by a psychiatric team that recommends immediate hospitalization in a psychiatric facility.\footnote{137}

Below, I examine how professionals in the various child service and intervention systems (mental health, juvenile justice, child welfare, and education) might view troubled and troublesome youth in general, and "Donny" in particular.

1. The Mental Health/Health Care "Systems"

The "medical model" has become dominant in the Western conceptualization of psychological problems. It has been widely employed for the purpose of most formal legal, economic, and social determinations surrounding those now viewed as having "mental disorders." It imports standard medical terminology\footnote{138} and the medical view of the disease process\footnote{139} into formulations about psychological

\footnote{135. Despite the challenges of labeling, the emotional, physical, and financial toll on families struggling to raise the most troubled and troublesome youth, and the distress experienced by the youth themselves, can be acute. For examples of some of the scenarios experienced by these youth and their families see \textit{Nowhere to Turn: Must Parents Relinquish Custody in Order to Secure Mental Health Services for Their Children?}: Hearings Before the Senate Comm. on Governmental Affairs, 108th Cong. 12-15 (2003).}

\footnote{136. An "appropriate" response is one that maximizes effectiveness consistent with the core values discussed in Part V of this Article.}

\footnote{137. Trafford, \textit{supra} note 9, at 205.}

\footnote{138. Language used to describe physical diseases is imported, for example, etiology, diagnosis, symptoms, pathology, morbidity, prognosis, treatment.}

\footnote{139. With the view that behavioral and interpersonal problems are diseases, the "medical model" conceptualizes such problems as: having discrete and discernable etiologies; being susceptible to precise identification and differentiation (from one another and from nondisease states) through diagnosis; and, (once identified) responsive to particular treatments that have been

http://scholarlycommons.law.hofstra.edu/hlr/vol33/iss4/9
problems. According to the medical view of deviance, most problematic forms of human functioning are the result of physiologically, anatomically, or genetically based illnesses that affect the brain, thereby altering perceptions, emotions, cognitions, and/or behavior. These manifestations, called symptoms, are merely the observable evidence of the disease process.

The past decades have been rich with controversy, however, as to the "true" nature and cause of these conditions. While an in-depth review of the predominant perspectives is beyond the scope of this Article, it is worth noting that the medical model has been rejected by a few renegades within psychiatry's own ranks, and by those who adopt the sociological formulations of social constructions. Academic psychology has never fully embraced the medical model, focusing more on interactions between individuals' inherent characteristics and the

developed for diseases within those categories. George W. Albee, Emerging Concepts of Mental Illness and Models of Treatment: The Psychological Point of View, 125 AM. J. PSYCHIATRY 870, 870 (1969); Paul H. Blaney, Implications of the Medical Model and Its Alternatives, 132 AM. J. PSYCHIATRY 911, 911 (1975). The basis of the model's diagnostic system is that the observation of certain symptoms can permit one to generalize more globally about the individual's functioning. See A. Lazare, Hidden Conceptual Models in Clinical Psychiatry, 288 NEW ENG. J. MED. 345, 346 (1973). Thus, on the basis of limited information, a clinician makes "predictions" about other features of the "disease" process that have not been directly observed or reported. Joseph Zubin, Classification of the Behavior Disorders, 18 ANN. REV. PSYCHOL. 373, 373-76 (1967). Historically, there have been two schools of the medical model within psychiatry: the organic school and the psychodynamic school. The organic perspective views mental disorders as actual physical diseases with biological origins. See, e.g., Harold I. Kaplan & Benjamin J. Sadock, Neurochemistry of Behavior, in 1 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 177 (Harold I. Kaplan et al. eds., 3d ed. 1980); Harold I. Kaplan & Benjamin J. Sadock, Neuropsychology of Behavior, in 1 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, supra, at 189; John D. Rainer, Genetics and Psychiatry, in 1 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, supra, at 135. The psychodynamic school views mental disorders as having psychological causes, such as unresolved Oedipal conflicts. See, e.g., William W. Meissner, Theories of Personality and Psychopathology: Classical Psychoanalysis, in 1 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, supra, at 631. While the dynamic school does not presume a physical basis for behavioral and interpersonal problems, it does adopt the medical terminology and framework, and thus implies that psychological problems can be viewed in a manner analogous to, or metaphorically as, physical illnesses.

In recent decades, particularly in light of increasing evidence of the role biological factors play in the development of conditions such as bipolar disorder and schizophrenia, the efficacy of certain psychopharmacological agents in controlling some of these conditions, and the reluctance of managed care organizations and third-party insurers to pay for long-term psychodynamic treatment, the organic model has clearly become the predominant one in psychiatry. See, e.g., PETER TYRER & DEREK STEINBERG, MODELS FOR MENTAL DISORDER: CONCEPTUAL MODELS IN PSYCHIATRY 101-40 (3d ed. 1998).

For such an analysis, see DONALD J. KIESLER, BEYOND THE DISEASE MODEL OF MENTAL DISORDERS (1999).


See supra notes 129-34.
psychosocial environment in the development of human functioning, and often rejecting psychiatry's inclination to find pathology in certain behavior patterns.

Although many disciplinary distinctions still remain, it is fair to say that modern scholarship in both psychology and psychiatry recognizes that the nature and causes of behavioral problems not only vary from one category to the next, but also from individual to individual. Modern theoretical models take into account the interaction of a myriad of biological and social factors that may contribute to the development, manifestation, and course of what are generally referred to as emotional or behavioral problems, or mental disorders. The specialty of

143. For a helpful analysis of the differences between the "medical model" and "psychosocial model" and the disciplinary preferences of psychiatry versus psychology, see Randall C. Wyatt & Norman Livson, The Not So Great Divide? Psychologists and Psychiatrists Take Stands on the Medical and Psychosocial Models of Mental Illness, 25 PROF. PSYCHOL. RES. & PRAC. 120 (1994).

These two models not only represent divergent etiological perspectives and treatment modalities but also suggest the social roles of practitioner and patients . . . .

The medical model conceptualizes a patient's maladaptive psychological, emotional, and interpersonal experiences primarily in terms of organic, biochemical, or physiological etiology, leading its adherents to advocate biochemical or physical methods of treatment. . . . The psychosocial model, by contrast, conceptualizes emotional disturbances as primarily the consequence of social, psychological, interpersonal, cultural, and ethical conflicts.

Id. at 120.

144. One example of this divergence between psychiatry and psychology is reflected in their historical positions on the pathology versus normality of homosexuality. Stephen F. Morin & Esther D. Rothblum, Removing the Stigma: Fifteen Years of Progress, 46 AM. PSYCHOLOGIST 947 (1991). The American Psychiatric Association had classified homosexuality as a mental disorder in its Diagnostic and Statistical Manual, and only partially retreated from that position with revisions in 1973. Id. at 947. Not until 1987 was sexual orientation removed completely from the Manual. Id. In that intervening period, however, the Psychological Association actively protested psychiatry's characterization of same-sex relationships as pathological. Id.; see also AM. PSYCHOL. ASS'N, RESOLUTIONS RELATED TO LESBIAN, GAY, AND BISEXUAL ISSUES, available at http://www.apa.org/pi/reslgbc.html (last visited June 15, 2005).

145. For example, there is now substantial professional consensus that schizophrenia and bipolar disorders do have biological, perhaps even genetic, bases. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Text Rev., 4th ed. 2000) [hereinafter DSM-IV-TR]. By contrast, conditions such as posttraumatic stress disorders or adjustment disorders are, first and foremost, responses to life events and circumstances. See id. For modern perspectives on the interaction of biological and psychosocial factors in causing the manifestations of various psychological disorders, see supra note 143.

146. See DSM-IV-TR, supra note 145.

147. See generally NATURE, NURTURE & PSYCHOLOGY (Robert Plomin & Gerald E. McClearn eds., 1993). Researchers are only beginning to appreciate the complex interaction of genetics, other physiological influences, and social environment and the reciprocal influences these factors may have on one another. An interdisciplinary panel of scientists recently stated: "Human development is shaped by a dynamic and continuous interaction between biology and experience." NAT'L RES.
developmental psychopathology has contributed much to our understanding of how complex, multilayered interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations, peer and neighborhood factors, school and community factors, and the larger social-cultural context), and the specific manner in which these factors interact with and shape each other over the course of development. 148

The medical model remains dominant in the field of mental health, however, at least to the extent that access to services or their financing occurs within or via the health care system and depends upon recognition of a condition akin to an illness by the various gatekeepers (i.e., mental health professionals, managed care organizations, and public and private insurers). Thus, the official "lens" of the mental health system is this diagnostic system. 149 The most commonly-used diagnostic criteria are those set forth in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)* which has gone through multiple revisions since its first edition in 1952, and has most
recently been revised in 2000 with the title: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. The *DSM-IV-TR* defines a mental disorder as:

[A] clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).... In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual....

The use of the term "mental disorder" in this Article refers to those syndromes or patterns described in the *DSM*, since that is the generally accepted meaning of the scientific and professional literature. The *DSM* system has been the subject of criticism over the years, including its classification of child and adolescent problems.

Viewed through the lens of the *DSM*, many of the problems putting troubled and troublesome youth at risk of out-of-home placement are consistent with a formal diagnosis. And while we would expect a *DSM* diagnosis assigned to children treated in a mental health facility, children subject to intervention by the juvenile justice, criminal justice or child welfare systems are often viewed as satisfying *DSM* criteria as well. For example, some children who violate criminal statutes might be diagnosed as having a conduct disorder, and some children maltreated

150. DSM-IV-TR, *supra* note 145. The Diagnostic and Statistical Manual has been revised periodically to integrate changing perspectives and advancing knowledge.

151. *Id.* at xxxi.

152. Criticisms focus on the heavy influence of the medical model in the *DSM* and the lack of underlying theory or empirical evidence supporting the classification system. *See, e.g.*, Mary L. Malik & Larry E. Beutler, *The Emergence of Dissatisfaction with the DSM*, in *RETHINKING THE DSM: A PSYCHOLOGICAL PERSPECTIVE* 3, 5-6 (Larry E. Beutler & Mary L. Malik eds., 2002).


154. Conduct disorders are defined generally by "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated," requiring manifestation of at least three instances of behavior falling within any of the following categories: aggression to people or animals (e.g., often bullies, threatens, or intimidates others, often initiates physical fights, has used a weapon, has been physically cruel to people or animals, has stolen while confronting a victim, has forced someone into sexual activity) deliberate destruction of property; deceitfulness or theft (e.g., breaking into someone else’s property, lies to or “cons” others, steals nontrivial items without confronting the victim), or serious violations of rules (including, but
by their parents might be diagnosed as having posttraumatic stress disorder or other DSM-IV-TR mental disorders.

So, how would Donny be viewed through the lens of the mental health system? The Washington Post writer has already told us that Donny suffers from attention deficit disorder, post-traumatic stress disorder, and depression, all three of which can be found in the DSM-IV-TR. She has also concluded that Donny is “mentally ill,” most likely with the help of the psychiatrists who are seeking Donny’s hospitalization. Donny’s academic problems, aggressive conduct, and threats of violence are all likely to be viewed by mental health professionals as symptoms of Donny’s mental illness. The child abuse Donny experienced is likely to be viewed as partly responsible for his mental illness. In other words, all of the maladaptive patterns of behaviors and emotions fit neatly within traditional psychiatric formulations of psychopathology and mental disorder. Consistent with such formulations, therefore, admission to a psychiatric hospital follows logically as the intervention of choice to deal with a child such as Donny, who presents to a hospital emergency room in crisis.
And, indeed, Donny's constellation of symptoms is not that uncommon in the population of troubled and troublesome youth who end up as residents in mental health facilities. For example, Table 1 lists the "presenting problems" of persons under age 18 admitted to inpatient and residential mental health facilities during 1997.

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162. Percentages do not add up to 100% because multiple presenting problems could be coded for each child.

163. This category includes depressed mood, eating disturbance, post-traumatic stress, phobia, grief and loss, sleep problems, anxiety, and self-harm.

164. This category includes runaway, fire-setting, delinquency, abuse perpetrator, sexual aggression, and involvement with the juvenile justice system.

165. The phrase "presenting problems" generally refers to the complaints described by patients (or in the case of children, their parents and or other adults as well) as motivating the contact with the professional, agency, or institution.

166. The year 1997 is the most recent for which national admission data are available. It is useful here to discuss the categories of facilities characterized as mental health organizations for the...
here, note that, like Donny, substantial proportions of the children admitted to these two types of facilities experienced symptoms of depression, had been abused or neglected, experienced difficulties in school, and displayed signs of aggression. One might also characterize the abuse Donny suffered as evidence of family problems. Furthermore, if Donny's school had called the police rather than an ambulance when Donny got into fights at school, Donny might have been adjudicated as delinquent, as had many of the children whose presenting problems were summarized in Table 1. Thus, given the data reported in that Table, the Boston Medical Center psychiatrists responded to Donny's case in a manner that was entirely consistent with generally accepted practice in their profession.

But a more important question to ask is: What happens after Donny is admitted to a psychiatric facility and treated? It is the answer to this question that is the most disappointing and which leads us to search for alternative solutions. The psychiatric hospital may be able to stabilize Donny's symptoms by placing him on medications for his attention deficit disorder, his depression, and the anxiety that is typically a component of Post Traumatic Stress Disorder [hereinafter PTSD], and may be able to quell his aggressive conduct and threats thereof while he

purpose of reporting in Table 1. "Psychiatric inpatient settings" includes hospitals which primarily provide "24-hour inpatient care and treatment in a hospital setting to persons with mental illnesses in a hospital setting" and "may be under State, county, private for profit, or private nonprofit auspices," and also includes general hospitals with a separate psychiatric service. Appendix A: Sources and Qualifications for Data from the Survey of Mental Health Organizations, in MENTAL HEALTH, UNITED STATES, 2002, 270 app. (Ronald W. Manderscheid & Marilyn J. Henderson eds., 2004). Whereas the hospital settings, in principle, focus more on short-term intervention, residential treatment centers for emotionally disturbed children, or "RTCs," by contrast, are viewed as providing longer-term residential care. DHHS provides the following definitions that elaborate on these distinctions:

Inpatient hospitalization: Mental health treatment provided in a hospital setting 24 hours a day. Inpatient hospitalization provides: (1) short-term treatment in cases where a child is in crisis and possibly a danger to his/herself or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

Residential treatment centers: Facilities that provide treatment 24 hours a day and can usually serve more than 12 young people at a time. Children with serious emotional disturbances receive constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization . . . .


167. For the formal diagnostic definition and criteria of attention deficit disorder, see DSM-IV-TR, supra note 145, at 85-93.
is in residence. Yet, there is little empirical evidence that the psychiatric hospitalization will have a longer-term impact on his functioning.\footnote{168} Furthermore, once discharged, there will be little in the way of noninstitutional mental health service available for him, other than monthly medication checks with the psychiatrist at a local hospital clinic or community mental health center. He is unlikely to be able to function without disruption in school. As discussed below,\footnote{169} his school may determine that he is "socially maladjusted," and thus not eligible for assistance for his emotional problems under the federal statute requiring school systems to provide individualized educational and related services to children with emotional disturbances: the Individuals with Disabilities Education Act.\footnote{170} As for his living situation, he will return either to the family setting in which he was abused, to a foster home, or to a group home in the community. Immediately below, this Article explores his case through the lens of the child welfare system, a system with which he has undoubtedly had contact.

2. The Child Welfare System

The modern child welfare system is primarily concerned with children whose family situations place them at risk of physical, sexual, or emotional abuse or neglect, although most children do not come to the attention of the child welfare system until after they have experienced abuse or neglect. In theory, the system intervenes to protect these children from future maltreatment, and tries to remediate the family situation so that children can safely remain with their natural families. If the court has removed the children from their homes as part of a safety plan, child protection workers strive for reunification between the children and their families, unless the juvenile court determines that such reunification is not in the child's best interests.\footnote{171}
Formally, these children are labeled as "dependents," a reflection of
the fact that the juvenile court has supplanted the authority of the
children's parents with its own. Consistent with the findings that these
children have been or are likely to be maltreated by their caregivers, the
child welfare system views these children as victims. These children
would not be under the jurisdiction of the system but for their parents'
failure to adequately fulfill their duties to protect, nurture, and support
their minor children. Thus, the children's suffering is viewed as the
unfortunate result of their parents' failings.

Recent scholarship has revealed that a substantial proportion of
children who are under the jurisdiction of the child welfare system
emerge from these experiences with a range of cognitive, social, and
behavioral problems, meeting the criteria of various DSM diagnoses.172
Furthermore, the data presented in Table 1173 reveal that 20.3% of
children admitted to inpatient psychiatric units in 1997, and almost half
(47.2%) of children admitted to residential treatment centers for
emotionally disturbed children, had been victims of child abuse or
neglect. These statistics support the notion that there is, indeed,
substantial overlap between the populations served by these two child
service and intervention systems.

These findings of a high incidence of psychological problems in the
population of children who have experienced abuse or neglect should not
be surprising. While one of the justifications for state intervention in the


172. See, e.g., PANEL ON RES. ON CHILD ABUSE AND NEGLECT, NAT'L RES. COUNCIL,
UNDERSTANDING CHILD ABUSE AND NEGLECT 208-23 (1993); Jane Timmons-Mitchell et al., Post-
Traumatic Stress Disorder Symptoms in Child Sexual Abuse Victims and Their Mothers, 6 J. OF
CHILD SEXUAL ABUSE 1 (1997); Lisa M. Linning & Christopher A. Kearney, Post-Traumatic Stress
Disorder in Maltreated Youth: A Study of Diagnostic Comorbidity and Child Factors, 19 J. OF
INTERPERSONAL VIOLENCE 1087 (2004); Symptoms associated with PTSD have been diagnosed in
13% to 51% of children exposed to domestic violence. B.B. ROBBIE ROSSMAN ET AL., CHILDREN
AND INTERPARENTAL VIOLENCE: THE IMPACT OF EXPOSURE 37 (2000). Children who have suffered
extreme neglect in infancy or early childhood, or who have had so many changes in caregivers so as to
to "prevent formation of stable attachments" may be diagnosed with a "Reactive Attachment
Disorder." DSM-IV-TR, supra note 145, at 127-30. "The essential feature of [this disorder] is
markedly disturbed and developmentally inappropriate social relatedness in most contexts that
begins before age 5 years and is associated with grossly pathological care." Id. at 127. The
diagnostic criteria actually cite "frequent changes in foster care" as one of several alternative
circumstances that might give rise to the disorder. Specifically, "pathogenic care" can be evidenced
by: "(1) persistent disregard of the child's basic emotional needs for comfort, stimulation, and
affection;[;] (2) persistent disregard of the child's basic physical needs[; or] (3) repeated changes of
primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster
care)." Id. at 130.

173. See supra note 161, Table 1.
family through the child protection system is to protect children from the *physical* ramifications of maltreatment, another justification, albeit less commonly articulated, is the protection of these children from *psychological* harm. Assuming children survive physical abuse or neglect—that their bones heal, that they recover from malnutrition, that they do not get a sexually transmitted disease or physical wounds from sexual abuse—the long-term effects that will remain with them for the rest of their lives are primarily psychological.\(^{174}\) Children who have been maltreated and are placed out of their homes by child protection services face risks not only from the abuse or neglect they have experienced, but also from the "trauma of separation from [their] biological family..."\(^{175}\) Thus, while some out-of-home placements may protect children from exposure to additional abuse or neglect, children removed from the home "are a particularly vulnerable group because they have experienced both a disturbed family situation and separation from their natural parents."\(^{176}\)

In light of these findings, one would anticipate a close collaboration between the mental health and child welfare systems in response to the potentially deleterious psychological concomitants of the underlying family circumstances that have led to child welfare system involvement, and to address any negative effects that removal from the home, separation from parents, and/or changes in foster care placements might trigger. Yet, such collaboration is not only atypical, it is relatively rare.\(^{177}\) Unfortunately, some children under the jurisdiction of the child

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176. *Id.* at 17.

welfare system have not only bounced from one foster care placement to
another, but have been in and out of various psychiatric institutions as
well. The failure of the state to create stability for some of these children
through provision of intensive community-based services is the focus of
the case of *Rosie D. v. Swift*, class action litigation that is proceeding in
Massachusetts. Rosie’s experiences are described as follows:

Rosie D. is a thirteen year old girl who suffered sexual and physical
abuse prior to her pre-adoptive placement in 1993. Rosie experienced
at least eight temporary placements by the Department of Social
Services before she was placed with Mr. and Mrs. D, just before her
fifth birthday. When Rosie began banging her head against the wall
and pulling out her hair, Mr. and Mrs. D. desperately contacted DSS
for assistance, to no avail. Within weeks of beginning kindergarten,
they were told to remove her from school because of her aggressive
behavior. She was forced to spend hours a day in restraints. Over the
next six years, Rosie was institutionalized at numerous facilities for
extended periods of time, primarily due to the lack of appropriate
home-based services to address her serious mental health condition.

[Although Rosie’s adoptive parents wished to keep her at home, Rosie
spent substantial time in psychiatric and residential treatment
institutions because Mr. and Mrs. D.] “were unable to manage her
mental health needs without additional assistance.” [As part of a class-
action suit, her family is seeking] “intensive, around-the-clock, home-
based services” [to prevent the further deterioration of her condition
and future hospitalizations].178

Rosie is fortunate to have adoptive parents. For most troubled and
troublesome youth in the child welfare system, permanent placement
with a well-functioning family is an elusive goal. Troubled and
troublesome children typically have special needs that cannot be met by
foster parents without special training and access to appropriate
supportive services. Thus, typically, these children experience repeated
changes in placement, as each placement fails, compounding the
children’s emotional difficulties.179

178. Complaint, Rosie D. v. Swift, No. 02-1604 (D. Mass. 2001); see infra notes 254, 260 and
accompanying text for further discussion.

179. In *Braam v. Washington*, a class of foster children whose placements had been changed
three or more times brought suit against the Department of Social Services, claiming that the state
had violated their substantive due process right to be free from unreasonable risk of harm while in
state custody. The Washington Supreme Court held that the children had a substantive due process
Revisiting Donny’s case, he reportedly experienced child abuse, which led to the development of PTSD and depression. Donny therefore is likely to be (or to have been) in foster care, and may be a difficult child for ordinary foster parents to handle. He will probably be moved from one foster home to another, or from foster home to his parents and back again, and before too long, he will end up back in a mental health system facility. Most likely, he will bounce back and forth among systems—including the juvenile justice system—in the absence of services that can truly meet his needs, the needs of his family (be it natural, foster, or adoptive), his school, and the larger community. Without effective intervention, Donny is likely to evolve from a troubled and troublesome child to a troubled and troublesome adult, and he may ultimately engage in serious criminal conduct, leading to his incarceration in an adult correctional facility. This brings us to an examination of his story through the lens of the juvenile justice system.

3. The Juvenile Justice System

The personnel at Donny’s school could have called the police rather than an ambulance. After all, Donny had gotten into fights at school and threatened the life of a peer. Those actions would likely justify the juvenile court’s intervention on a finding of delinquency, grounded in right to be free from such risk of harm when in state custody, and that provision of appropriate mental health services is encompassed within the state’s obligation as custodian and caretaker. Braam v. Washington, 81 P.3d 851, 857, 859-60 (2003) (en banc). The case was remanded for further proceedings, but settled in 2004. A discussion of the settlement agreement and a link to the agreement are available at Washington State Department of Social & Health Services, Settlement Agreement Reached In Braam Lawsuit (Aug. 11, 2004), at http://www1.dshs.wa.gov/mediareleases/2004/pr04207.shtml [hereinafter Settlement Agreement Reached]. The terms of the settlement include the development and implementation of steps to better protect and guard the welfare of children in foster care, such as provision of safer and more stable foster care placements, individualized mental health assessments and treatment, and adequate training and support to foster parents and relative caregivers. See id.

180. Research reveals that a range of problems in childhood, including a history of experiencing abuse, predisposes individuals to adult dysfunctional conduct, including criminal behavior. See, e.g., CATHY S. WIDOM & MICHAEL G. MAXFIELD, NAT’L INST. OF JUST., RES. IN BRIEF, AN UPDATE ON THE “CYCLE OF VIOLENCE,” Feb. 2001, available at http://www.ncjrs.org/pdffiles1/212690.pdf; Rani A. Desi et al., Childhood Risk Factors for Criminal Justice Involvement in a Sample of Homeless People with Serious Mental Illness, 188 J. NERVOUS & MENTAL DISEASE 324 (2000); see also Michael Wald & Tia Martinez, Connected by 25: Improving the Life Chances of the Country’s Most Vulnerable Youth (2003), available at http://www.hewlett.org/Archives/Publications/connectedBy25.htm (demonstrating the relationship between various “risk factors” during adolescence—such as failure to complete high school, juvenile justice or criminal justice system involvement, child welfare system involvement, and teenage pregnancy—and adult “disconnection” from society as manifested through, for example unemployment and participation in criminal activity).
either simple assault or battery charges. And indeed, children manifesting such behaviors are referred either to the mental health system or the juvenile justice system, with factors such as race, socioeconomic status, and gender more influential in that triage process than the children's conduct and apparent needs.\textsuperscript{181}

Not surprisingly, researchers report that a relatively high proportion of juvenile offenders and residents of juvenile justice facilities meet the criteria for serious mental disorders.\textsuperscript{182} Thomas Grisso, in summarizing the empirical research base, however, observed "troublesome variability" among the mental disorder prevalence rates reported across studies of juvenile justice populations.\textsuperscript{183} He attributes this variability to several factors, including a lack of uniformity in the ways in which the researchers defined and evaluated mental disorders, and in differences among the juvenile justice samples studied.\textsuperscript{184} While future research will likely present a more meaningful picture of the psychological functioning of various subgroups of the juvenile justice population,\textsuperscript{185} there are some consistencies in the existing data base. A review of early studies found that the rates of diagnosable mental disorders among youth involved with the juvenile justice system were "considerably higher" than for same-aged youth in the general population, even when excluding "conduct disorder" diagnoses.\textsuperscript{186} In a more recent federally-funded research network, Grisso and other members of a research network have developed and are testing various instruments that will greatly improve meaningful data collection on the presence, nature, effects, and responses to interventions of mental disorders experienced by various juvenile justice populations.\textsuperscript{187}

\textsuperscript{181} See supra Part III.B.3.


\textsuperscript{183} Grisso, supra note 182, at 7.

\textsuperscript{184} Some of the sources of variability include lack of consistency in: (1) which mental disorders are included (such as whether "conduct disorders" are included, given that they are defined, in part, by the same behavior as leads to juvenile justice system involvement); (2) how mental disorders are evaluated (such as what types of instruments and general methods are used to assess the youths); and (3) what are the characteristics of the sample (such as what types of facilities are surveyed, whether the youths are in pretrial detention or have been adjudicated delinquent, and so on). Id. at 7-13.

\textsuperscript{185} Through research funded by the MacArthur Foundation, Grisso and other members of a research network have developed and are testing various instruments that will greatly improve meaningful data collection on the presence, nature, effects, and responses to interventions of mental disorders experienced by various juvenile justice populations. Id. at 27-123.

\textsuperscript{186} OTTO ET AL., supra note 182, at 11-16, 21. The studies reviewed varied with respect to the setting and sample parameters. Most studies evaluated the youth during detention (while held pre-
funded study, 1,829 youths in juvenile detention were assessed to determine the prevalence of diagnosable mental disorders during the prior six months. The study found that, even after excluding conduct disorders, 60.9% of males and 70.0% of females met diagnostic criteria for one or more psychiatric disorders. Other disorders diagnosed in fairly substantial proportions are anxiety disorders (21.3% of males; 30.8% of females); affective/mood disorders such as depression (18.7% of males; 27.6% of females); and attention deficit disorder (16.6% of males; 21.4% of females). Finally, in another very recent study which examined a juvenile justice sample within several weeks of admission to a juvenile justice facility, and focused on functioning and behavior within the prior one month, Gail Wasserman and colleagues reported that 67.2% of the sample met the criteria for at least one mental disorder. While 31.7% of the sample met the criteria for adjudication), while others evaluated youth who had already been placed in residential settings. Id. at 30-41. Because the same behaviors that lead to juvenile justice system involvement serve as the basis for a conduct disorder diagnosis, it is useful to separate out youth for whom a conduct disorder is the only diagnosable condition. The studies reviewed by Otto and colleagues found prevalence rates of conduct disorders ranging from 50% to 90%. Id. at 21. Many youth had multiple diagnoses, an indication that they may be coping with more complicated and challenging emotional and functional difficulties. The review reported higher prevalence rates (than was found in the general population) of several other categories of disorders, including substance use disorders, affective/mood disorders, anxiety disorders (which includes post-traumatic stress disorder), learning disabilities and attention-deficit disorders, and psychotic disorders. Id. at 17-21. Psychotic disorders are relatively uncommon in children generally. In this review, study results found a prevalence rate ranging from 1% to 6% in the juvenile justice samples, which is higher than that observed in the general population of youth. Id. at 20.

187. See Teplin et al., Psychiatric Disorders supra note 182.
188. Many youth who get into trouble with the law meet the diagnostic criteria for conduct disorders, which are defined generally by "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated." DSM-IV-TR, supra note 145, at 93.
189. Teplin et al., Psychiatric Disorders, supra note 182, at 1136. If conduct disorders are not excluded, the study diagnosed at least one condition in 66.3% of males, and 73.8% of females. Thus, although conduct disorders were common (37.8% of males; 46.8% of females), most children diagnosed with conduct disorders met the criteria for other conditions as well. Substance use disorders, however, were the most commonly diagnosed condition for males and females, found in approximately half of the sample. Teplin et al., Psychiatric Disorders, supra note 182, at 1136. This finding is consistent with those of other studies. For example, the review of Otto and colleagues revealed that most studies find that 25-50% of youth involved with the juvenile justice system have substance use disorders, and some studies have reported even higher percentages. OTTO ET AL., supra note 182, at 18.
190. Teplin et al., Psychiatric Disorders supra note 182 at 1136.
191. Wasserman et al., supra note 182, at 3.
for a conduct disorder, most of those children met the criteria for other conditions as well.\footnote{192}

The studies just reviewed sampled youth involved with the juvenile justice system to ascertain what proportions of them met criteria for diagnosis of various mental disorders. Significant overlap in the juvenile justice and mental health populations has also been discovered by assessing what proportion of a sample receiving mental health services has either had contact with the juvenile justice system, or has engaged in conduct that could possibly lead to such involvement. For example, one team of researchers in Seattle, Washington found that children receiving public mental health services were almost three times more likely to have had contact with the juvenile justice system than a comparable sample in the general population.\footnote{193} The researchers compared those youth receiving public mental health services who had had contact with the juvenile justice system with those who had not had such contact, and found that the 41.6% who had been involved with the juvenile justice system were more likely to be African American (58.3% in the dual system group; 15.9% in the mental health-only group), and in state custody (56.5% of dual-system group and 15.9% of mental health-only group).\footnote{194} Substantially more of the dual system children had been expelled from or dropped out of school (62.1% versus 8.4%), had below-grade level academic performance (51.2% versus 31.6%) and were identified as seriously behaviorally disturbed (58.1% versus 23.3%).\footnote{195} Diagnostically, the most dramatic difference between the two groups was the higher presence of a conduct disorder diagnosis in the dual system group (20.7% versus 1.1%).\footnote{196} Other factors that distinguished the two groups were the higher levels of abuse or neglect and foster care placement experienced by the dual system group.\footnote{197} These findings are consistent with those reported by other investigators revealing that race often plays an important role in decisions whether or not children meeting criteria for multiple service and intervention systems are

\footnote{192. Specifically, 18.9% of the sample was diagnosed with an anxiety disorder, 9.1% was diagnosed with mood disorders, and 49.3% was diagnosed with substance use disorders. \textit{Id.}}


\footnote{195. \textit{Id.} at 446-47. The percentages of mental health system only children was calculated by this author by dividing the number of children who met the particular criterion by the total number of children in that group.}

\footnote{196. \textit{Id.} at 449.}

\footnote{197. \textit{Id.} at 448.}
referred to the juvenile justice system—with African-American youth disproportionately so referred. In addition, the high rates of co-occurrence of diagnosable mental health problems, justice system involvement, and a history of child abuse or neglect have also been observed by many researchers. These data support the assertion that many children in the juvenile justice system also meet mental health diagnostic criteria. Such findings reinforce the need to look beyond the lens of the system in which a child happens to be found in determining the child’s and family’s needs and the most appropriate response to these needs. Failure to do so will likely render interventions relatively ineffective.

The overlaps among systems and the populations they serve extend further, however. Research also reveals substantial overlap the juvenile justice and special education population, a finding that will be discussed immediately below. In addition, however, the child welfare and juvenile justice systems share many of the same children. Sometimes referred to as “dual jurisdiction” or “crossover” cases, the relationships among the populations served by these two systems is well known to researchers and many system workers, yet there is little coordination, collaborative service provision, or cross-system sharing of information and resources between systems. Sadly, the special needs

198. Id. at 449-50. See also Dorothy Otnow Lewis et al., Race Bias in the Diagnosis and Disposition of Violent Adolescents, 137 AM. J. PSYCHIATRY 1211, 1215 (1980) (finding that race, rather than frequency of aggressive conduct, distinguished the referrals of youth to the mental health versus juvenile justice system, with African-American youth more often placed in correctional facilities, and Caucasian youth more often placed in psychiatric facilities); Kenneth B. Nunn, The Child as Other: Race and Differential Treatment in the Juvenile Justice System, 51 DEPAUL L. REV. 679 (2002); NAT’L MENTAL HEALTH ASS’N., Mental Health and Youth of Color in the Juvenile Justice System, available at http://www.nmha.org/children/justjuv/colorjj.cfm.


200. See infra Part III.B.4-5.


203. For a discussion of research findings and proposals for improved service delivery, see, for example, M.L. Armstrong, Adolescent Pathways: Exploring the Intersections Between Child

http://scholarlycommons.law.hofstra.edu/hlr/vol33/iss4/9
of these children typically are not met by the child welfare or juvenile justice system, neither of which seems capable of responding to problems extending beyond the traditional boundaries of its system-specific statutorily-defined target population. Research also reveals substantial overlap between the juvenile justice and special education population, as discussed immediately below.

4. The Educational System

The Washington Post reporter describing Donny's situation indicates that he was aggressive at school, and that he has an attention deficit disorder. Formally now referred to as "Attention Deficit Hyperactivity Disorder" or "ADHD," this diagnostic category has undergone substantial reconceptualization over the years. Presently, the American Psychiatric Association identifies three variants. ADHD can seriously hinder academic success, and frequently appears in the


204. See supra Parts III.B.2-3.


206. The DSM-IV-TR identifies a "hyperactive-impulsive" type, an "inattentive" type, and a "combined" type mixing features that are typically ascribed to both of the first two categories. DSM-IV-TR, supra note 145, at 87. The "hyperactive-impulsive" type may present as having behavioral problems. In addition to a high activity level, substantial impulsivity (that is, difficulty inhibiting and delaying responses to stimuli), and difficulty sustaining attention, the condition may also be accompanied by "low frustration tolerance, temper outbursts, bossiness, stubbornness . . . ." DSM-IV-TR, supra note 145, at 87-89. By contrast, the predominantly "inattentive" type of ADHD entails less hyperactivity and impulsivity, and is characterized by the child's difficulty sustaining attention to tasks. Rejection by peers, poor self-esteem, and other negative consequences may follow from the interpersonal and academic problems. In a non-supportive environment, the child is likely to be blamed for the condition, and viewed as unmotivated or willfully disobedient, which will likely exacerbate existing problems. Anastopoulos & Shaffer, supra note 205 at 480-82.
presence of learning disabilities\textsuperscript{207} which have an independent, although often cumulative negative impact on educational success.\textsuperscript{208}

In recent years, scholars have underscored a strong relationship among ADHD, learning disabilities, and troublesome conduct, including conduct that triggers juvenile justice system intervention.\textsuperscript{209} In fact, studies of youth incarcerated in the correctional system suggest that between 30\% and 50\% of these youth experience some type of special education disability, as contrasted with a prevalence rate in the general population of approximately 10\%.\textsuperscript{210} One important question, therefore, whether we are talking about ADHD or any of a broad range of learning disabilities or mental disorders, relates to what obligations the educational system has to provide services to these children.

Until the 1970s, children with a range of disabilities were often excluded from attendance in their local schools, and from the regular

\begin{itemize}
\item \textsuperscript{207} The term “learning disabilities” refers to a heterogeneous group of neuropsychological conditions that can affect children’s learning processes in various ways (e.g., affecting various processes relating to reading, writing, spelling, listening, speaking, reasoning and mathematical skills) depending upon the specifics of each child’s condition. Byron P. Rourke & Jerel E. Del Dotto, \textit{Learning Disabilities: A Neuropsychological Perspective}, in \textit{Handbook of Clinical Child Psychology}, supra note 205, at 576; see also Nat’l Joint Comm. on Learning Disabilities, Am. Speech-Language Hearing Ass’n, \textit{Operationalizing the NJCLD Definition of Learning Disabilities for Ongoing Assessment in Schools} (1997), available at http://www.ldonline.org/njcld/operationalizing.pdf.
\item \textsuperscript{208} See Anastopoulos & Shaffer, supra note 205; Russell A. Barkley, \textit{Attention-Deficit/Hyperactivity Disorder}, in \textit{Child Psychopathology} 63 (Eric J. Mash and Russell A. Barkley eds., 1996); James H. Johnson et al., \textit{Aggressive, Antisocial, and Delinquent Behavior in Childhood and Adolescence}, in \textit{Handbook of Clinical Child Psychology} supra note 205, at 393, 404.
\item \textsuperscript{210} For a summary of empirical findings, see Nat’l Council on Disability supra note 209, at 56-57. The National Council called for better research, however, noting that studies differ with respect to definitions of disability, types of assessment procedures used, and particular subsets of the total population of juveniles who come into contact with the juvenile justice system. Id. at 57-58. Among those categories of disabilities included in many of the studies are: specific learning disabilities, attention deficit disorders, mental retardation, and “emotional disturbance.” See infra notes 220-26 and accompanying text for discussion of the “emotional disturbance” category.
\end{itemize}
classroom. According to Congressional findings prior to the 1975 enactment of the Education for All Handicapped Children Act of 1975 (P.L. 94-142), "one million of the [eight million] handicapped children in the United States [were] excluded entirely from the public school system and [did] not go through the educational process with their peers." Congress also found that "the lack of adequate services within the public school system" often required families to obtain services for their children that are "at great distance from their residence and at their own expense." Public Law 94-142 mandated that states provide a "free appropriate public education" to those children meeting the statute's definitions of "handicapped," as a condition of receiving certain federal funds. The legislation also sought to assure that, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

This latter requirement codified the notion that education for children with special needs should occur in the "least restrictive environment." The statutes were amended over the years, and their provisions were renamed the Individuals with Disabilities Education Act in 1990.

211. For a discussion of the norm of exclusion of children with special needs from regular classrooms and schools, and the cases initially challenging such exclusion, see, for example, Gary L. Monserud, The Quest for a Meaningful Mandate for the Education of Children with Disabilities, 18 ST. JOHN'S J. LEGAL COMMENT. 675, 683-711 (2004).
213. Id. at sec. 3(b)(1), (4).
214. Id. at sec. 3(b)(6).
215. Id. at sec. § 3(c), 4(a)(18); id sec. (a)(4), § 602(18).
216. Id. at sec. 5(a), § 612(5).
The IDEA includes within its definition of "child with a disability," a child who has an "emotional disturbance." Educational institutions, however, have demonstrated some reluctance to identify and serve children with emotional difficulties, a phenomenon that has been the subject of commentary, criticism, and litigation. The first hurdle that parents encounter is proving that their child is indeed emotionally disturbed under the terms of the Act. Governing regulations further define the term "emotional disturbance" as follows:

(i) The term means 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.


220. The definition of "child with a disability" under the Act "means a child":

(i) with mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance [hereinafter referred to as "emotional disturbance"] orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and
(ii) who, by reason thereof, needs special education and related services.

221. See, e.g., Bazelon Center for Mental Health Law, Failing to Qualify: The First Step to Failure in School? 3-5 (2003) [hereinafter "Failing to Qualify"]; Lucy W. Shum, Note, Educationally Related Mental Health Services for Children with Serious Emotional Disturbance: Addressing Barriers to Access Through the IDEA, 5 J. HEALTH CARE L. & POL'Y 233 (2002). The National Council on Disability, supra note 209 at 5, states: "Most sources suggest that many schools are not providing legally required services to youth with disabilities."
(ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.\(^{222}\)

This definition has been the subject of much criticism, particularly in its exclusion of children who are “socially maladjusted” from the category of emotionally disturbed children.\(^{223}\) Neither term was a diagnostic “term of art” in the mental health or education fields prior to their use in the legislation and regulations, and studies have revealed that those applying the definition do not apply the term in a systematic or consistent manner from setting to setting or case to case.\(^{224}\) There is also inherent illogic in excluding children who are “socially maladjusted” from the definition of “emotional disturbance” when the criteria for inclusion in the latter category incorporate difficulties such as “an inability to build or maintain satisfactory interpersonal relationships with peers and teachers,” or “inappropriate types of behavior or feelings under normal circumstances.”\(^{225}\) Given the confusion engendered by these seemingly inconsistent terms of inclusion and exclusion, it is not surprising that courts have split in their interpretations of these terms in reviewing children’s eligibility under these provisions.\(^{226}\)

Schools have invoked the “socially maladjusted” clause in order to exclude some children with emotional or behavioral problems from the reach of the IDEA. In particular, children diagnosed as having a “conduct disorder” are often determined to be “socially maladjusted,” and therefore not “emotionally disturbed” under the Act.\(^{227}\) Some argue

\(^{222}\) Child with a Disability, 34 C.F.R. § 300.7(c)(4) (2004).


\(^{225}\) Child with a Disability, 34 C.F.R. § 300.7(c)(4)(B)-(C) (2004).


that this exclusion was not intended by Congress, and does not make good policy sense because of the long-term costs to communities of not intervening early with these children through the educational system.

While some of these students may still qualify for services on the basis of other problems such as a specific learning disability like dyslexia, the school system is obligated to provide only the services necessary to address the disability on which eligibility is grounded. Even if a child’s condition qualifies her for services as emotionally disturbed under the IDEA, there is still the question of what services the school system is mandated to provide. While the legislation does require schools to provide qualified children with “special education and related services designed to meet their unique needs,” there has been substantial debate and litigation on the question of what is meant by the phrase “related services.” Mental health services, particularly those provided outside of the four walls of the public school, provided during non-school hours, or involving persons other than the child (such as parents) have been the subject of dispute.

Yet, all of these disputes about who does and does not qualify under IDEA and for which services misses the point. Children determined by the school system to be emotionally disturbed are at serious risk of poor academic performance and post-school adjustment. Research reveals that this subgroup of children is more likely than are other disabled children generally to drop out of high school (54.8% versus 36.4%), to be retained at grade level a year (16.1% versus 6.5%), or to be arrested within one year (25.0% to 12.2%) or three to five years (57.6% versus 29.5%) after leaving high school. These data only address those children who met the definitional criteria of emotionally

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228. See Forness & Knitzer, supra note 223.
230. Thus, while these children may receive special education services for the dyslexia (such as assistance with mastering reading and written tasks), they will not receive services to address other problems they or their family are experiencing.
233. See Callegary, supra note 232.
disturbed and were not excluded on the basis of "social maladjustment." One might predict that excluded children are likely to fare even more poorly than children who qualify for special education services. 235

Observers argue that the failure of schools to identify and serve children with a range of learning and emotional problems is a lost opportunity that ultimately results in many youths' appearance in the juvenile justice system. 236 Unfortunately, there is evidence that "as schools have become more restrictive and punitive (e.g., zero tolerance for misbehavior), they have increasingly pushed greater numbers of youth with disabilities into the juvenile justice system." 237 The story of "Chad" below, illustrates such a missed opportunity to provide services to a child before his condition escalates to the point where incarceration in a juvenile justice facility results.

"Chad"

[Chad's mother sought mental health intervention for her son, diagnosed with bipolar illness, when he was in junior high school.] The school system responded to his bipolar illness by insisting there was nothing wrong with him, refusing to provide special education services, and expelling him when he failed to follow school rules. His mother nearly lost her job because she was frequently absent from work to care for him, and her other children begged her to kick him out of the house. At age 12 when he first entered the juvenile justice system, the courts responded by incarcerating him . . . . [At the time Chad was placed in juvenile detention, he was reportedly] suffering from depression and suicidal ideation. He was held in isolation for 152 of his first 240 days. Because of the severity of his illness and the lack of proper treatment, this child was committed to a youth center five times and each time this pattern of isolation continued. [T]his child's behavior deteriorated and his symptoms of depression, aggression, and eventually self-mutilation, increased. This led to more periods of isolation as punishment for his . . . behavior . . . . 238

235. This prediction is based both on the expectation that children who are excluded on the basis of "social maladjustment" are likely to have more severe behavioral and social problems, which place them at greater risk for functional difficulties. These children may also be expelled or suspended for their conduct, which is likely to exacerbate these difficulties. Furthermore, to the extent that the school's services would be helpful, they are denied the opportunity to benefit from them.

236. See, e.g., FAILING TO QUALIFY, supra note 221 at 14-15; NAT'L COUNCIL ON DISABILITY, supra note 209, at 5; Peter E. Leone et al., School Failure, Race, and Disability: Promoting Positive Outcomes, Decreasing Vulnerability for Involvement with the Juvenile Delinquency System (2003).

237. See, e.g., FAILING TO QUALIFY, supra note 221, at 2-3; NAT'L COUNCIL ON DISABILITY, supra note 209, at 5, 57-58.

238. The name "Chad" is fictitious and was supplied by this author. "Chad's" story is drawn from Juvenile Detention Centers: Are They Warehousing Children with Mental Illness: Hearing
If the school had identified Chad's condition as an "emotional disturbance," had not expelled him, and had provided or helped his family access comprehensive services, might he have avoided the escalation that led to his confinement in a secure juvenile justice facility? There is a growing body of empirical research suggesting that some school-based mental health programs may be effective in assisting troubled and troublesome youth and their families with various problems. And, while these programs have been developed with particular reference to the school as the site of service delivery, there is no reason why the school could not serve to connect families to a wider range of services, including those described in Part VII below. The school setting is the formal service location in our nation having the most contact with American children. As such, it is a logical and natural place to identify and intervene early with children and families experiencing emotional and behavioral difficulties.

5. Which Lens is the "Right" One?

Donny's case, and that of many other troubled and troublesome youth, can be viewed through the lenses of the mental health, child welfare, juvenile justice, and educational systems. Too frequently, troubled and troublesome children end up in one system or another for

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Before the Senate Comm. on Governmental Affairs, 108th Cong. (2004) (Statement of Carol Carothers, Executive Director, NAMI Maine).

239. Mental health services provided in the school may be best referred to as "promising" interventions. While there is not yet a well-developed empirical data base indicating which types of school-based services are effective with which types of problems, initial studies suggest that at least some populations are likely to benefit from certain types of school-based services. See, e.g., Paula Armbruster & Judith Lichtman, Are School Based Mental Health Services Effective? Evidence from 36 Inner City Schools, 35 COMMUNITY MENTAL HEALTH J. 493 (1999); Jenni Jennings et al., Implementing and Maintaining School-Based Mental Health Services in a Large, Urban School District, 70 J. SCH. HEALTH 201 (2000); Laura A. Nabors & Matthew W. Reynolds, Program Evaluation Activities: Outcomes Related to Treatment for Adolescents Receiving School-Based Mental Health Services, 3 CHILD. SERVS: SOCIAL POL'Y, RES. & PRAC. 175 (2000); Eric M. Vernberg et al., Innovative Treatment for Children with Serious Emotional Disturbance: Preliminary Outcomes for a School-Based Intensive Mental Health Program, 33 J. CLIN. CHILD & ADOLESCENT PSYCHOL. 359 (2004); Mark Weist et al., Psychosocial Functioning of Youth Receiving Mental Health Services in the Schools Versus Community Mental Health Centers, 35 COMMUNITY MENTAL HEALTH J. 69 (1999); see also Rones & Hoagwood, supra note 67, for a discussion of limitations of school-based programs.

reasons unrelated to their needs. Various systems may reject these children because of financial considerations; the child may need to be “packaged” so as to fit within whatever system will finance the intervention. But, the services available in that system may not be the most appropriate for the child. Or, perhaps the most appropriate system is overburdened; children may need to be served by whichever system has available slots. Perhaps no one has performed a comprehensive enough assessment to find out what the child and her family really need. Or, perhaps the various systems are unable to escape from the influence of narrow system-specific formulations and solutions. In a provocative briefing paper, the Youth Transition Funders Group referred to what it calls the “tunnel problem.”

A youth’s entry point into the series of systems that serve youth usually determines how government responds, not the youth’s underlying problems. Each of the many systems that serve youth has a fixed menu of services or solutions to offer. Because most agency staff members think primarily of the set of solutions within their system, they usually send youth down one of these “service tunnels.” The tunnel may be the most appropriate choice among the agency’s set of options, but may still be an ineffective course of action. Once a youth starts down a particular tunnel, it is often hard to reverse course and take a different path.

Which lens is or which lenses are correct is an empirical question, the response to which will differ from case to case. The lens that is correct for any given child is the lens that permits that child to function as successfully as possible in all of those spheres that contribute to positive adjustment and personal satisfaction in our society, while at the same time protecting others in the community. One can debate what qualities and skills facilitate positive adjustment and positive satisfaction, and precisely what constitutes such adjustment and satisfaction. Yet, we know that, in general, certain things are more likely than not to be a part of such positive adjustment, such as success in school, the ability to form and maintain healthy social and intimate relationships, the ability to perform age-appropriate tasks of self-care and independence, the capacity to understand and abide by the most basic of society’s rules (such as those that prohibit physical aggression

242. Id.
against others), and the absence of certain dysfunctional and emotionally difficult psychological states (such as debilitating levels of depression or anxiety). While it may not be possible for all people to achieve success and satisfaction in all of these spheres, the lens or lenses that are correct are those that promote troubled and troublesome youth’s positive adaptation in these realms to the greatest extent possible.

Most of the time, a single lens is inadequate for the task of understanding troubled and troublesome youth and their needs. In order to serve some youth and their families, it may be necessary to view them through all of the systems’ lenses. Or, perhaps innovative perspectives such as those advanced by Urie Bronfenbrenner and James Garbarino should replace the lenses of the individual systems.243 Often what children and families need—an intensive and multifaceted combination of interventions that work with them and their families in their natural settings (i.e., home, school, and community)—is not available in any of the service or intervention systems.244

IV. TRENDS IN CURRENT RESPONSES TO TROUBLED AND TROUBLESOME YOUTH: THE MANY SIGNS OF CRISIS

Children are really suffering. . . . There are children at home getting no services; children in foster care not getting mental health services; children in the hospital who don’t need to be in the hospital; and children in jails and prisons who are there because judges feel they need some kind of residential care.245

In this Part, I describe five indications that thousands of troubled and troublesome youth and their families are in crisis because child service and intervention systems have failed to meet their underlying needs. These crises have, in turn, become the community’s crises, as families needing service turn to hospital emergency rooms, the juvenile justice system, and the child welfare system, and the problems of troubled and troublesome youth exacerbate in downward spirals that affect their siblings, their parents, their peers, their neighbors, their schoolmates, and the community-at-large. Ironically, these phenomena

243. See infra notes 795, 804 and accompanying text.
244. See infra Part VII.
occur in spite of a range of federal efforts to reduce institutional interventions and to shift the locus of care to the community for populations that include large numbers of troubled and troublesome youth. 246

A. Waiting for Appropriate Services: “Stuck Kids” and Unmet Needs

Reports from around the country indicate that families encounter excessively long waiting lists when seeking community-based mental health services for their children. 247 Ironically, in an era when empirical research has demonstrated that a range of innovative community-based approaches to children’s emotional and behavioral problems yields high levels of success, even in the most challenging cases, 248 government has failed to invest in expansion of community-based mental health services. 249 Data reveal that increases in utilization of inpatient mental health services by children between 1986 and 1997 dramatically outpaced growth in the outpatient sector, despite initiatives aimed at obtaining the opposite result. 250

Not only is there an “absence of service options at the front end of the system,” 251 that is, prior to the point at which children’s circumstances lead to removal from the home, but there is also “an inadequate range of services at the back end,” 252 leading to delays in discharging children from various residential placements. Apparently, “stuck kids” wait on inpatient psychiatric units or in residential treatment centers for emotionally disturbed children, ready for discharge, but unable to leave because of the unavailability of community-based services. 253 One expert estimated that during one fiscal year, children in

246. These efforts are analyzed in Part VI.
248. For a discussion of these community-based alternative approaches, see Part VII.
249. See, e.g., Pottick et al., supra note 161, at 314.
250. Id. at 316-17.
252. Id.
253. See, e.g., id. at 366 (referring to the phenomenon as “kidlock”); ISSUE BRIEF, supra note 12, at 5; Goldberg, supra note 245, at A1.
Massachusetts "spent 20,811 days—the equivalent of 57 years—stuck in [psychiatric] wards" waiting for community-based mental health services to become available.\textsuperscript{254} A 2003 report by the Association of Academic Health Centers reported that "[a]round the country, many children are literally trapped in psychiatric hospitals or general care wards, because they can't be discharged for lack of community services to take over their care. With stuck kids occupying psychiatric beds, other children in need are put on waiting lists . . . ."\textsuperscript{255}

The problem of stuck kids is just one of the signs that the affordable, accessible, and appropriate services necessary for troubled and troublesome children and their families are not available in most communities. The authors of a recent U.S. Department of Health and Human Services report on children's utilization of mental health services concluded:

Although the extent of unmet need for youth in our country is unknown, evidence is emerging that youth continue to face significant barriers to receiving appropriate services and remain "stuck" in inappropriate levels of care . . . and that unmet need is likely to be greater among minority and uninsured youth than other youth.\textsuperscript{256}

Public interest lawyers have responded to the range of service gaps by suing states for their failures to provide adequate mental health services to various subgroups of children.\textsuperscript{257} The plaintiffs and claims vary from one suit to the next. In general, however, the claims are grounded in alleged denials of statutory rights created by Medicaid, the IDEA, Section 504 of the Rehabilitation Act, and most recently, following the favorable result in the \textit{Olmstead} case,\textsuperscript{258} the Americans

\begin{itemize}
\item \textsuperscript{256} Pottick et al., \textit{supra} note 161, at 323.
\item \textsuperscript{257} See generally Lenore B. Behar, \textit{Using Litigation to Improve Child Mental Health Services: Promises and Pitfalls}, 30 \textit{ADMIN. & POL'Y IN MENTAL HEALTH} 199 (2003); \textit{JENNIFER MATHIS, Community Integration of Individuals with Disabilities: An Update on Olmstead Litigation}}, 25 \textit{MENTAL & PHYSICAL DISABILITY L. REP.} 158 (2001).
\item \textsuperscript{258} 527 U.S. 581 (1999). The plight of “stuck kids” in psychiatric hospitals is not unlike the circumstances of the plaintiffs in \textit{Olmstead v. L.C.}, who have been deemed appropriate for release, but who remain institutionalized because of inadequate availability of community services. See \textit{id.} at 593. For a discussion of the \textit{Olmstead} decision and its implications for children who are unnecessarily institutionalized, see \textit{infra} notes 541-56 and accompanying text.
\end{itemize}
TROUBLED AND TROUBLESOME YOUTH

with Disabilities Act ("ADA"). For example, in *Rosie D. v. Swift*, a class of "Medicaid-eligible" children with identified "behavioral, emotional, or psychiatric disabilities" who "have been hospitalized or are at risk of hospitalization" claimed that the state of Massachusetts had failed to provide them with the intensive, home-based mental health services "medically necessary" for them to avoid hospitalization and function successfully in the community. While the *Rosie D.* case has not yet been adjudicated on the merits or settled, a class of California Medicaid beneficiaries succeeded in obtaining a favorable judgment in *Emily Q. v. Bonta*. The *Emily Q.* plaintiffs were defined as children who have been hospitalized in a psychiatric facility, who were hospitalized at the time the litigation was filed, or who were at risk for such hospitalization. The court ordered the state of California to provide a range of individualized community-based mental health services in order to allow the children to function successfully in the community.

Some cases have focused on children with mental health needs who have been or are at risk of being removed from their homes by the child welfare or juvenile justice system. For example, the *Katie A. v. Bonta* plaintiffs are children in California who "are in foster care or are at imminent risk of foster care placement," have a diagnosable mental disorder and who need individualized *home-based* mental health services. The claims in this case were grounded in the defendants' alleged obligations to provide such services under Medicaid and the ADA, as well as in several state and federal constitutional claims. The favorable result in *Emily Q.* may have motivated the state of California's


relatively quick settlement in *Katie A.* The state, county, and city defendants agreed to provide the requested home-based services as is necessary "to prevent removal from their families" or, where such removal cannot be prevented, "to facilitate reunification, and to meet their needs for safety, permanence, and stability."265

The *Willie M.* case involved children diagnosed with serious emotional, mental, or neurological disorders whose conduct had been characterized as "violent or assaultive," who presently were, had been, or were at risk of being involuntarily institutionalized or placed in a residential program, and who were not receiving appropriate community-based services.266 Thus, these children were at greatest risk for juvenile justice system confinement because of the dangerous nature of their tendencies towards others. The plaintiffs alleged that the state of North Carolina failed to provide them with services as required under the Education for All Handicapped Children Act (the predecessor of IDEA), Section 504 of the Rehabilitation Act of 1973, and recited state and federal constitutional claims as well. The case was ultimately resolved by a consent decree. Services provided under the agreement included a variety of home-based and outpatient services, residential placements in group homes or therapeutic foster homes as needed, and a range of educational services.267 Determining that the state had complied with all of the requirements of the consent decree, the case was dismissed in early 1998, after almost twenty years of monitoring.268


265. Id.


268. Id. According to the North Carolina Department of Health and Human Services:

The Willie M. program's total annual expenditure exceeds $75 million, including state and federal sources. State studies show that 85% of the Willie M. children are enrolled in school, 57% have not been physically violent in the previous three months, and 90% have not been arrested or convicted of a crime in the previous three months. More than 80% of the children live in the community, including their natural homes, therapeutic foster homes, or group homes.

*Id.*
Actions have been filed, decided on the merits, or settled in other states as well. These cases highlight the depth of need for appropriate non-institutional mental health services for children. Strategically, the grounding of claims in statutory rights to services is logical, and has been relatively successful. Yet, hundreds of thousands of families are not within the jurisdictions or classes identified in the lawsuits. Many are not eligible for public insurance programs such as Medicaid or SCHIP. According to one independent state commission:

Overall, more children are turned away from the public mental health system than are served. As a result, thousands of children and families [in California] suffer needlessly because mental health care is unavailable. In the end, the lack of timely and adequate care costs taxpayers millions of dollars in additional criminal justice, education, and health costs—while at the same time diminishing the economic potential of these young people.

In light of reductions in governmental expenditures on mental health services, the possibility that federal insurance programs such as Medicaid may experience future reductions, and the shrinking levels of private third-party reimbursement for all levels of health care, proactive policy reform is absolutely necessary to insure that there exist appropriate community-based services for those children and their families in need.

269. See, e.g., Settlement Agreement, J.K. v. Eden, No. Civ 91-261 TUC JMR at ¶ 18 (D. Ariz. 2001) (agreement that Arizona will provide “accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults”); Arizona Vows to Improve Children’s Mental Health Care, 36 PSYCHIATRIC NEWS 1 (2001); see generally Second Amended Complaint, French v. Concannon, Civ. Action No. 97-CV-24-B-C (D. Maine 1997); French v. Comm’r of Maine Dep’t of Human Servs., Joint Stipulation Regarding Plaintiffs’ Motion for Preliminary Injunction (Mar. 19, 1998) (agreement that Maine will provide home-based mental health services to children allegedly entitled to receive such services under Medicaid).

270. For a thoughtful analysis of the impact of children’s unmet mental health needs on children, their families, social institutions, and society-at-large, see generally Patrick Gardner, Unmet Mental Health Needs Cause Failure Across Youth-Serving Institutions, XXII YOUTH L. NEWS 1 (2001).

B. "Boarding" in Emergency Rooms and on Medical Wards

The inaccessibility and unavailability of appropriate community-based mental health services for youth and their families has led to a "spill-over" of individuals and families into other service and intervention systems, and in particular, hospital emergency rooms. Given existing legal mandates and financial incentives, discussed below, hospital emergency rooms have served as a magnet for children and families in crisis unable to access services through other channels.

In July 2004, officials in Clark County, Nevada, the county in which Las Vegas is located, declared a state of emergency:

The state of Nevada’s refusal over the past 15 or 20 years to properly fund mental health reached a breaking point over the weekend. With one-third of the emergency-room beds in 11 area hospitals filled with mentally ill patients on Friday, and with health care officials calling the situation the worst mental health crisis in the region’s history, Clark County Manager Thom Reilly declared a state of emergency. In reaction, Gov. Kenny Guinn released up to $100,000 in emergency funds to pay for the staff and space needed to relieve the crisis.272

One emergency room director analogized the effect of these psychiatric patients in Clark County hospitals to closing "down three emergency wards in Las Vegas."273 Officials expressed concern that the crisis was not only hampering these hospitals’ present responses to traditional medical emergencies, but would seriously undermine their ability to respond to a large-scale medical disaster or mass casualty incident.274

The problem of high levels of emergency-room use by those with mental health problems is not unique to Nevada.275 Awareness of this trend prompted a coalition of emergency-room physicians, mental health advocates, and mental health professionals to co-sponsor a national

274. Id.
survey investigating the pervasiveness of the problem.\textsuperscript{276} The "Psychiatric Emergencies Survey," conducted by the American College of Emergency Physicians ("ACEP") with the support of the National Mental Health Association, the National Alliance for the Mentally Ill and the American Psychiatric Association, revealed that over 60\% of responding emergency physicians had seen an increase in the numbers of persons with psychiatric emergencies seeking services in their emergency rooms during the prior six to twelve months.\textsuperscript{277} Over 80\% of respondents reported that the "boarding" of psychiatric patients has had a "negative effect on the care of other patients."\textsuperscript{278} The term "boarding" in this context refers to the phenomenon of persons with mental disorders remaining in hospital emergency rooms while waiting for mental health services to become available.\textsuperscript{279}

Although the ACEP survey did not solicit information as to the age distribution of the "boarders" in the respondents' emergency rooms, reports continue to pour in from around the country indicating that the presence of children with mental health crises in emergency rooms persists.\textsuperscript{280} For example, in New York City, an official at Children's Hospital of New York-Presbyterian, one of New York's largest health centers, reports that the number of children arriving at its emergency room with psychiatric symptomatology jumped from around 200 in 1994 to 800 in the year 2002.\textsuperscript{281} A Yale-New Haven Children's Hospital study found a 59\% increase in children in psychiatric crisis visiting its


\textsuperscript{278.} \textit{Id.} at Item 11.


emergency room between 1995 and 1999. In all of these cases, officials comment that this trend seriously impedes effective emergency room functioning, and that emergency rooms are poorly equipped to meet the needs of emotionally disturbed children.

The problem does not end in the emergency room, however. Once evaluated, many young boarders are transferred to general pediatric medical wards where they wait until mental health services become available. The following description of the phenomenon is provided by one team of physicians:

One significant change in mental health services for children and adolescents that is not frequently mentioned... is that pediatric hospitals have been transformed into a safety net for youths in need of inpatient psychiatric care. Because of the shortage of pediatric and adolescent mental health services, pediatric patients who require psychiatric hospitalization may be admitted instead to a medical service because there are no available inpatient psychiatric beds. These psychiatric patients on the medical service are termed psychiatric "boarders."

Boarding children do not receive much in the way of treatment. For example, in one study, Sharfstein and colleagues reported that not one boarder kid in their sample of ten children covered by Medicaid received "any of the five key services that Medicaid requires to be available in psychiatric hospitals, including group therapy and family therapy" while boarding. A Washington Post reporter describes the emergency room experience of the nine-year-old boy whom we called "Donny," who was diagnosed with ADD, PTSD, and depression, "acts out," gets into fights at school, and is allegedly a victim of child abuse:

282. Walker, supra note 280. Subsequent data from Connecticut suggest that the problem has not abated in that locale, despite state action to divert the children to other services. Hathaway, supra note 280 ("A flood of disturbed youngsters continues to inundate the emergency rooms at children's hospitals in Hartford and New Haven [Connecticut]... Despite the state's initiatives to keep children out of emergency rooms, where they sometimes languish for days, the kids keep coming... Psychiatric admissions of children [to emergency rooms] have nearly doubled, from 14 cases per thousand in 1995 to 24 in 2002, according to statistics gathered by the Connecticut Hospital Association.").

283. Goldberg, supra note 245; Trafford, supra note 9; Lombardi, supra note 9.


286. See supra note 137 and accompanying text.
The school puts him in an ambulance and sends him to the emergency room at Boston Medical Center. There he is evaluated by a psychiatric team that recommends immediate hospitalization in a psychiatric facility.

But there’s no place for him to go. Boston Medical Center has no psych unit for children and adolescents. All the beds for disturbed youngsters at other institutions in the state are filled.

And so the boy becomes a boarder kid. Too sick to go home, he boards at the hospital in a kind of medical limbo until a bed can be found. He is one of a growing number of children stuck in hospitals waiting for care. Usually the wait is a day or two, but sometimes it can stretch weeks and even months.

Boarder kids get no real psychiatric treatment. They stay in the ER or on a general pediatric floor. They have to be watched 24 hours a day by a security guard or “sitter” to make sure they don’t wrap an IV tube around their neck or assault another patient. They just sit there and wait.

The physician in charge of pediatric emergencies at Boston Medical Center is quoted as stating that “[t]here is no real therapy going on. They languish there for days.” According to the Washington Post, 50% of children for whom staff recommend inpatient mental health treatment “end up as boarders.” The number of boarder kids entering in emergency rooms and forced to wait there or on other medical units for mental health services has increased substantially in recent years:

In Massachusetts, an estimated 200 youngsters were boarding in hospitals during May. At the Yale-New Haven Children’s Hospital in

287. Trafford, supra note 9.
288. Id. (quoting Sigmund J. Kharasch).
289. Id.
290. Although there are no data addressing how many “boarder kids” must wait in emergency rooms, rather than on medical wards, reports indicate that at least some children spend days in the hectic and potentially frightening environment of the emergency room. See id.; see also sources cited supra note 280 (describing the case of a boy who waited six days with his mother in the emergency room before transfer to a psychiatric placement).
Connecticut, 80 percent of kids needing hospitalization for psychiatric disorders had to be boarded during April. At Johns Hopkins Hospitals in Baltimore, the psych units for children and adolescents are full two-thirds of the time, and in the last five years, visits to the ER by youngsters in psychiatric crisis have tripled.291

While there are no comprehensive empirical data informing us of the scope of the problem of “boarder kids,” or how long these children remain in emergency rooms or on non-psychiatric medical wards, two sets of pediatricians in Massachusetts reported on initial investigations conducted at their respective hospitals. Mansbach and colleagues, in the one published empirical study of the pediatric boarding phenomenon, reported that during a one-year period spanning from 1999-2000, 315 juvenile patients for whom psychiatric admission was recommended arrived at the emergency room of Boston Children’s Hospital.292 Of these, 67% were placed in an inpatient or residential mental health facility, while another 103 children, or 33% of the sample, were boarded on medical units.293 The total number of boarding days for these children was 304, with a median of two days, but a range of one to fifty-one days. These findings were consistent with those obtained by Sharfstein and colleagues at Boston Medical Center.294 Sharfstein found that during a five-month period in 1999, 67 of 196 children (34%) with “acute psychiatric needs in the Emergency Department were admitted to the inpatient pediatric service” to await the availability of a bed on a psychiatric service.295

Mansbach and his team were disturbed by several of their findings. They found that the child’s race was a factor in whether he boarded, with African-American children more likely to experience delay in placement.296 In addition, the most severely disturbed children—those with suicidal and homicidal ideation or conduct—were the most likely to board. This latter finding suggests that those psychiatric facilities choosing which patients to admit may not apply the standard method of triaging which requires that the most severely and acutely ill patients receive priority in obtaining service.297

291. Trafford, supra note 9.
292. Mansbach et al., supra note 284, at 694-95.
293. Id.
294. Sharfstein et al., supra note 285.
295. Id.
296. Mansbach et al., supra note 284 at 697. Other statistical analyses performed by the authors demonstrated that the observed racial differences could not be attributed to non-racial factors such as socioeconomic status or whether or not the child was in foster care. Id.
297. Id.
Boarding, as described here, presents an excellent example of the type of "cost-shifting" that occurs as agencies and governmental entities seek to avoid the expense of providing mental health services. The Emergency Medical Treatment and Active Labor Act ("EMTALA"), passed by Congress in 1986, requires hospitals receiving certain categories of federal funds to evaluate whether or not "an emergency medical condition" exists when patients seek services in their emergency rooms. 298 If such a condition does exist, the hospital is obligated either to "stabilize" the individual's condition or transfer the individual under certain limited circumstances. 299 Passed for the purpose of limiting the practice of "dumping" of poor and uninsured patients who require emergency treatment, EMTALA was not, however, accompanied by federal funding to assist facilities in carrying out its mandate. 300 Given the unavailability of community-based mental health services described immediately above, many children and families will appear in the emergency room only after circumstances have become critical. For those who are uninsured, the emergency room is likely to be the only avenue available to them for receiving care. And even for those with some form of insurance, exhaustion of coverage maximums, low rates of reimbursement, and limitations on types of covered services place them in the same position as the uninsured.

The rates of reimbursement to hospitals from public and private insurance plans for the emergency room services to emotionally disturbed children are quite low, particularly when juxtaposed with high levels of staffing required by these crisis situations. 301 By failing to fund adequate public community-based services, the state shifts the costs of providing services for uninsured and inadequately insured children to the hospitals, many of which are private, non-profit facilities. Because the costs to the hospitals are so high, many facilities have been forced to close their trauma centers and emergency departments in order to

301. For example, the actual costs of providing care to ten children who presented to the Boston Medical Center emergency room, studied by Sharfstein and colleagues, totaled $21,102.98 (which included, for example, 24-hour security guards for children whose conditions necessitated such measures). Yet, because of limitations on the types of services for which it can be reimbursed, Medicaid and Massachusetts Behavioral Health Partnership (the for-profit company managing the behavioral health component of the state's Medicaid program) paid only $6,540.01. See Sharfstein, et al., supra note 285, at 3, 19-23. Thus, the hospital was significantly under-reimbursed.
survive financially. Obviously, this result ultimately reduces the available medical services to the entire community, and thus should be of concern to the general public as well as policymakers.

C. Relinquishing Custody and "Warehousing"

Heather’s mother found her daughter “hard to manage.” When Heather was six years old, her mother began a ten-year course of unsuccessful attempts to access appropriate mental health services. “By fifth grade, Heather had experienced countless visits to crisis [inpatient psychiatric] units. Ineffective and missing services paved the way to police intervention. [Heather] assaulted her peers.” Her mother reports watching “with terror and a broken heart” Heather’s life “spinning out of control.” By age 12, [Heather] “was sexually acting out, using alcohol and other drugs, and carving her body.” When she assaulted her mother, police facilitated Heather’s hospitalization in a psychiatric facility. Heather’s mother was told that “the only option for keeping her safe was residential treatment.” Because her family did not have adequate insurance or funds to afford these services, Heather’s mother indicated that she was told: “In order to get her the service that she needed, I would have to refuse to take her home from the hospital,” that is, relinquish custody, so that she would be eligible for services. Her mother reported that September 27, 1999 was “the most devastating day of my life. I had to tell my fragile daughter that I would not take her home.” Heather’s mother reported that “[p]sychologists did not want to label my daughter with bipolar at age ten. Instead, they waited all those years and she got lots of other labels—delinquent, addict, promiscuous, violent, and runaway.” Heather was placed in a series of residential programs, none of which was successful. After an assault on a staff member, she was classified as qualifying for special education services on the basis of an emotional disturbance. Heather was repeatedly returned home, but no services were provided to the family by any of the systems that had been involved in Heather’s case. The subsequent years were characterized by substance abuse, running away, law violations (e.g., breaking a window, stealing mother’s car, possession of drugs), a placement in a youth detention center and a locked behavioral treatment center.

302. See Lee, supra note 300, at 166-67 (citing evidence that in Los Angeles, ten of eighteen trauma centers closed in recent years).

303. Heather’s story is drawn from: Testimony of Theresa Brown, Nowhere to Turn: Must Parents Relinquish Custody in Order to Secure Mental Health Services for Their Children?: Hearings Before the U.S. Senate Committee on Governmental Affairs, 108th Cong. 169, 10-12 (2003).
Scenarios similar to Heather's have occurred tens of thousands of times in recent years. As noted in the introduction to this Article, parents across the country have relinquished custody of their children to the child welfare or juvenile justice systems in the hope that doing so would access the mental health services for their children that they had either been unable to afford, unable to wait for, or unable to find. The first official recognition of this problem came in a 2003 GAO report. Yet, prior to the GAO investigation, the press and public interest and advocacy organizations attempted to publicize the phenomenon they referred to as "custody relinquishment." There was even an occasional article in the scholarly literature. It took the GAO investigation, however, to attract the attention of lawmakers. Two Congressional committees held hearings and conducted investigations of their own in response to the GAO report, focusing first on the general issue of custody relinquishment, and then on the large numbers of children for whom this relinquishment results in warehousing in juvenile detention facilities. In a July 2004 report, the U.S. House of Representatives Committee on Government Reform reported that during the six-month

304. See supra note 87 and accompanying text.
305. GAO, 2003, supra note 4 at 4. The GAO asserted that its estimate that 12,700 children were placed in these systems in order to access mental health services was likely to be an underestimate of the scope of the problem because officials in several states ("including officials of 5 states with the largest populations of children") did not respond to the GAO survey. Id.
307. In 1999, NAMI conducted a national survey of parents of children with mental disorders to investigate the extent of the phenomenon of custody relinquishment. See NATIONAL ALLIANCE FOR THE MENTALLY ILL, FAMILIES ON THE BRINK: THE IMPACT OF IGNORING CHILDREN WITH SERIOUS MENTAL ILLNESS (1999), available at http://www.nami.org/youth/brink.html. Twenty-three percent of 903 respondents indicated having been advised to relinquish custody of their children in order to access otherwise unaffordable mental health care, and 20% indicated that they followed that advice. Id. Many of these parents report that their children were subsequently physically or sexually abused in the hospital, residential treatment center, or detention facility. Id. The Bazelon Center for Mental Health Law published a series of reports on the topic. See, e.g., BAZELON CENTER FOR MENTAL HEALTH LAW, STAYING TOGETHER: PREVENTING CUSTODY RELINQUISHMENT FOR CHILDREN'S ACCESS TO MENTAL HEALTH SERVICES (1999); BAZELON CENTER FOR MENTAL HEALTH LAW: AVOIDING CRUEL CHOICES (2002); BAZELON CENTER FOR MENTAL HEALTH LAW: MERGING SYSTEM OF CARE PRINCIPLES WITH CIVIL RIGHTS LAW (2001).
309. See generally Nowhere to Turn: Must Parents Relinquish Custody in Order to Secure Mental Health Services for Their Children?: Hearings Before the U.S. Senate Committee on Governmental Affairs, 108th Cong. 169 (July 15 & 17, 2003); INCARCERATION OF YOUTH supra note 6; Juvenile Detention Centers, supra note 7.
period from January 1 to June 30, 2003 "nearly 15,000 incarcerated youth waited for community mental health services" in juvenile detention facilities.\(^{310}\)

The GAO concluded that the following factors combine to lead to the custody relinquishment phenomenon: shortages in mental health services in the community; limited public or private health insurance coverage for mental health conditions; difficulty meeting eligibility requirements of various child-serving agencies; and inability to access services through agencies such as the school system.\(^{311}\) In some instances, according to the GAO, these agencies misinterpret their responsibilities, thus inappropriately denying service.\(^{312}\) Parents, unable to afford or find care, are advised by staff of governmental agencies, by law enforcement, and by other professionals to relinquish custody—which they can do by voluntarily entering into a custody relinquishment agreement with the child welfare system or by having their child arrested for a status offense or criminal violation so that their children will be more likely to receive mental health care.

While some children whose parents relinquish custody do, indeed, obtain services (such as a spot in a residential treatment facility), many others do not. Furthermore, the trauma of removal from home and school and separation from parents, siblings, extended family and friends is at best counterproductive, and more likely, quite destructive to the child’s psychological well-being.\(^{313}\) Parents lose the opportunity to care for and guide the daily lives of their children while the state

\(^{310}\) See INCARCERATION OF YOUTH, supra note 306, at ii. The methodologies employed by the GAO, 2003, supra note 4, and House Committee, INCARCERATION OF YOUTH, supra note 6, relied solely on appraisals by child welfare and juvenile justice administrators as to both the numbers of children inappropriately referred to their facilities, as well as the nature of those children’s service needs. The accuracy of the estimates is unknown. In addition, when the Report to the House Committee asserts that the youth in question are waiting for community mental health services, it appears to include inpatient or residential mental health treatment facilities as among those services for which the youth wait. Id. at 3-4 ("Community mental health services’ refers to mental health services that are available outside of the juvenile justice system, including inpatient hospitalization, outpatient services, residential treatment, and specialized foster care.") Thus, while the phrase “community mental health services” typically refers to noninstitutional services, the Report apparently uses this term to refer more generically to mental health services, whether those services are provided in an institutional or outpatient setting, as long as the placement is not in a juvenile justice facility.

\(^{311}\) See GAO, 2003, supra note 4, at 5, 20-30.

\(^{312}\) Id. at 30-31.

\(^{313}\) See Cohen et al., supra note 308, at 129-30 (citing a “sense of loss and grief” experienced by these children with respect to “the loss of relationships with family members, the loss of the child’s own role within their nuclear family unit, and the perception of guilt—it was his or her own behavior that . . . led to placement” and “feelings of worthlessness”).
assumes decisionmaking authority over the child. Sadly, many of the settings into which these children are placed are highly inappropriate for them. Children with emotional disorders who are placed in detention are often kept in isolation, and may become victims of physical or sexual abuse. 314 Many are suicidal or have attacked others. 315 The facilities report that they are ill-equipped to serve or handle emotionally disturbed youth, and that the influx of large numbers of such children waiting for mental health services disrupts their ability to serve the rest of their residents according to their formal mandates. 316

The juvenile justice and child welfare systems are the “end of the road” in terms of state provision of services. Like emergency rooms, they cannot refuse to provide service. If they are overwhelmed, they continue to function, but simply do a poorer and poorer job as their resources are stretched beyond recognition. Not surprisingly, the 2004 Congressional investigation found that the cost of incarcerating children who await community-based mental health services is exceedingly high—approximately $100 million annually. 317 Ironically, the state ultimately pays the bills, whether the services are provided under one administrative agency or another. Although researchers are in the early phases of examining the short- and long-term cost differentials of responding to troubled and troublesome youth with appropriate community-based versus inappropriate institutional services, initial examinations suggest that community-based options are more cost-effective. 318

314. See Juvenile Detention Centers, supra note 7, at 2-3.
315. See INCARCERATION OF YOUTH, supra note 306, at 8-9. A Tennessee juvenile justice administrator commented: “I find the last place some of these kids need to be is in detention. The kids with conduct disorder end up being locked in their cell for their actions. Those with depression are locked up alone to contemplate suicide.” Id. at 13-14.
316. See id. at 9-10.
317. Id. at 11.
318. For example, research suggests that an intensive and multifaceted community-based intervention model called Multisystemic Treatment leads to more favorable outcomes in youth, and is less expensive than institutional alternatives. See infra notes 821-31 and accompanying text. Research also indicates that another innovative model, Therapeutic Foster Care, delivers services that are more effective and less expensive than more restrictive interventions. See infra notes 842-49. There has been far more research on the comparative costs of institutional and community-based care for adults with mental disorders, and persons of all ages with intellectual disabilities, than for troubled and troublesome children. While the needs of mentally disordered adults and persons with intellectual disabilities do not constitute precise analogs to those of troubled and troublesome youth, the findings of studies focusing on these other groups are instructive. For example, one study examined the cost-efficacy of services to “chronically mentally ill” adult patients over ten years. See J.P. Dauwalder & L. Ciompi, Cost-Effectiveness Over 10 Years: A Study of Community-Based Social Psychiatric Care in the 1980s, 30 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 171 (1995). The investigators concluded that a combination of community-based interventions was more
Despite some indications of progress in one jurisdiction or another, there remain serious problems requiring more aggressive action. In October 2003, Senator Susan Collins introduced Senate Bill 1704 ("The Keeping Families Together Act"), which garnered the widespread support of dozens of mental health, children’s, and consumer advocacy organizations. The proposed legislation seeks to eliminate the practice of custody relinquishment for the purpose of accessing mental health services for children by providing grant funds for states to create accessible and affordable networks of appropriate children’s mental health services. Unfortunately, the bill did not progress toward passage since its 2003 introduction, leading sponsors to introduce it again in 2005.

D. Homeless, Runaway, and "Thrownaway" Kids

The Office of Juvenile Justice and Delinquency Prevention ("OJJDP") reported that in 1999, approximately 1,682,900 youth experienced at least one "runaway" or "thrownaway" episode. Other effective and less expensive than institutional care, a finding that confirmed general trends in the research literature. Id. at 181-82. In addition, policy researchers have compared the annual costs of serving individuals with intellectual disabilities, including children, in various settings. See, e.g., Darrell R. Lewis & David R. Johnson, Costs of Family Care for Individuals with Developmental Disabilities, in COSTS AND OUTCOMES OF COMMUNITY SERVICES FOR PEOPLE WITH INTELLECTUAL DISABILITIES 63 (Roger J. Stancilffe & K. Charlie Lakin eds., 2005). Lewis and Johnson’s figures indicate that, for children with severe intellectual disabilities, care in large institutions is more than three times as expensive as family care, over twice as expensive as small group home care, and slightly more expensive than care in larger community-based group settings. Id. at 79. As noted below, cost-savings multiply when one looks beyond the costs of service delivery and considers the savings that flow from using effective versus ineffective interventions, such as reduced need for expensive services in the future and, in the case of juveniles in the justice system, reduced recidivism and avoidance of entry into the criminal justice system as adults. See infra notes 850-852 and accompanying text.

320. See id.
321. The bill has been renamed the "Keeping Families Together Act of 2005." See S. 380, 109th Cong. (2005); H.R. 2865, 109th Cong. (2005). As of this writing, it has not made it out of committee in either house.
322. HAMMER ET AL., supra note 18, at 2 (2002). The terms are defined as follows:

A runaway episode is one that meets any one of the following criteria: A child leaves home without permission and stays away overnight; a child 14 years old or younger (or older and mentally incompetent) who is away from home chooses not to come home when expected to and stays away overnight; a child 15 years old or older who is away from home chooses not to come home and stays away two nights.

A thrownaway episode is one that meets either of the following criteria: A child is asked or told to leave home by a parent or other household adult, no adequate alternative care is arranged for the child by a household adult, and the child is out of the household.
studies have placed the numbers substantially higher. Federal data collection relating to these phenomena commenced in 1999, and therefore it is not possible to determine whether these numbers reflect changes in patterns over recent years.

Those children who end up on the streets face real risks. OJDDP estimated that 71% of these youth "could have been endangered during their runaway/thrownaway episode by virtue of factors such as substance dependency, use of hard drugs, sexual or physical abuse, presence in a place where criminal activity was occurring, or extremely young age (13 years old or younger)." This population overlaps substantially with other groups discussed in this Article. These children could be adjudicated as status offenders because they have run away. But many could fall within the child welfare system’s jurisdiction as well. For example, the 1999 survey found that approximately 21% of the runaway or thrownaway youths had experienced physical or sexual abuse in their homes during the prior year, leading them to fear a return home. Other studies have reported that higher proportions of the runaway/thrownaway population have experienced such abuse.

overnight; a child who is away from home is prevented from returning home by a parent or other household adult, no adequate alternative care is arranged for the child by a household adult, and the child is out of the household overnight.

Id. at 2.

323. See, e.g., David J. Steinhart, Status Offenses, 6 THE FUTURE OF CHILDREN: THE JUVENILE COURT 86, 93 (1996) (discussing research findings placing the estimate of children who had some runaway experience in a twelve-month period in 1992-93 at 2.8 million, or 15% of the population of children ages 12-17 years of age.


325. HAMMER ET AL., supra note 18, at 2; see also Amy J. L. Baker et al., Recidivism at a Shelter for Adolescents: First-time Versus Repeat Runaways, 27 SOC. WORK RES. 84, 85 (2003) (noting lack of access to medical care, inadequate food and clothing, high rates of exposure to violence and sexual victimization, tendency to engage in “survival sex” and substance abuse). Homeless and runaway youths are also at greater risk for HIV infection. See Mary Jane Rotheram-Borus et al., Homeless Youths and HIV Infection, 46 AM. PSYCHOL. 1188 (1991).

326. See HAMMER ET AL., supra note 18, at 8.

327. See Baker et al., supra note 325, at 84-85; see also GAO, 1989, supra note 324, at 24 (noting that approximately 36% of homeless youth report parental neglect, and approximately 29% of runaway youth report sexual or physical abuse). Kimberly A. Tyler et al., Family Risk Factors and Prevalence of Dissociative Symptoms among Homeless and Runaway Youth, 28 CHILD ABUSE & NEGLECT 355, 358-59 (2004) (reporting that in a sample of runaway youth, 43% had experienced parental neglect, 26% had experienced sexual abuse within the family, and 82% had experienced physical abuse within the family); Les B. Whittle et al., Families of Homeless and Runaway Adolescents: A Comparison of Parent/Caretaker and Adolescent Perspectives on Parenting, Family
Research reveals that runaway and homeless adolescents are significantly more likely to have diagnosable psychological problems than are same-aged peers. For example, one recent study found that 89% of runaway and homeless adolescents in a national study met the criteria for at least one of the following mental disorders: conduct disorder, major depressive episode, post-traumatic stress disorder, alcohol abuse, or drug abuse. Approximately two-thirds of the sample met the criteria for two disorders. Other studies have corroborated findings that high proportions of runaway or homeless children have serious mental health symptoms or disorders. Furthermore, studies suggest that the homes from which the children run away are characterized by a high level of emotional conflict. Given the apparent overlap between runaway and thrownaway adolescents and other troubled and troublesome youth, it is highly likely that the availability of a continuum of appropriate home- and family-based interventions would ameliorate some the circumstances and conditions that lead these adolescents to depart from their homes.

E. Still "Skyrocketing" Rates of Mental Hospitalization

In light of all of the other places that troubled and troublesome youth have been turning up, it is perhaps surprising that the rates of children entering hospitals and residential treatment centers for mental health treatment have continued to surge. The admission numbers reported below suggest that the term "skyrocketing" is an even more

Violence, and Adolescent Conduct, 21 CHILD ABUSE & NEGLECT 517, 523 (1997) (noting a high level of reports by runaways of physical and sexual abuse).


329. See id.

330. See, e.g., Les B. Whitbeck et al., Depressive Symptoms and Co-occurring Depressive Symptoms, Substance Abuse, and Conduct Problems Among Runaway and Homeless Adolescents, 71 CHILD DEV. 721 (2000); Lara E. Embry et al., Risk Factors for Homelessness in Adolescents Released from Psychiatric Residential Treatment, 39 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1293 (2000) (summarizing research); Robert E. Booth & Yiming Zhang, Severe Aggression and Related Conduct Problems Among Runaway and Homeless Adolescents, 47 PSYCHIATRIC SERVS. 75 (1996); Tyler et al., supra note 327, at 361-62 posit a relationship between the experiences of abuse prior to running away and the development of emotional problems. One study found that repeat runaways are more likely to have emotional problems than those who run away for the first time. Baker et al., supra note 325, at 89-90. One study found that one-third of a sample of youth who had been hospitalized for mental health treatment experienced one or more episodes of homelessness within the five-year period following that hospitalization. Embry et al., supra. Because these individuals were studied five years after their adolescent hospitalizations, they were adults at the time of the study.

The admission data indicate each time a child entered a mental health facility for a minimum of a 24-hour stay within an identified annual period. These data do not differentiate between admissions of children who are new to the facility that year and re-admissions of children who stayed in that or another facility previously during that annual period. While it would be useful to know what proportion of the admissions reported here are readmissions, the high rates are disturbing regardless. Each admission of a child to a residential psychiatric facility represents a crisis in the life of that child, that child’s family, and possibly also many others in the community. Whether the high rates of admission reflect a dramatic increase in the numbers of children admitted to these facilities or reveal a “revolving door” phenomenon in which children are repeatedly admitted and discharged, the findings detailed here are cause for alarm.

Table 2 reports rates of three variables of usage of inpatient psychiatric care of minors between the 1920s and 1990s. The first variable is rates of admission. Between the 1920s and 1970s, annual admission rates of minors for inpatient psychiatric care increased almost

332. I first referred to rates of admission of minors to mental hospitals as “skyrocketing” in my 1988 piece. See Weithorn, Skyrocketing Admissions, supra note 16.

333. Indeed, research reveals that in the current climate of reduced availability of intensive mental health services and reimbursement limitations in public and private insurance programs, length of stays on psychiatric units have become shorter. See, e.g., NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS., LENGTH OF STAY IN STATE PSYCHIATRIC HOSPITALS, No. 02-06 (2002); Benton H. McFarland et al., Psychiatric Hospitalization Length of Stay for Medicaid Clients Before and After Managed Care, 29 ADMIN. & POL’Y IN MENTAL HEALTH 191 (2002); Kathleen J. Pottick et al., Changing Patterns of Psychiatric Inpatient Care for Children and Adolescents in General Hospitals, 1988-1995, 157 AM. J. PSYCHIATRY 1267 (2000); Kathleen J. Pottick et al., Factors Associated with Inpatient Length of Stay for Child and Adolescents With Serious Mental Illness, 23 SOC. WORK RES. 213 (1999). Furthermore, some studies have suggested that current insurance-related limitations on length of stay in psychiatric facilities have led to briefer hospitalizations which are, in turn, more likely to be followed by readmissions. See, e.g., Cynthia A. Fontanella, Psychiatric Readmission of Adolescents in the Public Mental Health System, Center for Health Care Strategies, Inc. Resource Paper (2004); Roberto Figueroa et al., Use of Claims Data to Examine the Impact of Length of Inpatient Psychiatric Stay on Readmission Rate, 55 PSYCHIATRIC SERVS. 560 (2004); Oscar Hereen et al., The Association Between Decreasing Length of Stay and Readmission Rate on a Psychogeriatric Unit, 53 Psychiatric Servs. 76 (2002) (observing this phenomenon with geriatric patients); Thomas Wickizer & Daniel Lessler, Do Treatment Restrictions Imposed by Utilization Management Increase the Likelihood of Readmission by Psychiatric Patients? 36 J. AM. MED. ASSOC. 844 (1998); Thomas M. Wickizer et al., Effects of Health Care Cost-Containment Programs on Patterns of Care and Readmissions Among Children and Adolescents, 89 AM. J. PUB. HEALTH 1353 (1999).

334. Admission data are converted into “rates” per 100,000 children in the population. This conversion allows for more meaningful comparisons across years, because it controls for changes in the size of the national population of children over the time periods studied.
ten-fold, from 13 admissions per 100,000 youth in the national population to 123.8 youth per 100,000 in 1971. Admission rates continued to climb during the latter three decades of the century, rising to 128.1 youth per 100,000 in 1980, to 186.3 in 1986, and to a startling 412.1 in 1997. Thus, between 1971 and 1997, the rate increased over 330%.

335. See infra Table 2 and accompanying notes.
336. Id.
Table 2

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<tr>
<td>Number Admissions</td>
<td>5,908</td>
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<td>Rates/100,000</td>
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<td>186.3</td>
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<tr>
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<tr>
<td>Rates/100,000</td>
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<td><strong>Total Admissions: Psych + RTC</strong></td>
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<td>Number</td>
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<td>Rate/100,000</td>
<td>13.0</td>
<td>139.0</td>
<td>225.3</td>
<td>506.9</td>
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337. These data report residence levels of persons under the age of 18, with the exception that the 1920s data, and community mental health center data from 1971, which report admissions for persons under age 20.

338. LERMAN, DEINSTITUTIONALIZATION, supra note 20, at 138.

339. The 1971 “Inpatient Psych” data include admissions of persons under age 18 to public and private psychiatric hospitals and mental health units of general hospitals, as well as inpatient admissions of persons under age 20 to community mental health centers. NAT’L INSTIT. OF MENTAL HEALTH, UTILIZATION OF MENTAL HEALTH FACILITIES 1971, 21, 26, 31 Tables 4, 9, 14 (1973) [hereinafter NIMH 1971]. The rate of 123.8 per 100,000 reported here differs from the figure of 111 that Lerman reports, LERMAN, DEINSTITUTIONALIZATION, supra note 20, at 138, and which I reported previously, see Weithorn, Skyrocketing Admissions, supra note 16, at 783, because the 111 figure does not include admissions to community mental health centers (CMHCs). Given the inclusion of this category of admission data in subsequent-year data sets, I have included the community mental health centers numbers in the 1971 figures.

The RTC admission data include all admissions to Residential Treatment Centers for Emotionally Disturbed Children in 1971. NIMH 1971, supra, at 19 (Table 2). DHHS reported the total number of admissions to RTCs for emotionally disturbed children in 1971 as 11,148, Id. at 19. While one might assume that all of these admissions were of persons under the age of 18, data reported in subsequent years suggest that a small proportion of admissions (i.e., approximately 5%) are persons aged 18 or older. See, e.g., Laura J. Milazzo-Sayre, et al., Persons Treated in Specialty Mental Health Care Programs, United States, 1997, in MENTAL HEALTH, UNITED STATES, 2000, at 172, 194 Table 10. Therefore, I reduced the 1971 total of 11,148 by 5%, arriving at the figure of 10,591.

Residence and Patient Care Episode data for 1971 were also adjusted down 5% for the reasons just noted. Thus, the initial RTC Residence total of 17,489 and PCE total of 28,637, see NIMH 1971, supra, at 20 (Table 3), were adjusted to 16,616 and 27,205 respectively. Residence data for inpatient psychiatric facilities for 1971 are not available, although PCE data for inpatient psychiatric facilities for that year are available, thus permitting the computation of residence data. The total number of PCEs for 1971 is 111,021. Id. at 39 (Table 20). The 111,021 figure was obtained by subtracting the total number of outpatient PCEs of persons under age 18, as reported in Table 20, i.e., 632,216, from the total number of PCEs—inpatient and outpatient—i.e., 743,237. Id. Because the PCE variable consists of the sum of residence figures on a given day of the year plus all admissions in the subsequent one-year period, residence data can be calculated by subtracting admission data from PCEs. Thus, the 1971 Inpatient Psych admission figure (87,588) was subtracted from the 1971 PCE figure (111,021) to arrive at the 1971 Residence figure (23,433).


The continued increase in the rate of admission between 1986 and 1997 is initially surprising in light of the emergence and ultimate domination of managed care policies that have restricted use of expensive interventions such as inpatient mental health treatment.344 Yet, these policies place limits on the length of hospital stays, which results in more frequent readmissions of patients.345

Particularly notable between 1971 and 1980 was a shift in the relative frequency with which children and adolescents admitted for inpatient psychiatric treatment used public versus private facilities. In 1971, private hospital admissions accounted for 37.4% of juvenile mental hospitalizations.346 By 1980, the proportion of total psychiatric

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<th>Table 2 (continued from p. 1383)</th>
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<tr>
<td><strong>Patients in Residence</strong></td>
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<tr>
<td><strong>Inpatient Psych</strong></td>
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<td>Number in Residence</td>
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<td>Rate/100,000</td>
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<tr>
<td><strong>RTC</strong></td>
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<tr>
<td>Number in Residence</td>
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<tr>
<td>Rate/100,000 in Residence</td>
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<tr>
<td><strong>Total in Residence: Psych + RTC</strong></td>
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<tr>
<td>Number in Residence</td>
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<td>Rate/100,000 in Residence</td>
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| **Patient Care Episodes**        |
| **Inpatient Psych**              |
| Number PCEs                      | 10,154 | 111,021| 134,612| 298,654|
| Rate/100,000 PCEs                | 23.0   | 159.0  | 214.0  | 429.1  |
| **RTC**                          |
| Number PCEs                      | N/A    | 27,205 | 47,204 | 98.935 |
| Rate/100,000 PCEs                | N/A    | 39.0   | 75.0   | 142.1  |
| **Total PCEs: Psych + RTC**      |
| Number PCEs                      | 10,154 | 138,226| 181,816| 397,589|
| Rate/100,000 PCEs                | 23.0   | 198.0  | 289.0  | 571.2  |
admissions that occurred in private facilities had risen to 61.2%. The rate of admission of minors to public facilities decreased 35.9% during this nine-year period while the rate of admission of minors to private facilities jumped 69.3%. Rates of admission to public facilities rose slightly in the 1980s and 1990s. Yet, private facility admissions continued to soar, and accounted for approximately three-quarters of juvenile psychiatric admissions by 1997. These data strongly support Paul Lerman’s prediction, made over twenty years ago, that the private sector of the mental health industry is the fastest growing system of juvenile institutional care in the United States. The shift toward private domination of the inpatient mental health sector reduces the accessibility of inpatient mental health services for families without wealth or good insurance coverage. Historically, state hospitals, like the juvenile justice and child welfare systems, had not turned away those viewed as needing their services, irrespective of financial resources or insurance benefits. The reduction of public mental health beds appears to constrict those options available to those who have exhausted, or never had, such resources or benefits, making it more likely that such individuals will turn to other service and intervention systems when in crisis.

Rates of admission to residential treatment centers for emotionally disturbed children rose substantially in the past three decades as well.

347. In 1980, of the 81,532 psychiatric admissions of individuals under age 18 in the United States, 49,910, or 61.2% were to private hospitals (16,735 of free-standing private psychiatric hospitals and 33,175 to private general hospitals). NAT'L INST. OF MENTAL HEALTH, USE OF INPATIENT PSYCHIATRIC FACILITIES BY CHILDREN AND YOUTH UNDER AGE 18, UNITED STATES, 1980, at 12 (1986) [hereinafter NIMH 1980].

348. Rates of psychiatric admission of minors to state and county mental hospitals, general hospitals, and community mental health centers decreased from 77.5 in 1971, NIMH 1971, supra note 339, at 26, to 49.7 in 1980. NIMH 1980, supra note 347, at 12 Table 1. The rate of 49.7 admissions per 100,000 persons under the age of 18 is the sum of the rates for state and county mental hospitals (26.1), for public general hospitals (16.4) and for “multiservice” mental health facilities (7.2). Id. Beginning with the 1980 data set, NIMH no longer referred to the community mental health center category as such, but used the term “multiservice” facility. Community mental health centers are public facilities.

349. In 1971, the rate of admission per 100,000 persons under age 18 to private facilities was 46.3, NIMH 1971, supra note 339, at 26, while in 1980 that rate was 78.4. NIMH 1980, supra note 347, at 12. The 1980 figure is the sum of the rate of 26.3 per 100,000 for private psychiatric hospitals and 52.1 for private general hospitals. Id.

350. Rates of juvenile admission to public facilities rose from 49.7 per 100,000 in 1980, to 59.8 in 1986.


352. See supra Table 2 and accompanying text for data regarding reductions in public mental health facility beds.
increasing from 10,591 admissions of persons under the age of 18 in 1971 to 65,949 such admissions in 1997, an increase of over 600%. Examining the combined inpatient and residential treatment center figures, total admission rates rose between 1971 and 1997 from 139 to 506.9, a 365% increase. It is highly likely, however, that these data underestimate the increase in admissions.

Two other statistics developed by DHHS help complete the picture of institutional use. Residence data, referred to by DHHS as persons “under care population” include “all persons who were admitted to the program before the first day of the specified survey month and who received service from the program during the survey month.” In other words, this statistic takes a one-day snapshot of those persons residing in the institution for the purpose of receiving services. The other statistic, called “patient care episodes” (“PCEs”), is the sum of the one-day residence count and the number of admissions for the one-year period immediately following. Thus, this variable is the most comprehensive, in that it combines admission and residence data.

Table 2 reveals numbers and rates of minors admitted to and residing in mental health facilities from the 1920s through the 1990s, as well as the total PCEs. It is striking to note that, in contrast to admission

353. Charles Kiesler and Celeste Simpkins demonstrated that a substantial proportion of admissions for psychiatric treatment are to “scatter beds,” that is, beds in regular medical or surgical units of general hospitals for the purpose of receiving psychiatric treatment. See Charles A. Kiesler & Celeste G. Simpkins, The Unnoticed Majority in Psychiatric Inpatient Care 1-7 (1993) [hereinafter Unnoticed Majority]. Kiesler and Simpkins found that for the year 1980, over 60% of the episodes of psychiatric inpatient treatment that occurred in general hospitals took place on regular medical or surgical wards, and not on specialized psychiatric units. Id. at 1-7 & Table 1.1. These data reflected episodes for individuals across the age span. DHHS does not include scatter beds in their counts.

One might wonder what the relationship is to the phenomenon analyzed by Kiesler and Simpkins, and that of children who “board” on pediatric units, waiting for mental health services. See supra Part IV.B. for discussion of the “boarding” phenomenon. Because boarders are admitted to general pediatric wards, this population may overlap with those described by Kiesler and Simpkins as occupying “scatter beds.” But, there may also be important distinctions. Patients in the population described by Kiesler and Simpkins were admitted to scatter beds in general hospitals in order to receive psychiatric treatment. Given the minimal information available about the phenomenon of pediatric boarding, it appears that boarding serves to provide a temporary place of containment for children in crisis while they await placement in a mental health facility rather than as a locus for provision of the recommended treatment.

354. Mental Health, United States, 2002, supra note 13, app. at 373, 373. Residence data are also converted to rates per 100,000 children in the population to control for changes in the national population of children from one annual period to the next.

355. This comprehensive statistic provides a more meaningful picture of the actual “use” of that facility throughout the year than do either admission or residence data alone. These data are also converted into rates for 100,000 whenever possible to control for changes in population from year to year.
data, which increased in a linear fashion throughout the twentieth century, residence data peaked in the 1970s, and were cut in half between 1971 and 1997. Because the number of children in residence in mental health facilities at any one time is capped by the number of beds, the reduction in residence numbers is consistent with reports that psychiatric facilities have closed, or down-sized, resulting in an overall reduction in the beds available for psychiatric patients. 356

PCE data, as the composite of admission and residence counts, reflect the substantial increase that occurred for both of its components between the 1920s and 1970s, with an almost 700% increase in PCE rates over that fifty-year period. Despite the “tempering” role that the decreases in residence counts have on the 1980s and 1990s numbers, the increase in the rates per 100,000 of PCEs between 1971 and 1997 is over 170%, with a doubling of rates between 1986 and 1997. Thus, despite substantial reductions in both the number of inpatient and residential mental health facilities serving children and the number of beds available, PCEs have continued to climb. These data, of course, do not include children served in scatter beds of general hospitals for the purpose of receiving mental health treatment, nor do they include children who “board” on medical units or in emergency rooms.

A comparison of the inpatient and RTC residence data reveals that, while residence rates per 100,000 children in hospital-like facilities were cut in half between 1971 and 1997, residence rates of children to RTC doubled during that same period. Thus, when taken together, these two types of facilities reveal a combined residence rate that has grown steadily over the century. The increase in filled beds accounted for by the RTCs has more than offset the reductions in the psychiatric inpatient units. These data are certainly consistent with the growth and increasing importance of RTCs in serving children identified as emotionally disturbed. Perhaps the most dramatic figures of all, however, are the patient care episode figures in the final portion of Table 2. These data combine the one-day residence count with the number of additional admissions that occur throughout the year, as a more stable measure of the number of instances that the facility provided service to a child in a

356. See Ronald W. Manderscheid et al., Highlights of Organized Mental Health Services in 2000 and Major National and State Trends, in MENTAL HEALTH, UNITED STATES, 2002, supra note 13, at 243, 244-47 & Table 2. The statistics reveal that between 1970 and 2000, the total number of psychiatric beds in mental health facilities or units dropped by more than half. More startling, however, is the reduction in public psychiatric beds—that is, beds in state and county mental hospitals. Availability of such public beds dropped by over 85% between 1970 and 2000, from 413,066 to 59,403.
one-year period. While the rate of PCEs in psychiatric facilities increased 34.6% between 1971 and 1986, the rate doubled between 1986 and 1997. The PCEs for RTCs almost doubled (up 92.3%) between 1971 and 1986, with an additional increase of 89.4% from 1986 to 1997. Finally, PCEs in both types of facilities combined increased 46% between 1971 and 1986, and 97.6% between 1986 and 1997.

Those analyzing national data sets for DHHS were also surprised at the continuing increase in the use of inpatient mental health services:

Contrary to expectations, inpatient care increased at a greater rate than outpatient care. However, the increase in the inpatient rate dwarfed that of outpatient care between 1986 and 1997. Despite reforms, youth do not appear to be diverted away from inpatient care as was planned; in fact, they are hospitalized more than before. 357

F. Conclusion

Throughout the second half of the twentieth century, policymakers sought to reduce the use of institutional interventions with children, as well as with persons identified as mentally disordered or mentally disabled. Yet, more children have experienced episodes in institutions in recent years than at any other time in this century.358 Thus, paradoxically, our nation sustains high levels of institutionalization of children despite the inconsistency of those trends and our society’s core legal values as discussed in Part V below, and articulated policy goals, as discussed in Part VI below.

V. DISCONTINUITIES BETWEEN CORE TRADITIONS IN AMERICAN LAW AND PUBLIC POLICIES AFFECTING TROUBLED AND TROUBLESOME YOUTH

Institutionalization is a decisive and unusual event.... [I]n our society, children normally grow up in families, not in governmental institutions.359

High rates of institutional and other out-of-home placements for troubled and troublesome youth are incompatible with core traditions in American law. Troubled and troublesome youth are routinely removed from their homes and communities, confined in various institutional

357. Pottick et al., supra note 161, at 316-17.
358. See Lerman, Twentieth-Century Developments, supra note 20, at 105.
settings, and segregated from the mainstreams of their communities. These responses are inconsistent with our nation's asserted policies of protection of family integrity, avoidance of unnecessary incarceration, and social inclusion of those with special needs. Furthermore, this pattern of response poorly serves the police power and *parens patriae* goals underlying governmental intervention in the lives of troubled and troublesome youth and their families.

While it is true that, in some instances, troubled and troublesome youth must be placed in settings other than their family's home—either for their own protection, or for the protection of others—today, thousands of children annually are placed or retained in such settings unnecessarily. Parts III, IV and VI of this Article demonstrate that substantial numbers of troubled and troublesome youth live in out-of-home placements, receive inappropriate or unduly restrictive intervention, and are bounced back and forth among child service and intervention systems because of poorly conceived, poorly implemented, or poorly funded federal, state, and local policies. While these patterns have persisted for decades, data suggest exacerbation of these problems in recent years, with numbers of affected children continuing to surge.  

Part VII briefly describes a rich body of empirical data revealing that for many troubled and troublesome youth, home-based and community-based interventions can avoid the need for out-of-home placements. This Part demonstrates that high rates of out-of-home placements, particularly institutional placements, are inconsistent with core American legal traditions.

### A. The Starting Point: The Primacy of the Family

Few would argue with the premise that the family is a central—if not the most central—social institution in American life. It has often been said that "families are the building blocks out of which the larger units of social organization are fashioned."  

The law is concerned with the family, its structure, its functioning, and its welfare, because we view the well-being of society-at-large as linked to that of the family.

From ancient times, it has been widely recognized that there exists an essential connection between families and the larger societies that contain them. It is not only that families are the schools of first instance, in which children learn to embrace their deepest and most

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360. *See discussion supra* Part IV.

primitive assumptions about life and other people. It is also, as
Confucius, Plato, and probably a hundred of their forerunners
recognized, that the family is a sort of molecule, the very stuff of
which the larger society is composed, so that the welfare of the one
and the other are indissolubly coherent.\(^\text{362}\)

The family is also the institution within which we reproduce
ourselves—biologically, socially, and politically.

One of [the family’s] main roles is to be the basis of the orderly
production and reproduction of society and its culture from one
generation to the next . . . . A central role of the family is to arrange
in a reasonable and effective way the raising of and caring for children,
ensuring their moral development and education into the wider culture.
Citizens must have a sense of justice and the political virtues that
support political and social institutions. The family must ensure the
nurturing and development of such citizens in appropriate numbers to
maintain an enduring society.\(^\text{363}\)

Some conceptions of the American family have changed throughout
the centuries, however. Historian John Demos, citing an essay by a
seventeenth century clergyman, referred to the colonial family as “a little
commonwealth.”\(^\text{364}\) It was the “fundamental economic, educational,
political, and religious unit of society,” serving many functions that have
since been transferred to governmental and private agencies such as
schools and hospitals, and to commercial units such as businesses and
financial institutions.\(^\text{365}\) As more and more traditional family functions
have been performed by persons and entities outside of the family, there
have remained certain core functions that most agree are still best
provided within the family. Chief among these is the procreation and
upbringing of children, with the family serving as the primary source of
care, nurturance, support, socialization, and inculcation of values.
Arguably, the perceived importance of parents in the socialization
process increased during the nineteenth and twentieth centuries.

During the nineteenth century, children came to be seen more
explicitly than ever as vulnerable, malleable charges with a special
innocence and with particular needs, talents, and
characters . . . . Though other institutions such as the common school

\(^{362}\) David D. Haddock & Daniel D. Polsby, \textit{Family as a Rational Classification}, 74 WASH. U.


\(^{364}\) Demos, \textit{supra} note 361, at 46.

\(^{365}\) STEVEN MINTZ & SUSAN KELLOGG, \textit{DOMESTIC REVOLUTIONS: A SOCIAL HISTORY OF
AMERICAN FAMILY LIFE} xiv (1988).
and the church shared its duties, molding the nation’s young... became more clearly the primary responsibility of the family. [Y]outhful minds and bodies would develop properly only in a special, sheltered home under the watchful guidance of concerned... parents... In the child-centered homes that began to sprout within the nation’s middle class, the parent-child relation... became an all-important nexus.366

The twentieth century saw a continuation of the emphasis on the special role of families in the upbringing of their children. Yet, the twentieth century—and the second half of the century in particular—brought with it many changes in family structure, forms, and roles. Notions of what constitutes a family and what roles family members should play continue to fluctuate as our society and its family law respond to dramatic increases in nontraditional family forms,367 high rates of family dissolution,368 and the continuing struggle for gender equality. In this context, family law struggles with how to configure and balance the multifaceted interrelationships of the family members with one another, with those outside of the family, and with the complex web of private and public entities ranging from employers, schools, law enforcement, and so on. Yet, despite the dramatic transformations in families and family law, the primacy of the parental role in raising children has remained a centerpiece in the law of family relations.369

Indeed, while values of care and support characterize social and legal expectations surrounding a variety of family relationships, such as

368. See ELLMAN ET AL., supra note 367, at 232-68.
369. See Troxel, 530 U.S. at 64-67 (summarizing relevant Supreme Court doctrine and reaffirming parents’ fundamental rights “to make decisions concerning the care, custody, and control of their children”).
those between spouses and spouse-equivalents, and those between adult children and their aging dependent parents, arguably there is no set of family obligations more universally embraced in America, or more deeply embedded in our family law, than the duties of parents to care for their minor children. The notion that parents are invested with the responsibility to care for, support, and raise their children remains one of the most stable features of family life in American culture:

It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.

The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. The primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

This language from the Court's opinions in Prince v. Massachusetts and Wisconsin v. Yoder makes clear that, according to constitutional doctrine, parents are entrusted with the responsibility for their children's upbringing and preparation for adult life. In addition, certain rights, rising to the level of fundamental rights, accompany these parental obligations. These constitutionally-protectible rights insulate parents from state intervention in childrearing in many contexts, investing parents with significant decisional autonomy regarding their children's


371. See, e.g., VT. STAT. ANN. tit. 15 § 1201 (2004) (defining provisions of "civil unions" a status available to same-sex couples, providing all of the rights, responsibilities, and obligations of marriage to those who enter into it); See, e.g., CAL. FAM. CODE § 297 et seq. (2005) (defining provisions of a "domestic partnership," a status available to same-sex couples and some opposite-sex couples over the age of 62, providing for most of the rights, responsibilities, and obligations of marriage to those who enter it).

372. See, e.g., Lee E. Teitelbaum, Intergenerational Responsibility and Family Obligation: On Sharing, 1992 UTAH L. REV. 765 (1992) (addressing social, ethical, and legal issues relating to adult children's care for aging and ill parents); CAL. FAM. CODE § 4400 (2004) (imposing on adult children of dependent parents a duty of support: "Except as otherwise provided by law, an adult child shall, to the extent of his or her ability, support a parent who is in need and unable to maintain himself or herself by work.").

373. See generally ELLMAN ET AL., supra note 367, at 447-680, 944-1305.


376. See discussion in Troxel, 530 U.S. at 65-67 ("[I]t cannot now be doubted that the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children.").
upbringing, and safeguarding their opportunities to have the custody and companionship of their children. 377 The Supreme Court, however, has not explicitly carved out a symmetrical fundamental right of children in a continuing relationship with their parents 378 or other family members, 379 although it has alluded occasionally to children's interests in maintaining the parent-child bond. 380

What are the policy rationales for the elevation in American constitutional jurisprudence of parental decisionmaking authority and parental rights to the custody and companionship of their children? Understanding the theories underlying this powerful grant of autonomy helps us to appreciate why high rates of out-of-home placements of troubled and troublesome youth are inconsistent with our core legal traditions. Jurists and scholars have proffered a range of explanations for the constitutional protection of parental discretion in childrearing.

Natural law perspectives view parental rights as "pre-political; the law presupposes rather than creates them; and they arise from a relationship that is entirely apart from the power of the State" although "one of the state's most basic functions is to protect these rights." 381


378. Dismissing a child's claim that she has a due process right to maintain a relationship with her biological father, notwithstanding a statute presuming her mother's husband to be her father, Justice Scalia stated: "We have never had occasion to decide whether a child has a liberty interest, symmetrical with that of her parent, in maintaining her filial relationship. We need not do so here because, even assuming such a right exists, [her] claim must fail." Michael H., 491 U.S. at 130.

379. But see Justice Stevens' dissenting opinion in Troxel, in which the Court held that parents' fundamental rights to custody and control over their minor children place certain limits on the state's authority to permit grandparent visitation:

While this Court has not yet had occasion to elucidate the nature of a child's liberty interests in preserving established familial or family-like bonds, . . . it seems to me extremely likely that, to the extent parents and families have fundamental liberty interests in preserving such intimate relationships, so, too, do children have these interests, and so, too, must their interests be balanced in the equation.

530 U.S. at 88 (Stevens, J., dissenting). Professor Emily Buss challenges the proposition that formal recognition of children's rights to maintain relationships with others over parental objection would indeed result in greater protection for children's interests and welfare, given most children's inevitable dependence on adults to exercise these rights on their behalf. See Emily Buss, Children's Associational Rights?: Why Less is More, 11 WM. & MARY BILL. RTS. J. 1101, 1103-16 (2003).

380. See Santosky, 455 U.S. at 760 ("[U]ntil the State proves parental unfitness, the child and his parents share a vital interest in preventing erroneous termination of their natural relationship.").

381. Katharine T. Bartlett, Rethinking Parenthood as an Exclusive Status: The Need for Legal Alternatives When the Premise of the Nuclear Family Has Failed, 70 VA. L. REV. 879, 887-88 (1984) [hereinafter Bartlett, Rethinking Parenthood]. This perspective, of course, grounds the existence of parent-child rights on the biological connection between parents and children, and does
Other theories focus instead on the responsibility of parents to raise, support, and nurture children, emphasizing the logic of vesting those legally charged with the duty of raising children with some measure of authority in choosing how to accomplish the task. Three linked presumptions support the notion that parental discretion is a good starting point for allocation of authority in raising children: (1) the law presumes that minors' immaturity, inexperience, and undeveloped capacity for judgment limit their ability to direct their own lives; (2) parents "possess what a child lacks" in these areas of functioning; and (3) parents generally "act in the best interests of their children." In the absence of evidence to the contrary, the law presumes that parents are capable of acting, and are motivated to act, in their children's "best interests," and that they are better equipped to do so than are the children themselves. Furthermore, powerful emotions underlie parental inclinations to promote their children's welfare. The parent-child relationship is unique in the sheer depth and intensity of the emotional ties that pervade it: "natural bonds of affection" characterize most relationships between parents and children, including the inherent selflessness that parents often exhibit.

Yet, there is substantially greater protection of parental autonomy than one would expect from a result-oriented "best interests" inquiry alone. If a result-oriented best interests formulation served to fully explain the constitutional protection of parental autonomy, then supervision of parental autonomy could arguably follow whenever others (e.g., the state, third parties, or the children themselves) could demonstrate that they are better situated than are the parents to act in the children's best interests. At least in principle, however, the state does not intervene in childrearing every time it discerns that there is a "better" way to raise the children than that chosen by the parents. Doing so would create several problems. First, determining precisely what constitutes children's "best interests" can be a highly speculative

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382. See Parham, 442 U.S. at 602 (setting forth those presumptions on which parental autonomy in childrearing is grounded).
383. Id.
384. See Barbara Bennett Woodhouse, Of Babies, Bonding, and Burning Buildings: Discerning Parenthood in Irrational Action, 81 Va. L. Rev. 2493, 2494-97 (1995) [hereinafter Woodhouse, Burning Buildings] (noting that intense emotions experienced by parents with respect to their children often lead parents to engage in actions that might be viewed as irrational if observed in other relationships (such as the willingness of parents to risk their own lives to protect their children from dangers)).
endeavor. This fact argues against state intervention in the family in the face of anything other than serious dangers to the child’s welfare in matters reflecting substantial societal consensus. Second, under our democratic theory of government, diversity in family values and concomitant childrearing approaches is preferred over the “standardization” that would result if the state did not allow parents to exercise discretion in most areas of their children’s upbringing. This premise was stated with clarity by the Supreme Court in Pierce v. Society of Sisters, as the Court struck down an Oregon statute which mandated that eight- to sixteen-year-old children attend public school, thereby precluding parents’ opportunity to choose among educational institutions:

The fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the state to standardize its children by forcing them to accept instruction from public teachers only. The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.

Thus, in the absence of evidence that alternative methods of childrearing are truly harmful to children, variation among family approaches is to be encouraged rather than hindered.

Third, given the strength of the emotional bonds that form between parents and children, not only can we expect that most parents strive to promote their children’s welfare, but also that disruptions of parent-child relationships exact a cost to the child’s well-being that must be carefully considered.


386. See Michael Wald, State Intervention on Behalf of “Neglected” Children: A Search for Realistic Standards, 27 STAN. L. REV. 985, 992 (1975). Professor Wald points out that “[n]o national consensus exists concerning what constitutes a ‘healthy’ adult” or “how to raise a child to make him ‘healthy’—however ‘healthy’ may be defined.” Id. He asserts that state intervention in families for the purpose of child protection should not seek “to regulate all aspects of childrearing,” but should instead focus on “basic harms from which we wish to protect all children.” Id. at 993. See also Emily Buss, “Parental” Rights, 88 VA. L. REV. 635, 648 (2002) (arguing that state intervention in the family should be limited to circumstances “where the state’s relative childrearing expertise is greatest—where the developmental stakes are most public, or where the consensus if most unqualified” and that even then “we should be slow to allow state intervention if the child’s welfare is our goal” because of the costs of intervention to the child are so great).


388. Id. at 535.
measured against the benefits of state intervention. Decades of theory and research in developmental psychology confirm the importance to children's well-being of healthy parent-child bonds and of continuity in such caregiving relationships. Thus, there is inherent value in allowing


390. Scholarship examining the role of attachment relationships in the formation of healthy child and adult functioning has flourished over the last several decades. Researchers have explored the evolutionary role and neurobiological bases of attachment behavior, and studied how the nature and quality of attachment relationships affect psychological functioning throughout the lifespan. There is now a rich empirical base from which to conclude that the quality of children's relationships with adult caregivers strongly influences their well-being. The best compilation of modern attachment research is available in HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS (Jude Cassidy & Phillip R. Shaver eds., 1999).

Many in the legal world rely on the writings of Goldstein, Freud, and Solnit as support for the proposition that continuity and permanence are important to children's welfare. See generally JOSEPH GOLDSTEIN, ANNA FREUD & ALBERT J. SOLNIT, BEYOND THE BEST INTERESTS OF THE CHILD (1973); JOSEPH GOLDSTEIN ET AL., BEFORE THE BEST INTERESTS OF THE CHILD (1979); JOSEPH GOLDSTEIN ET AL., IN THE BEST INTERESTS OF THE CHILD (1986). While these writings provide accessible discussions of the contribution that maintenance of emotional bonds with parent figures makes to children's development, these works have also provoked substantial criticism. Jean Koh Peters summarizes these critiques as relating to: (1) "inappropriate or inadequate data and authority for the psychological principles underpinning their work"; (2) "concern that the . . . work reflected an overly narrow and culture-bound view of families, which failed to recognize the existence and success of diverse family forms larger than the two-parent nuclear family"; and (3) fears that the authors' principles would be disproportionately harsh on poor families and children." Jean Koh Peters, The Roles and Content of Best Interests in Client-Directed Lawyering for Children in Child Protective Proceedings, 64 FORDHAM L. REV. 1505, 1545 (1996). For example, Katharine Bartlett criticizes Goldstein et al.'s unsubstantiated assumption that children's maintenance of relationships with a range of people with whom they have emotional bonds "jeopardizing their adjustment to new family situations," and should be strongly disfavored. See Bartlett, Rethinking Parenthood, supra note 381, at 908. By contrast, Bartlett argues that children suffer when relationships to important caregivers are disrupted, even if those caregivers are not legally-recognized parents and children are required to manage a complex web of relationships to adults who may not be in familial relationships with each other. Id. at 902-912. And, indeed, empirical research has only scratched the surface in understanding the nature and process of children's attachment to multiple caregivers, revealing a far more complex picture than that portrayed by Goldstein et al. See, e.g., Carollee Howes, Attachment Relationships in the Context of Multiple Caregivers, in HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS, supra, at 671. Initial findings support Bartlett's position, and challenge the wisdom of excluding multiple caregivers from a child's life. For example, in summarizing the research findings to date, Howes concludes that "[p]articularly for children with difficult life circumstances . . . it seems possible that alternative attachment figures can provide children with a 'safety net' for their future development." Id. at 685. And for children who are removed from the home and placed with substitute caregivers such as foster parents, a range of factors may contribute to the children's overall development including: the nature and quality of the caregiving provided in the home of origin and the child's attachment to his/her legal parents, the history of traumatic or deleterious conditions or events, the nature of the care provided by the substitute caregivers and the child's attachment to those persons, the length and number of out-of-home placements, and so on. Michael Rutter and Thomas G. O'Connor emphasize that there exists a "paucity of systematic research" providing clear answers to guide legal decisionmaking. See Michael Rutter & Thomas G.
parents significant independence in childrearing, and reserving state intervention for truly exceptional circumstances in which the child's welfare is seriously at risk, so as to protect the parent-child relationship from ongoing interference from the state.

State protection of parental autonomy has also been viewed as a sort of *quid pro quo*—a reciprocal component that goes hand-in-hand with the weighty responsibilities of parenthood. Professor Katharine Bartlett refers to this as the "exchange" theory of parenthood: parental duties create parental rights and vice versa. Professor Elizabeth and Robert Scott argue that legal protection for parental discretion serves to promote parental commitment to their children's interests by serving as "an important inducement to encourage investment [by parents in their] children's welfare." The Scotts analogize the parent-child relationship to that of the relationship between fiduciaries and beneficiaries. They assert that, like the responsibilities of fiduciaries, the duties of parents are complex, not easily reducible to specific obligations, demand considerable decisionmaking discretion, and are difficult to monitor. The broad discretion granted to fiduciaries in carrying out their duties—subject primarily to general obligations of care and loyalty—not only allows fiduciaries to fulfill their duties more efficiently than would an arrangement that micro-managed their day-to-day functions, but also


393. *Id*. at 2402. Professor Barbara Bennett Woodhouse has applied a similar concept of "stewardship" or "trusteeship." See Woodhouse, *Burning Buildings*, supra note 384.

394. Scott & Scott, *supra* note 392, at 2419-20. Beneficiaries, like children, are presumed to "lack the requisite information or expertise to understand or evaluate the fiduciary's performance" thus rendering these individuals "particularly vulnerable and unable fully to protect and assert [their] own interests." *Id*. at 2420.
serves as a “reward” of sorts for their commitment to the interests of their beneficiaries. 395

Professors Scott note that parent-child relationships begin with a powerful emotional attachment that predisposes the parents to make their children’s interests paramount, and in an intact family, these predispositions together with “internalized informal norms about parenting, are assumed to function effectively, mitigating potential conflicts of interest...” 396 Thus, according to the Scotts, parental rights and their concomitant broad grants of discretion enhance parents’ commitment to serving the interests of their beneficiaries by promoting parental investment in the childrearing process. Consistent with this perspective, we presume not only that parents will generally be capable and motivated to act in their children’s best interests, but that a broad grant of autonomy to parents in childrearing is an essential component of the arrangement. That grant of autonomy helps parents maintain their motivation to place the children’s interests first, and is also highly practical, because the state is unlikely to be able to manage all of the day-to-day decisions and functions required of parents. 397

Yet, before the law can protect the primacy of a particular family in the upbringing of children, it must first determine which constellation of persons form the parent-child unit to be afforded protection. While in most instances, there is neither debate nor uncertainty as to who comprises a child’s family, the matter may be disputed in others. The law typically privileges certain indicia of parenthood over others when determining precisely whose relationship with a particular child is entitled to legal protection. Formal factors, such as biology and, in the case of men, marriage to the child’s mother, weigh heavily in determinations of parentage ordinarily trumping purely functional factors. 398 Thus, persons to whom we might generically refer as “de

395. See id. at 2429.
396. Id. at 2446. By contrast, the Scotts argue further that, once the family is “fractured,” either through “voluntary” actions such as parental separation or divorce, or because the state has found parental conduct inadequate, as in the child protection context, more intrusive legal regulation replaces the more extralegal and internalized informal norms. Id.
397. See The Constitution and the Family, 1980, supra note 389 at 1214 (noting that parents are far more qualified than the state to provide “the intimacy, stability, emotional support required for a child’s healthy development .... [and to] make all of the countless detailed, subjective decisions necessary in rearing children ....”); Buss, “Parental” Rights, supra note 386, at 656 (observing that the law’s placement of childrearing responsibility with parents serves as a means of “ensuring the effective satisfaction of [the] important responsibilities” that include “intense day-to-day involvement of nurturance and long-term investment that instills values and fosters skills”).
398. See, e.g., Smith v. Foster Families for Equality and Reform, 431 U.S. 816, 846-47 (1977) (holding that “[w]hatever liberty interest might otherwise exist in the foster family as an institution,
facto,” “functional,” or “psychological” parents, but without formal claims to parental status, may not be accorded legal recognition despite having assumed the responsibilities of parenthood and developed those “natural bonds of affection” unique to parent-child relationships. 399

In recent decades, the law has had to confront a myriad of situations in which parties with traditional claims of parenthood are pitted against those who assert claims based on nontraditional factors, such as having formed a functional parent-child relationship, stimulating rich debates in the scholarly literature as to what factors should form the basis for legal parenthood, 400 and whether determinations of parenthood must necessarily exclude legal claims to a continuing relationship with children by nonparents with whom a child has a deep attachment. 401 Along these lines, Professor Barbara Bennett Woodhouse argues that notions of parenthood should be “child-centered,” that is, vest parental status in those who have “earned” it by meeting children’s needs for nurturance, care, and protection through unwavering commitment to the child through “life-sustaining and responsive caregiving.” 402

that interest must be substantially attenuated where the proposed removal from the foster family is to return the child to his natural parents”); Michael H., 491 U.S. at 131 (upholding California’s conclusive presumption of legal paternity in favor of a mother’s husband in face of putative biological father’s claims). For a discussion of the distinction between “formal” and “functional” models of family relationships, see ELLMAN ET AL., supra note 367, at 20-39; David D. Haddock & Daniel D. Polsby, Family as a Rational Classification, 74 WASH. U. L.Q. 15 (1996); Martha Minow, Redefining Families: Who’s In and Who’s Out? 62 COLO. L. REV. 269 (1991).


401. See, e.g., Bartlett, Rethinking Parenthood, supra note 381.

402. See, e.g., Woodhouse, Hatching the Egg, supra note 385, at 1749, 1752-55. Professor Woodhouse argues that constitutional precedents protecting family privacy, such as Meyer and Pierce, reveal their “dark side” when parental autonomy operates like a form of ownership favoring those who have a possessory claim of parenthood but have failed to meet the child’s needs for care and nurturance. Barbara Bennett Woodhouse “Who Owns the Child?”: Meyer and Pierce and the Child as Property, 33 WM. & MARY L. REV. 995, 1000-01, 1042 & n.209 (1992); Barbara Bennett Woodhouse, The Dark Side of Family Privacy, 67 GEO. WASH. L. REV. 1247 (1999). Woodhouse argues that vestiges of traditional views of women and children as the property of husbands and fathers continue to influence modern child-family-state jurisprudence: “Themes of individualism, private enterprise, and parental rights of ownership mark our history and survive in our state laws of custody and our constitutional doctrines of family ‘autonomy’ and ‘privacy.’” Woodhouse, Hatching the Egg, supra note 385, at 1809-12. In its place, she proposes a generist model, invoking a metaphor of a “dynamic stewardship, in which power over children is . . . earned through actual care giving . . .” Id. at 1814-15.
For our purposes here, it is not necessary to confront the question of whether certain nontraditional relationships between adults and children should be given legal protection. In focusing on the primacy of the family, my objective is to propose a reordering of priorities for state intervention with troubled and troublesome youth, so that promotion of these children's adaptive functioning within the family, and the strengthening of the family itself become serious goals. Families of troubled and troublesome youth, however, are often disorganized, disrupted, and dysfunctional. Perhaps a stable or otherwise influential force in the child's life is a grandparent, a stepparent, an aunt, an older sibling, or a foster parent. My discussion of the primacy of the family does not, a priori, suggest which persons might fruitfully be engaged in family-based interventions supportive to the child. Rather, my purpose is to speak more broadly of the central role that family relationships play in our law, culture, and in our psychological well-being, and to redirect state efforts toward investing in such relationships.

Consistent with this point, while much of the foregoing helps to explain why our government employs a policy of restraint regarding intervention in the family, it does not tell us what obligations the state has to help families succeed in the childrearing mission. As social changes have made family life more challenging for many, our notions of family as a self-sustaining unit have not evolved to accommodate the complexities that affect American families' abilities to meet the needs of their children. Recognizing that the burdens borne by some parents in modern American society are increasingly heavy, some observers propose a greater governmental and community role in supporting families by providing for a range of services. Yet, there is a lack of agreement, perhaps even "confusion and ambivalence," as to "which responsibilities the individual family should shoulder and which should be assumed by other nonfamilial institutions." The resulting policy approach to social problems is "splintered," "piecemeal or makeshift." The United States has "no coherent 'family policy'" and a "constricted

403. See, e.g., STEPHANIE COONTZ, THE WAY WE NEVER WERE: AMERICAN FAMILIES AND THE NOSTALGIA TRAP 210 (1992) (arguing that the "rest of American culture should adopt standards of childrearing that do not confine responsibility to parents" and stating that the "truly dysfunctional thing about American parenting is that it is made out to be such a frighteningly... private and exclusive job"); see also Anne L. Alstott, What Does a Fair Society Owe Children—and Their Parents?, 72 FORDHAM L. REV. 1941 (2004).
404. MINTZ & KELLOGG, supra note 365, at xvii.
405. Id. at xvii.
capacity” to support the family in meeting its obligations to our society’s children.

Frequently, as in the case of troubled and troublesome youth, our society swings between solutions that are polar opposites of one another. Families are either left to their own devices exclusively—to deal with troubled and difficult youth, to finance interventions, and to struggle to provide adequate and safe homes and environments against sometimes-overwhelming odds—or children are removed from the family home under the auspices of the mental health, child welfare, or juvenile justice systems. American policies should focus first and foremost on strengthening and supporting families so that they are best equipped to confront the challenges of raising children in today’s society, which places many “socially-toxic” influences in children’s developmental paths. This conclusion follows logically from the constitutional importance of the parent-child relationship, the primacy of the family in American culture, and the psychological evidence underscoring the importance of healthy parent-child relationships for children’s futures. While some troubled and troublesome children must be removed from their homes for their benefits or for the safety of others, the research findings discussed in Part VII suggest that such removals are typically not necessary to achieve the goals of state intervention discussed immediately below.


The law governing state regulation of children and families is unique because of the state’s distinctive relationship to children. Although American law clearly protects parental authority in most aspects of childrearing—creating a “private realm of family life which the state cannot enter”—parental discretion is not absolute. It must yield when its exercise interferes with the state’s interests, and occasionally, when it interferes with the children’s interests. The

406. Demos, supra note 361, at 60.
407. See, e.g., JAMES GARBARINO, RAISING CHILDREN IN A SOCIALLY TOXIC ENVIRONMENT (1995) (emphasizing factors such as the availability of guns and school and community violence, domestic violence, the prevalence of divorce and absent fathers, poverty and racism); see also Barbara Bennett Woodhouse, Reframing the Debate About the Socialization of Children: An Environmentalist Paradigm, 2004 U. CHI. LEGAL F. 85, 85-92 [hereinafter, Woodhouse, Socialization of Children] (discussing the potentially negative impact of media and marketing influences on children).
Supreme Court, in *Prince v. Massachusetts*, best articulated the state’s dual *parens patriae* and police power interests in the children’s development, and how those interests are balanced against the rights of parents to control their children’s upbringing:

[T]he family itself is not beyond regulation in the public interest . . . . Acting to guard the general interest in youth’s well being, the state as *parens patriae* may restrict the parent’s control by requiring school attendance, regulating or prohibiting the child’s labor, and in many other ways . . . . [T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child’s welfare.

The state’s authority over children’s activities is broader than over like actions of adults . . . . A democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies. It may secure this against impeding restraints and dangers, within a broad range of selection. Among evils most appropriate for such action are the crippling effects of child employment, more especially in public places, and the possible harms arising from other activities subject to all the diverse influences of the street . . . . [L]egislation appropriately designed to reach such evils is within the state’s police power . . . .

The term *parens patriae* is translated literally as “parent of the country,” and refers to the traditional role that the state has played, much like a guardian or benevolent parent, in safeguarding and serving those who cannot protect their own interests because of incapacity or youth. In the context of children, the state’s *parens patriae* power

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409. *Id.* at 166-68 (citations and footnotes omitted). The Court stated further: “Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.” *Id.* at 170.

410. See *BLACK’S LAW DICTIONARY* 1003 (5th ed. 1979).

411. The origins of the doctrine of *parens patriae* are fairly obscure, which is surprising in light of the expansive range of state interventions that this doctrine currently justifies. Justice Marshall recounts the doctrine’s heritage in a case concerning a state’s right to sue for economic injuries attributable to a violation of the federal antitrust statutes:

The concept of *parens patriae* is derived from the English constitutional system. As the system developed from its feudal beginnings, the King retained certain duties and powers, which were referred to as the “royal prerogative.” . . . These powers and duties were said to be exercised by the King in his capacity as “father of the country.” Traditionally, the term was used to refer to the King’s power as guardian of persons under legal disabilities to act for themselves. For example, Blackstone refers to the sovereign or his representative as “the general guardian of all infants, idiots, and lunatics,” and as the superintendent of “all charitable uses in the kingdom.” In the United
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authorizes its regulation of children and their families, for the purpose of protecting the children’s welfare. Thus, under this limited power, “the state may pursue ends that would be impermissible under the police power because they are unrelated to any harm to third parties or to the public welfare.”

The state’s police power interest, by contrast, justifies regulations that seek to “secure generally the comfort, safety, morals, health, and prosperity of” the society as a whole, thus permitting the regulation of children and families where doing so is deemed necessary to promote the general welfare. The distinction between two subtypes of police power justifications is of particular relevance to our discussions of state intervention with troubled and troublesome youth. The first subtype,
which I refer to as policies justified by public safety-oriented purposes, seeks to regulate the conduct of particular individuals who present a danger to others so as to protect society from this danger. Clearly, our criminal justice system and law enforcement apparatus are in place primarily to further these police power goals.415 In the case of juveniles, government intervention in the lives of youth who endanger the public by committing violent acts would fall under this subtype of the police power.416

The police power however, extends to “all aspects of the public welfare,”417 and is not limited solely to restricting the dangerous conduct of some for the protection of others. Given that children are the future adult citizens of our nation, their socialization and positive development is critical to the well-being of the rest of us in society, and perhaps even to our democratic form of government.418 Thus, the socialization-oriented dimensions of the police power, as exercised in relation to children, authorizes fairly broad governmental intervention including, but not limited to, state requirements for school attendance and prohibitions against child labor.419

Thus, while the parens patriae and police power justifications for regulating children’s lives are theoretically quite distinct, many regulations of children’s and families’ lives are justified by both sets of interests. To the extent that an intervention authorized by the police power seeks to further the common good by promoting the child’s healthy development into well-educated, productive, and well-adjusted adults, that intervention may also be justified under the parens patriae power, in that such positive development is likely to be in the children’s own best interests as well as those of their community. Furthermore, the convergence of these two sets of justifications in particular contexts has allowed the state to forge some of its most expansive interventions in the


415. Among those purposes served, in theory, by the criminal justice system are incapacitation, deterrence, and retribution. See, e.g., BLOCH & MCMUNIGAL, supra note 121, at 28-60.

416. For a rich and provocative analysis of the independent role of “preventive detention” (i.e., incapacitation) in public safety-oriented police power confinements, see Christopher Slobogin, A Jurisprudence of Dangerousness, 98 NW. U. L. REV. 1 (2003).


419. As noted below, however, these two types of regulations are also justified by parens patriae purposes. See infra note 420 and accompanying text.
lives of children and families, such as universal compulsory education, child labor restrictions, and the development of state-based child welfare and juvenile justice systems.

Our government has generally relied first on parents to guard, secure, and provide for children’s welfare. Twentieth century constitutional jurisprudence has clarified that family privacy, of which parental autonomy is a core component, is a fundamental constitutional right, thereby shielding parental autonomy from state interference except where state intervention is necessary to achieve a compelling state interest. Protection of children’s welfare, either under parens patriae or police power theories, is generally viewed as compelling, and thus substantive scrutiny of regulations intervening in the family will focus on whether the means chosen by the state are sufficiently narrow. Yet, this particular allocation of authority between the parents and state leaves us with a bit of a dilemma:

If the state must assume some responsibilities for children, how can it discharge those responsibilities when childrearing is still considered a private responsibility? The dominant solution ever since the early nineteenth century has been to allow the state to intervene into childrearing only when families are considered to have failed.

420. For example, we compel parents to obtain vaccinations for their children and to insure that their children attend school because we believe these mandates are in the joint interests of the children and society. Arguably, it is the convergence of societal and individual interests that gives the state its legitimacy in mandating compliance with these particularly intrusive directives, because either interest alone would be insufficient. We do not compel children or adults to participate in medical research, even though universal participation might make a significant contribution to societal public health goals as does obtaining required vaccinations. In our political system, the police power interests of such a policy alone does not justify the intrusion on personal autonomy that coerced research participation would entail. Likewise, generally, we do not compel individuals to undergo medical procedures that are for their benefit only. Here, parens patriae motives alone do not outweigh individual autonomy interests. When the parens patriae and police power interests operate in concert, however, there exists greater justification for particularly intrusive social policies.

421. The notion of “rehabilitation,” central to the creation of the juvenile justice system, reflects converging parens patriae and police power goals, in that such rehabilitation, in theory, benefits the offender and the public. For a fresh perspective on the concept of rehabilitation within the juvenile justice system, see Christopher Slobogin, Treating Kids Right: Deconstructing and Reconstructing the Amenability to Treatment Concept, 10 J. CONTEMP. LEGAL ISSUES 299 (1999).


Generally, families are left on their own or with limited assistance to provide for their children’s caregiving and support. The state stands ready to intervene, typically with removal of children from the home, when the family is viewed to have failed their children. That failure may manifest in any of several ways. Law enforcement, school personnel, or others may respond to the troubled and troublesome behavior of children which may be viewed as disobedient, dangerous, or as symptoms of emotional disorder. Child welfare personnel or others may focus on suspected parental inadequacies or maltreatment. Children’s exit from the home may follow, either through state action, parent-initiated removal (which is often grounded in inability to access or afford appropriate assistance), or child-initiated departure.

A broader vision of the state’s converging *parens patriae* and police power interests, as articulated in *Prince*, however, arguably extends beyond mere protection of children from immediate dangers in the face of alleged parental inadequacy. The frequently-quoted statement that “[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies” suggests that the state would be wise to make an investment in children, viewing children as the raw material out of which tomorrow’s citizenry will be formed. Failure to promote the “healthy, well-rounded growth of young people” will squander society’s human capital to the detriment of this and future generations. Failure to make such an investment is, of course, very short-sighted, when a

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425. See, e.g., Kay P. Kindred, *God Bless the Child: Poor Children, Parens Patriae, and a State Obligation to Provide Assistance*, 57 OHIO ST. L.J. 519, 534-36 (1996) (arguing that modern application of the *parens patriae* doctrine via the child welfare system intervention in impoverished families fails to achieve children’s best interests and recommending that the state has affirmative obligations to assist the family so that minimal intrusion in the family unit is required in the protection of children’s well-being); Sarah Ramsey & Daan Braveman, “Let them Starve”: *Government’s Obligation to Children in Poverty*, 68 TEMP. L. REV. 1607 (1995) (arguing for an affirmative government obligation to assist children in poverty, relying on the doctrine of *parens patriae* and other sources of law, acknowledging that “it may be difficult to use existing legal bases to impose an affirmative obligation on government to support poor children”). *Id.* at 1647.


society cares about its future and has the resources to promote children's healthy development and growth.

American jurisprudence frequently characterizes interrelationships of parents, the state, and children as adversarial, as these parties struggle for control of children's destiny. Yet, such a characterization is rarely appropriate. Most of the time, the interests of the state, parents, and children are in harmony. The state values parental autonomy, for all of the reasons set forth above, including that such autonomy is most likely to promote the children's best interests, and thus also, the common good of society. It is in the interest of the community that families succeed—not fail—in their childrearing function. Thus, a model that emphasizes a parent-state partnership formed around common concerns in childrearing and socialization, rather than as a struggle over adverse interests, is most likely to meet the needs of children, parents, and the larger community. 428 Such a model, however, will require a greater investment by the state in promoting children and families' long-term welfare, along lines to be elaborated in Part VII of this Article. While the costs of doing so at the front-end may require more early investment in the process, it is highly likely that the ultimate costs, human and financial, will be substantially less than if we respond with state intervention or support only after circumstances have led to a crisis which the state cannot ignore. 429

C. Avoidance of Unnecessary Restrictions of Liberty—Even for Children

The Fifth and Fourteenth Amendments of the U.S. Constitution guarantee that no one shall be deprived of "life, liberty, or property, without due process of law . . ." 430 In addressing the question of what process is due one whose liberty the state seeks to restrict, courts, legislatures, and scholars have focused overwhelmingly on criminal

428. See Woodhouse, Socialization of Children, supra note 407, at 85-92 (discussing how a parent-state partnership can benefit children in the face of deleterious influences from the media and marketing strategies); see also Barbara Bennett Woodhouse, A Public Role in the Private Family: The Parental Rights and Responsibilities Act and the Politics of Child Protection and Education, 57 OHIO ST. L.J. 393, 394-95 (1996).

429. See, e.g., ANNETTE U. RICKEL & EVVIE BECKER, KEEPING CHILDREN FROM HARM'S WAY: HOW NATIONAL POLICY AFFECTS PSYCHOLOGICAL DEVELOPMENT 89-146 (1997); NAT'L RESEARCH COUNCIL, LOSING GENERATIONS: ADOLESCENTS IN HIGH-RISK SETTINGS (1993); RESILIENCE AND VULNERABILITY: ADAPTATION IN THE CONTEXT OF CHILDHOOD ADVERSITIES (Suniya S. Luthar ed., 2003); INVESTING IN CHILDREN, YOUTH, FAMILIES, AND COMMUNITIES: STRENGTHS-BASED RESEARCH AND POLICY (Kenneth I. Maton et al. eds., 2004).

430. U.S. CONST. amend. V & XIV.
defendants. This follows logically from the textual emphasis on the criminal justice context in the Constitution, and from the practical reality that the most sizable group of persons at risk from state deprivations of their physical liberty are criminal defendants.

Not until the mid-twentieth century did courts and legislatures begin to address the procedural and substantive due process rights of two other groups of individuals whose physical liberty was systematically restrained by the state pursuant to various statutes: minors incarcerated (or at risk of incarceration) under the authority of the juvenile justice or mental health systems, and adults hospitalized (or at risk of hospitalization) in facilities for the mentally disordered or mentally disabled. Restrictions of liberty in the context of civil commitment and juvenile justice system intervention frequently involved a mixture of parens patriae and police power motives. When the regulation involved minors, socialization-oriented police power goals were inextricably intertwined with parens patriae goals because both envisioned shaping children into healthy, well-adjusted members of society. Given the benevolent purposes asserted to underlie such exercises of state power, government overreaching was somewhat less apparent than it was in the criminal justice context, where the state impairments of liberty were fueled solely by public safety-oriented police power goals. Minors’

431. See, e.g., U.S. CONST. amend. V (setting forth protections against double jeopardy in criminal trials and the right against self-incrimination); U.S. CONST. amend. VI (setting forth rights to speedy and public trial, trial by jury, notice of charges, confront witnesses, and assistance of counsel); U.S. CONST. amend. VIII (prohibiting excessive bail, excessive fines, and cruel and unusual punishment). The Fourth, Fifth, Sixth, and Fourteenth Amendments have guided the development of procedural rights of criminal defendants, and the Eighth Amendment has provided some substantive limits on criminal punishments that restrict liberty, such as whether and under what circumstances the death penalty is permissible, and whether there must be some form of proportionality between one’s offense and the length of one’s sentence of incarceration. See, e.g., Lockyer v. Andrade, 538 U.S. 63, 73-74 (2003); Ewing v. California, 538 U.S. 11, 20-23 (2003); see also Richard S. Frase, Excessive Prison Sentences, Punishment Goals, and the Eighth Amendment: “Proportionality” Relative to What?, 89 MInN. L. REV. 571 (2005).

432. See, e.g., In re Gault, 387 U.S. 1, 41 (1967) (determining that certain due process protections are constitutionally required “in respect of proceedings to determine delinquency which may result in commitment to an institution in which the juvenile’s freedom is curtailed . . . ”).

433. See, e.g., Parham v. J.R., 442 U.S. 571, 573 (1979) (“It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment.”).

434. See, e.g., Addington v. Texas, 441 U.S. 418, 425 (1979) (noting that “[t]his Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection”); O’Connor v. Donaldson, 422 U.S. 571, 573 (1975) (holding that hospitalization in a psychiatric facility, despite its allegedly benevolent purpose, implicated “every man’s constitutional right to liberty”).

435. See supra Part V.B.

constitutional rights are generally limited by the state’s special interests in guiding children’s lives, and traditional state deference to parental autonomy in childrearing. Here, I examine legal support for the notion that minors and persons viewed as mentally disordered have protectible rights to be free from unnecessary restrictions of their liberty. I begin with an examination of the constitutional parameters of the right to be free from physical restraint. Next, I consider sources of law that support a right to be free from unnecessary physical restraint—that is, in contexts where state intervention is justified by parens patriae or police power goals, the preference for less restrictive intervention modalities.

1. The Constitutional Parameters of Minors’ Interests in Freedom from Physical Restraint

Beginning in the mid-1960s, a line of cases established that minors were entitled to certain due process protections in the context of juvenile justice system adjudications. The new constitutional doctrines were foreshadowed by the Court’s 1966 decision in Kent v. United States. Holding that the District of Columbia juvenile court had failed to comply with its governing statute prior to waiving its jurisdiction and transferring a minor for prosecution in adult criminal court, the Court uttered its now-famous indictment of the juvenile justice system: “[T]here may be grounds for concern that the child receives the worst of both worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children.”

Experience should teach us to be most on our guard to protect liberty when the Government’s purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

437. See, e.g., Bellotti v. Baird, 443 U.S. 622, 634, 635-39 (1979) (“We have recognized three reasons justifying the conclusion that the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing.”). For a general discussion of state’s police power and parens patriae interests in children’s welfare see supra Part V.B.

438. The Court is particularly hesitant to extend constitutional rights to minors when doing so restricts parental autonomy. In exceptional circumstances, such as where an important constitutional interest of a minor is at stake, the Court has balanced the interests of the state, parents, and minor children. See, e.g., Parham v. J.R., 442 U.S. 584 (1979) (balancing the interests of children, parents, and the state in the context of parent-initiated and state-initiated psychiatric hospitalizations); Bellotti v. Baird, 443 U.S. 622 (1979) (balancing the interests of children, parents, and the state in the context of minors’ access to abortion).


440. Id. at 556. The Court in Kent declined to address the constitutional questions raised by the petitioner, grounding its holding on the juvenile court’s failure to provide those protections required in the applicable Juvenile Court Act. Id.
In 1967, announcing that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone," the Court extended various due process protections to juveniles, such as the right to notice of charges, and representation by counsel.\textsuperscript{441} Subsequent cases established that the juvenile court must also prove its case against minors using the most demanding standard of proof—beyond a reasonable doubt—consistent with the requirements in adult criminal court,\textsuperscript{442} and that the Fifth Amendment's Double Jeopardy Clause protects minors against prosecution for the same offense in both juvenile and criminal court.\textsuperscript{443}

With its holding that the Sixth Amendment's guarantee of a trial by jury does not extend to juvenile court, the Court stopped short of molding the juvenile court into a replica of criminal court.\textsuperscript{444} In 1984, when the Court upheld a New York statute authorizing pretrial detention of juveniles charged with offenses, it reminded us that the constitutional

\begin{itemize}
\item \textsuperscript{441} In re Gault, 387 U.S. 1, 13 (1967) (holding that alleged delinquents are constitutionally entitled to rights to counsel, notice of charges, confrontation of witnesses, as well as rights against self-incrimination).
\item \textsuperscript{442} In re Winship, 397 U.S. 358 (1970).
\item \textsuperscript{443} Breed v. Jones, 421 U.S. 519 (1975). The due process protections applicable to juvenile court apply in delinquency cases, but not necessarily to status offense adjudications. The Supreme Court has not decided any cases on point. See Jan C. Costello, "Wayward and Noncompliant People with Mental Disabilities, 9 PSYCHOL. PUB. POL'y & L. 233, 235-36 & nn.12-13 (2003). The extension of various procedural protections to status offenders is primarily a matter of state law, and rarely approaches the level of protection required for delinquents. See, e.g., Alecia Humphrey, The Criminalization of Survival Attempts: Locking Up Female Runaways and Other Status Offenders, 15 HAST. WOMEN'S L.J. 165, 168-69 & nn.15-19, 172 (2004) (discussing court decisions denying status offenders the same rights as are due delinquents and reporting findings that substantially fewer status offenders are represented by counsel than are delinquents); Erin M. Smith, In a Child's Best Interest: Juvenile Status Offenders Deserve Procedural Due Process, 10 LAW & INEQ. 253, 256-71 (1992); Cheryl Dalby, Gender Bias Toward Status Offenders: A Paternalistic Agenda Carried Out Through the JJDPA, 12 LAW & INEQ. J. 429, 438-40 & n.74 (1994); Evelyn C. Knauerhase, Note, The Federal Circle Game: The Precarious Constitutional Status of Status Offenders, 7 COOLEY L. REV. 31 (1990). Litigation as to the due process rights of status offenders was forestalled, to some extent, by implementation of the provisions of the Juvenile Justice and Delinquency Prevention Act ("JJDPA"), id. which required states to separate status offenders from delinquents and adult offenders, and to remove them from secure confinement. See infra note 650. Yet, as discussed below, status offenders are frequently placed in some form of confinement. See infra notes 447-73 and accompanying text.
\item \textsuperscript{444} McKeiver v. Pennsylvania, 403 U.S. 528 (1971). The Court in McKeiver concluded that the imposition of a jury trial on the juvenile court would not strengthen its factfinding function and would eliminate the benefits for the juvenile and for society of the remnants of a "unique" juvenile justice system. Id. at 547. Professor Emily Buss argues that, despite its asserted goal of retaining a juvenile justice system that addressed minors' special needs, the Court adhered to this narrow and nonsensical framing. Because neither adult rights nor no rights are well designed to secure fairness for children, the Court has waffled between the two, creating a patchwork better understood as an attempt to split the difference than to develop a coherent set of due process rights for children. Emily Buss, The Missed Opportunity in Gault, 70 U. CHI. L. REV. 39, 43 (2003).
\end{itemize}
rights of minors are not identical to those of adults, even where confinement in a juvenile justice facility is concerned. Justice Rehnquist wrote that: "The juvenile's ... interest in freedom from institutional restraints, even for the brief time involved here, is undoubtedly substantial .... But, that interest must be qualified by the recognition that juveniles, unlike adults, are always in some form of custody." A second line of cases addresses the constitutional limits on state authority to hospitalize and retain custody of individuals alleged to be suffering from mental disorders or mental disabilities. Although arising in the criminal justice context, the Supreme Court's opinion in *Jackson v. Indiana* is one of its earliest statements interpreting the Constitution as protecting the liberty interests of mentally disordered or disabled persons. In *Jackson*, the Court held that a defendant committed to a psychiatric facility for the purpose of evaluating and restoring his competency to stand trial could not be incarcerated under the authorizing statute once it was determined that he was incompetent and would not become competent in the foreseeable future. While the state could seek his commitment under other statutorily permitted bases, his continued detention under the initial statute was constitutionally impermissible. The Court asserted: "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the person is committed." Although

445. Schall v. Martin, 467 U.S. 253 (1984). The statute in question permitted detention of the juvenile if the court determined that there was a "'serious risk' that the child 'may before the return date commit an act which if committed by an adult would constitute a crime.'" *Id.* at 255.

446. *Id.* at 265. In *Schall*, the Court justified New York's preventive detention policy, in part, on the state's *parens patriae* interests in the welfare of the child:

Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae* .... In this respect, the juvenile's liberty interest may, in appropriate circumstances, be subordinated to the State's "*parens patriae* interest in preserving and promoting the welfare of the child." *Id.*

447. 406 U.S. 715 (1972). *Jackson* concerned a "mentally defective deaf mute with a mental level of a pre-school child" who "cannot read, write, or otherwise communicate except through limited sign language." *Id.* at 717. He was charged with the thefts of four and five dollars respectively, and hospitalized in an Indiana psychiatric facility for a determination of his competency to stand trial. *Id.* The defendant was found to be incompetent and committed until such time as he was determined to be competent, despite psychiatric findings that he would never be able to develop the necessary communication skills to participate adequately in his defense. *Id.* at 718-20.

448. *Id.* at 718.

449. *Id.* at 738. The Court cited Indiana's civil commitment statutes as alternative bases under which the state could proceed. *Id.*

450. *Id.*
the *Jackson* Court addressed fairly limited questions, the language of the unanimous opinion underscored that even severely mentally disabled individuals are entitled to some form of due process protection of their liberty interests. Furthermore, the Court held that due process required that such a person’s continuing commitment be justified by its purposes.

Three years later, in *O’Connor v. Donaldson*, the Court considered the claims of a civilly committed psychiatric patient, Kenneth Donaldson, who alleged that hospital personnel were obligated to provide him with treatment or to release him. The Court declined to address the question of whether there is a constitutional right to treatment attendant to involuntary hospitalizations, or to examine the constitutionality of the grounds set forth in civil commitment statutes. Rather, it characterized the case as raising “a single, relatively simple, but nonetheless important question concerning every man’s constitutional right to liberty.” Noting that the jury below had found that Donaldson’s continued confinement was not justified by any of the criteria set forth in current commitment statutes (i.e., protection of the public or of “his own survival or safety,” or “to alleviate or cure his illness”), the Court held that there was no constitutionally permissible basis for the continued restriction of Donaldson’s liberty. The Court uttered the powerful words: “Mere intolerance or animosity cannot constitutionally justify the deprivation of a person’s physical liberty,” and answered negatively the question of whether “the State [may] fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different . . . .” Thus, despite the Court’s failure to address certain questions raised below, it clarified that even those persons determined to be “mentally ill” by the courts that civilly commit them retain cognizable liberty interests.

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451. Justices Powell and Rehnquist “took no part in the consideration or decision of this case.” *Id.* at 741.


453. Below, the Fifth Circuit held that such a constitutionally based right to treatment existed: “[R]egardless of the grounds for involuntary civil commitment, a person confined against his will at a state mental institution has ‘a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.’” *Id.* at 573 (citing *Donaldson v. O’Connor*, 493 F.2d 507, 520 (5th Cir. 1974)).

454. “[T]here is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment.” *Id.* at 573.

455. *Id.*

456. *Id.* at 574-75.

457. *Id.*

http://scholarlycommons.law.hofstra.edu/hlr/vol33/iss4/9
In *Addington v. Texas*, the Supreme Court considered the standard of proof constitutionally required in civil commitment hearings.\(^{458}\) It asserted that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."\(^{459}\) The *Addington* Court held that states must apply a standard of proof no lower than "clear and convincing evidence" in civil commitment proceedings. It concluded that this standard struck the proper balance between protecting prospective committees' liberty rights and the state's *parens patriae* and police powers.\(^{460}\)

Thus, the Supreme Court's jurisprudence addressing the physical liberty rights of adults for whom civil commitment is sought, and of juveniles processed through the juvenile court for alleged violations of criminal statutes, clearly holds that both classes of individuals are entitled to various procedural and substantive protections before those liberty interests are infringed, although the nature and extent of those protections vary across settings, populations, and in light of particular state purposes.\(^{461}\) The state's paternalistic purposes in restricting these individuals' liberty distinguish these restrictions from those that occur pursuant to adult criminal proceedings, as do the state's police power goals of socializing children. These purposes do not *extinguish* the individuals' physical liberty interests, but they do reduce the procedural protections or substantive showings necessary to obtain a constitutionally-permissible commitment.\(^{462}\)

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459. *Id.* at 425.
460. *Id.* The *parens patriae* power authorized the state to assist those persons unable to care for themselves because of emotional disorders, while the police power authorized the state "to protect the community from the dangerous tendencies of some who are mentally ill." *Id.* at 426.
461. See, e.g., *Kansas v. Hendricks*, 521 U.S. 346, 350-60 (1997). In *Hendricks*, the Supreme Court held constitutional the standards and procedures authorizing long-term "civil" commitment of sexually-violent predators under Kansas statutes. An individual who had been convicted of a sexually violent offense could be so committed after serving his sentence, if found to have a "mental abnormality" or a "personality disorder" that "makes it difficult, if not impossible, for the person to control his dangerous behavior." *Id.* at 358. Such commitments would be impermissible for other classes of offenders who have served their sentences. Arguably, therefore, the state's authority to seek and obtain continued detainment of sexually violent predators, but not other offenders who might also be dangerous to the public, hinges on the determination that the dangerousness of sexually violent predators is linked to their "mental abnormalities." For an analysis of these decisions and of scholarly commentary, see RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 641-64 (4th ed. 2004).
462. Of course, until the constitutionalization of the juvenile court in the 1960s and 1970s, *parens patriae* and socialization-oriented police power considerations justified unchecked juvenile court discretion. And, prior to the articulation of due process protections for those viewed as needing psychiatric hospitalization during those same decades, asserted *parens patriae* justifications likewise facilitated expansive state intervention into such persons' lives.
In 1979, the Supreme Court determined what procedural and substantive requirements are constitutionally adequate if a child’s parents or guardians seek that child’s admission to a state mental institution. *Parham v. J.R.* was framed as a parent-child conflict.\(^{463}\) In response to J.R.’s argument that Georgia’s procedures did not adequately protect his liberty interests, the Court asserted: “[W]e assume that a child has a protectible interest . . . in being free of unnecessary bodily restraints . . . .”\(^{464}\) Thus, even a minor whose parents and the state concur in seeking his admission to a mental hospital for purportedly benevolent purposes\(^{465}\) has a protectible interest in his physical liberty. The Court, however, declined to provide extensive due process protections in the context of collaborative decisions by parents and doctors to admit children to inpatient facilities, and held that the determination of a physician employed by the admitting facility as to the child’s “need for treatment” would protect sufficiently against the “risk of error inherent in a parental decision to have a child institutionalized for mental health care.”\(^{466}\) The grounding of the Court’s decision so heavily in deference to parental autonomy implies that the Court might have been more aggressive in its protection of minors’ liberty interests if the child and parents were joined in a claim against a state’s procedures for committing minors to psychiatric hospitals.\(^{467}\)

One of the most articulate expressions of the rights of minors to freedom from physical restraint appeared in a concurrence by Justice O’Connor in the case of *Reno v. Flores*.\(^{468}\) Speaking of alien juveniles detained by the Immigration and Naturalization Service, Justice O’Connor opined:

> [I]n my view these children have a constitutionally protected interest in freedom from institutional confinement. That interest lies within the core of the Due Process Clause, and the Court today does not hold


\(^{464}\) Id. at 601. For an analysis of the *Parham* decision, see Weithorn, *Skyrocketing Admissions*, supra note 16, at 808-13.

\(^{465}\) The state’s willingness to accept the child for admission to the state hospital is the manner of concurrence I refer to here.

\(^{466}\) *Parham*, 442 U.S. at 606-08.

\(^{467}\) While the Court has not had occasion to determine what standards and procedures it would require if a child and parent were joined in opposing the child’s civil commitment, some state statutes do mandate legal requirements similar to an adult civil commitment to such cases. *See* Weithorn, *Skyrocketing Admissions*, supra note 16, at 831-35.

\(^{468}\) *See* 507 U.S. 292, 315-19 (1993) (O’Connor, J., concurring). Justice Souter joined Justice O’Connor in her concurrence. This case challenged an Immigration and Naturalization Service regulation that permitted the release of detained juvenile aliens only to their parents, close relatives, or legal guardians, and not to other “responsible adults.” Id. at 294-99.
otherwise. Rather, we reverse the decision of the Court of Appeals because the INS program challenged here, on its face, complies with the requirements of due process.

"Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action." (quoting Foucha v. Louisiana, 504 U.S. 71, 80 (1992)). "Freedom from bodily restraint" means more than freedom from handcuffs, straitjackets, or detention cells. A person's core liberty interest is also implicated when she is confined in a prison, a mental hospital, or some other form of custodial institution, even if the conditions of confinement are liberal. This is clear beyond cavil, at least where adults are concerned. Children, too, have a core liberty interest in remaining free from institutional confinement. In this respect, a child's constitutional "freedom from bodily restraint" is no narrower than an adult's. Beginning with In re Gault . . . we consistently have rejected the assertion that "a child, unlike an adult, has a right 'not to liberty but to custody.'"

Our decision in Schall v. Martin . . . makes clear that children have a protected liberty interest in "freedom from institutional restraints," . . . even absent the stigma of being labeled "delinquent," . . . or "mentally ill" . . . . In Schall, we upheld a New York statute authorizing pretrial detention of dangerous juveniles, but only after analyzing the statute at length to ensure that it complied with substantive and procedural due process. We recognized that children "are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as parens patriae" . . . . But this parens patriae purpose was seen simply as a plausible justification for state action implicating the child's protected liberty interest, not as a limitation on the scope of due process protection . . . . It may seem odd that institutional placement . . . even where conditions are decent and humane and where the child has no less authority to make personal choices than she would have in a family setting, nonetheless implicates the Due Process Clause. The answer, I think, is this. Institutionalization is a decisive and unusual event. "The consequences of an erroneous commitment decision are more tragic where children are involved. Childhood 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." (Parham, 442 U.S. at 627-28 (Brennan, J. dissenting). Just as it is true that "in our society liberty [for adults] is the norm, and
detention prior to trial or without trial is the carefully limited exception... so too, in our society, children normally grow up in families, not in governmental institutions... 469

This brings us to the question at the heart of this Section: Are high rates of institutionalization of troubled and troublesome youth under the authority of the juvenile justice, mental health, or child welfare systems—for reasons falling within the state's police power authority to promote children's healthy socialization or the state's parens patriae authority to protect minors for the minors' own benefit—compatible with American legal traditions protecting these minors' physical liberty interests? They clearly are not, despite language or results in cases such as Parham and Schall that permit parens patriae commitments of minors with fewer procedural requirements and less stringent substantive standards than are required for similarly-situated adults. These precedents underscore that individuals retain constitutionally protectible interests in physical liberty which survive diagnosable mental disorders, community disfavor of these individuals' presence in its midst, and circumstances in which minors' parents are joined with the state in seeking their incarceration. Justice O'Connor's analysis of the constitutional precedent accurately understands the import of decisions to remove children from their homes, even where these children may be placed in a location which provides them with no less "freedom" than they had in their own family's custody. As she points out: "Institutionalization is a decisive and unusual event... In our society, children normally grow up in families, not in governmental institutions" and thus placement of children in institutions implicates their interests in freedom from restraint of their physical liberty. 473 The challenge remaining, therefore, is to discern precisely what standards and

470. As Part III examines in greater detail, the population of troubled and troublesome youth who are the focus of this Article are not those whose incarceration follows primarily from the state's exercise of its police power authority to punish, incapacitate, or deter those who have endangered the public. Rather, the focus here is on those minors whose incarceration is grounded primarily on the state's interests in promoting the minors' own welfare, for the benefit of the minors themselves or for general welfare of society-at-large. For elaboration on this distinction, see supra Part III.
471. But see supra note 462.
472. See, e.g., O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (analogizing institutionalization of the "harmless mentally ill... whose ways are different" in order to protect those in the community from exposure to these individuals to incarceration of the "physically unattractive or socially eccentric" for the same purpose).
473. Flores, 507 U.S. at 318.
procedures are required to render impairments of those rights permissible.

2. The Preference for Less Restrictive Alternatives in Responding to Troubled and Troublesome Youth

The view that there is, or should be, a constitutional right to the least restrictive alternative when restrictions of physical liberty are implicated is grounded in application of that mode of constitutional analysis that requires strict scrutiny of policies that impair fundamental constitutional rights. If a court determines that the right in question is fundamental, the court may uphold a statute infringing that right only if the statute's purpose serves a compelling government interest and the means used to achieve that purpose are the most narrowly tailored, or least restrictive of the underlying right.474

Constitutional jurisprudence relating to restraint of physical liberty focuses to a greater degree on procedural rather than substantive requirements of the Due Process Clauses of the Fifth and Fourteenth Amendments.475 Justice Scalia, in the majority opinion in Reno v. Flores, distinguishes between procedural and substantive restrictions on liberty interests:

[Our cases interpret] the Fifth and Fourteenth Amendments' guarantee of "due process of law" to include a substantive component [as well as a procedural component], which forbids the government to infringe certain "fundamental" liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.476

Some scholars assert that the Supreme Court does not consistently apply its own doctrine, in that it identifies freedom from bodily restraint as a fundamental right, but then does not apply strict scrutiny to statutes authorizing incarceration.477

474. See id. at 301-02.
476. Flores, 507 U.S. at 301-02 (emphasis in original).
477. This argument is made with respect to criminal statutes, see generally Colb, supra note 475, and commitment authorized by post-conviction institutionalization of sexually-violent predators. See generally Janus & Logan, supra note 475. If the Court did apply strict scrutiny to criminal sentencing laws, most cases of criminal sentencing would not be affected. The states’ interests in deterring, incapacitating, or punishing serious or violent lawbreakers are clearly
Despite the infrequency with which the Supreme Court has spoken of the fundamental nature of the right to be free from confinement, several cases underscore that such a characterization is correct. For example, in *Foucha v. Louisiana*, a case that concerned the standards and procedures for continued hospitalization of persons found to be not guilty by reason of insanity, the Court stated:

"[T]he Due Process Clause contains a substantive component that bars certain arbitrary, wrongful government actions ‘regardless of the fairness of the procedures used to implement them.’" Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action. "It is clear that commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." We have always been careful not to "minimize the importance and fundamental nature” of the individual’s right to liberty. 478

In *United States v. Salerno*, a constitutional challenge to the Bail Reform Act, the Court labeled the right to liberty implicated by pretrial detention as important and “fundamental.” 479 If the right to be free from bodily restraint is fundamental, and therefore triggers strict scrutiny, states would be required to show that the state purposes served by compelling. By contrast, the application of a strict scrutiny to certain non-violent offenses could lead some to question whether incarceration is the least restrictive means necessary to achieve the criminal justice system’s goals.

478. *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (quoting Zinermon v. Burch, 494 U.S. 113 (1990)); *Jones v. United States*, 463 U.S. 354, 361 (1983) (citations omitted); *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982). This language in *Foucha* was cited with approval most recently by the Supreme Court in *Hamdi v. Rumsfeld*, 124 S. Ct. 2633, 2646 (2004) ("It is beyond question that substantial interests lie on both sides of the scale in this case. Hamdi’s ‘private interest . . . affected by the official action,’ is the most elemental of liberty interests—the interest in being free from physical detention by one’s own government.") (citation omitted). *Hamdi* challenged that he had been provided with a constitutionally inadequate opportunity to contest the factual basis of his detention as an "enemy combatant." Also see Justice O’Connor’s characterization of the fundamental nature of the right to be free from physical restraint in her concurrence in *Reno v. Flores*. See * supra* note 469 and accompanying text.

479. *United States v. Salerno*, 481 U.S. 739, 750-51 (1987). The *Salerno* Court, however, upheld the constitutionality of the Bail Reform Act of 1984, a statute that requires courts to detain arrestees prior to trial "if the Government demonstrates by clear and convincing evidence after an adversary hearing that no release conditions ‘will reasonably assure . . . the safety of any other person and the community.’" *Id.* at 741. In a stinging dissent, Justice Marshall (joined by Justice Brennan) challenged that the statute was “incompatible with the fundamental human rights protected by our Constitution.” *Id.* at 755 (Marshall, J., dissenting). He argued that the statute was unconstitutional because it allowed indefinite confinement of individuals not yet convicted of crimes on the basis of judicial findings of future dangerousness. *Id.* Thus, while the *Salerno* Court clearly articulated that the right to physical liberty is *fundamental*, it also revealed a willingness to impair that right in the face of certain legislative concerns.
statutes impairing that liberty were compelling, and that the means used to achieve these ends are necessary—that is, that they are the least restrictive, least intrusive, or least drastic means possible. The inquiry is particularly relevant here. If strict scrutiny of state regulations infringing minors’ physical liberties is constitutionally required, then the state must select the least restrictive among effective means to achieve compelling police power or parens patriae interests in the welfare of minors who would otherwise be confined under the auspices of the juvenile justice, mental health, or child welfare systems.

Despite the logic of a constitutional analysis that requires states to consider, and perhaps even create, less restrictive alternatives to institutionalization in the mental health context, the Supreme Court has never explicitly recognized such an obligation under the federal Constitution. The Court has had the opportunity to require greater scrutiny of statutes and practices authorizing commitments, and has not done so. Yet, elements of the “least restrictive alternative doctrine” shape several areas of modern mental health law. This is due, in part, to the role that sources of law other than the federal Constitution—such as

480. The Court enunciated the principle of the least drastic alternative in Shelton v. Tucker, 364 U.S. 479, 488 (1960), a case that challenged the constitutionality of a state statute requiring teachers to disclose their organizational affiliations. Focusing on the means chosen by the state to achieve its goals together with the fundamental nature of the underlying liberties (of speech and association), the Court held that even where “the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.” Id. (footnotes omitted). Since then, the “least restrictive alternative” doctrine has become well-established in First Amendment jurisprudence. For example, in United States v. Playboy Entm’t Group, Inc., 592 U.S. 803, 813 (2000), the Court stated that “a content-based speech restriction... can stand only if it satisfies strict scrutiny... If a less restrictive alternative would serve the Government’s purpose, the legislature must use that alternative.” Accord Ashcroft v. A.C.L.U., 124 S.Ct. 2783, 2791 (2004).

481. For a discussion of legal theories supporting various notions of constitutionally based rights to treatment, see, for example, Bruce A. Arrigo, The Logic of Identity and the Politics of Justice: Establishing a Right to Community-Based Treatment for the Institutionalized Mentally Disabled, 18 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 1 (1992); MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 113-23 (2000) [hereinafter PERLIN, HIDDEN PREJUDICE].

482. See, e.g., Heller v. Doe, 509 U.S. 312 (1993). In this case, a class of involuntarily committed “mentally retarded” individuals challenged the constitutionality of Kentucky’s statutes authorizing their commitment. The Court upheld the statutes, applying rational basis review. The Court refused to apply heightened scrutiny because the plaintiffs did not raise the question of the level of scrutiny below. It did, however, state: “We have applied rational-basis review in previous cases involving the mentally retarded and the mentally ill,” and “a classification neither involving fundamental rights nor proceeding along suspect lines is accorded a strong presumption of validity.” Id. at 321, 319.
legislation, common law, and state constitutional law—play in determining prevailing legal policies. For example, Professor Bruce Winick, in a review of the civil commitment statutes of all fifty states and the District of Columbia, determined that thirty of these statutes make explicit reference to less restrictive alternative treatments, and most of those require that the court choose the least restrictive of the appropriate treatments. Federal and state case law interpret various statutory provisions, and scholarship reinforces the doctrinal consistency and the practical and clinical benefits of identifying and selecting less restrictive alternatives prior to institutionalizing an individual.

483. See, e.g., Reisner et al., supra note 461, at 751 (asserting that “the constitutional status of the [least restrictive alternative] doctrine may not be an important issue [in] evaluating the impact of the doctrine on the dispositional decision made by the committing authority” because so many states have embedded the doctrine, in some form, in their commitment statutes).


486. BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 71-72, Table 3.6 at 94-97 (2005).

487. See, e.g., Covington v. Harris, 419 F.2d 617, 623-25 & nn.15-16 (D.C. Cir. 1969) (construing 1964 amendments to D.C. Code, affirming Lake v. Cameron, citing to the least restrictive alternative doctrine set forth in Shelton v. Tucker, and holding that the least restrictive alternative doctrine applies not only to the state’s action in committing an individual to a mental hospital, but also to its decisions to place an individual in a more, rather than less, restrictive unit within the hospital); Lake v. Cameron, 364 F.2d 657, 659-61 (D.C. Cir. 1966) (construing the District of Columbia Hospitalization of the Mentally Ill Act, to hold that the District was obligated to investigate less restrictive alternatives to hospitalization and to determine whether the appellant and the public would be sufficiently protected by such alternatives).

488. Scholarly commentary has underscored, however, that the parameters of the doctrine of the least restrictive alternative are somewhat blurry. For example, does the doctrine merely require the state to explore the availability of less restrictive alternatives, or does it impose upon the state an obligation to create and provide such alternatives? What evidence of efficacy is necessary in determining which treatment type will be ordered? On what dimensions should restrictiveness be evaluated? For scholarly discussions of these and other dilemmas see, for example, P. Browning Hoffman & Lawrence L. Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of its Senses, 14 SAN DIEGO L. REV. 1100 (1977); David L. Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 MICH. L. REV.
One very clear example of such clinical benefits can be found in an article by Professor Michael Perlin. In Parham v. J.R., the Supreme Court determined that states need not comply with the same level of due process protections attendant to adult commitments when considering the petitions of parents who seek their minor children’s admission to mental hospitals. In Parham, former Supreme Court Chief Justice Warren Burger characterized due process protections as “time-consuming procedural minuets.” New Jersey law, however, provided children with more protections than were constitutionally required under Parham. The New Jersey Mental Health Advocates Office, at that time headed by Professor Perlin, represented children whose parents sought their institutionalization in psychiatric facilities. Perlin studied effects of legal advocacy for the children, and found that advocates who served as guardians ad litem or amicus curiae for the children were able to open many doors for children and their families. These advocates obtained independent clinical evaluations of the children, investigated alternatives less restrictive than hospitalization, opened funding channels, and facilitated family contact with community agencies. Many of the children in the study actually required certain special educational and other noninstitutional services, provision of which was likely to avert the need for a restrictive and potentially inappropriate intervention such as psychiatric hospitalization.

The least restrictive alternative doctrine has also been invoked “as a device for regulating treatment imposed on persons after they have been committed or otherwise subjected to state intervention.” The constitutional basis for a post-commitment right to the least restrictive treatment modalities is weak. This follows from the failure of the Court to hold that committed patients have a broad constitutionally-based right to treatment while in state custody. In Youngberg v. Romeo, an
in institutionalized developmentally disabled man—who had been repeatedly injured by his own and his fellow residents’ actions and who had been shackled and otherwise restrained by the hospital for his own and others’ protection—claimed that he had a “liberty interest in safety, freedom of movement, and training within” the Pennsylvania state institution to which he was committed. The Court held that Romeo was entitled to “minimally adequate training... in light of [his] liberty interests in safety and freedom from unreasonable restraints.” This holding is generally viewed as recognition of a fairly narrow post-commitment right to treatment in light of the low standard articulated (i.e., minimal adequacy), and the caveat that the right is triggered only when provision of such treatment is necessary to serve the goal of protecting the individual’s physical safety in the least restrictive manner. Furthermore, while the Court held that involuntarily committed residents enjoy “constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests,” it instructed reviewing courts to grant substantial deference to the judgments of reasonableness of the treating professionals. Thus, the Court did acknowledge a liberty interest in freedom from unnecessary physical restraint within the hospital setting, but did not elaborate on the parameters of that right, if any, beyond the circumstances presented in Youngberg.

The third context in which the right to the least restrictive alternative is invoked concerns the obligations of states to create and

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494. Youngberg, 457 U.S. at 315.
495. Id. at 322.
496. See, e.g., PERLIN, HIDDEN PREJUDICE, supra note 481, at 120-23; Christopher Slobogin, Mark R. Fondacaro & Jennifer Woolard, A Prevention Model of Juvenile Justice: The Promise of Kansas v. Hendricks for Children, 1999 WIS. L. REV. 185, 212-13 (viewing Youngberg as an endorsement of a constitutional right to treatment for involuntarily committed persons to the extent that it entitles them “to the care necessary to prevent unnecessary restraint”). Slobogin and colleagues also argue, however, that this holding “could easily be parlayed into a robust right to any treatment necessary to reduce prolonged confinement.” Id.
497. Youngberg, 457 U.S. at 324.
498. Id. at 322-23.
499. In a different context, in a case challenging the administration of antipsychotic medication to a criminal defendant during his trial, the Court appears to have adopted a doctrine analogous to the least restrictive alternative principle. In Riggins v. Nevada, the Court held that the state of “Nevada certainly would have satisfied due process if... treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential” to the safety interests the Court found to be compelling. 504 U.S. 127, 135 (1992).
fund community-based treatment alternatives. While there is scant evidence for a constitutionally based right to such treatment,\textsuperscript{500} statutory bases for such rights have been recognized under, for example, the ADA, IDEA, and under state and federal Medicaid provisions.\textsuperscript{501}

During the 1990s, an innovation referred to as "outpatient commitment" or mandated community treatment began to appear in the statutes of an increasing number of states.\textsuperscript{502} Policies and practices grouped together under the rubric of outpatient commitment arose in response to a variety of social concerns.\textsuperscript{503} These statutes allow states to experiment with an alternative mechanism to achieve state police power and \textit{parens patriae} goals in a less restrictive context. States may authorize mandated community treatment as an arguably least restrictive alternative to hospitalization for persons who otherwise meet state commitment criteria; as a preventive intervention, applying criteria less stringent than those needed for inpatient hospitalization; or post-hospitalization, as a condition of discharge after inpatient treatment.\textsuperscript{504}

Professor John Monahan and others point out that mandated community treatment actually subsumes a range of legal, clinical, and social welfare approaches to promoting psychiatric patients' adherence to treatment regimens.\textsuperscript{505} In fact, empirical research reveals that court-ordered participation in outpatient treatment as a form of civil commitment is not

\textsuperscript{500} But see Jan C. Costello & James J. Preis, \textit{Beyond Least Restrictive Alternative: A Constitutional Right to Treatment for Mentally Disabled Persons in the Community}, 20 \textsc{LoY. L.A. L. Rev.} 1527, 1542-43 (1987) (stating that \textit{Youngberg} may have created a right to community-based treatment with its holding of a constitutional right to "minimally adequate treatment" necessary to reduce unnecessary restriction of liberty).

\textsuperscript{501} See supra Part III.

\textsuperscript{502} See generally \textsc{Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law} (Deborah L. Dennis & John Monahan eds., 1996) [hereinafter \textit{DENNIS \\& MONAHAN]].

\textsuperscript{503} As detailed in Part VI, deinstitutionalization of mental hospitals was not accompanied by a commensurate increase in services that would have given persons viewed as seriously or chronically mentally ill the best chance of functioning adaptively outside of the hospital. Problems associated with the deinstitutionalized mentally ill, such as homelessness and commission of criminal violations, triggered enactment of various outpatient commitment policies.

\textsuperscript{504} \textsc{Reisner et al.}, supra note 461, at 755-56; \textsc{NAT'L Health Policy Forum, Outpatient Commitment in Mental Health: Is Coercion the Price of Community Services? Issue Brief # 757 (2000)}, available at http://www.nhpf.org/index.cfm?fuseaction=Details&key=363; \textsc{Melton et al.}, supra note 83; \textsc{Reisner et al.}, \textit{supra} note 461, at 755-58.
the most common mechanism used to secure treatment compliance.\footnote{506} Cooperation with treatment regimens may also be required by governmental and community agencies providing various social services (such as Social Security benefits or federally subsidized housing).\footnote{507} In addition, criminal court judges may mandate community treatment compliance as a condition of probation and alternative to a jail or prison sentence.\footnote{508} To the extent that the concept of mandated community treatment serves to compel cooperation with outpatient treatment regimens by individuals who would otherwise be hospitalized, it reflects influence of the least restrictive alternative doctrine.\footnote{509}

In conclusion, the state's \textit{parens patriae} and socialization-oriented police power goals in intervening in the lives of children and families do not negate those children's rights to be free from unnecessary restraint. In some respects, these dual goals may \textit{heighten} the importance of avoiding unnecessary deprivations of these children's liberty. To the extent these interventions are intended to benefit the minors for their own sakes or for our sake, incarceration and other out-of-home placements should be justified by empirical data demonstrating the efficacy of such interventions in achieving the goals of removal.

\footnote{506. Monahan et al., \textit{Use of Leverage}, supra note 505, at 43-44.} \footnote{507. \textit{Id.}; Monahan et al., \textit{Mandated Treatment}, supra note 505, at 31-32.} \footnote{508. Monahan et al., \textit{Mandated Treatment}, supra note 505, at 32-33; see Monahan et al., \textit{Use of Leverage}, supra note 505, for findings of recent empirical investigation examining the forms of leverage used to induce psychiatric outpatients to comply with the recommended treatment regimen.} \footnote{509. "Requiring adherence to community-based mental health treatment is now the single most contested human rights issue in mental health law and policy." Monahan et al., \textit{Mandated Treatment}, supra note 505, at 29. Yet, most of the debate focuses on formal judicial outpatient commitment orders as contrasted with other forms of leverage. Monahan et al., \textit{Use of Leverage}, supra note 505, at 43. Recent empirical findings reveal that such formal judicial orders constitute "the least prevalent form of leverage," with access to housing, avoidance of criminal penalties, and other forms of leverage far more common. \textit{Id.} at 43-44. Thus, they argue, debates about these phenomena should expand to encompass the range of forms of coercion used to promote psychiatric patients' compliance with treatment regimens in the community. \textit{Id.}}
Constitutional precedent, utilitarian policymaking, and clinical wisdom converge in adherence to the principle that “the nature and duration” of a deprivation of liberty must “bear some reasonable relation to the purpose for which” it is undertaken. 510

The legal grounding of the least restrictive alternative principle, developed with reference to the Due Process Clause and rights to be free from unnecessary restraints of liberty, is clearly distinct from that of the least restrictive environment and most integrated setting principles grounded in the IDEA and ADA, as discussed immediately below. Yet it is striking that the potential practical effects of the doctrines are parallel, in that they strive to provide services in the least restrictive, or most integrated, setting possible. And, as noted in Section D below, legal theories grounded in the IDEA and ADA demonstrate greater practical promise of leading to the provision of such services.

D. Inclusion in the Mainstream of Community Life

The IDEA and ADA signaled dramatic paradigm shifts in legal characterizations of the rights of persons identified as having mental disorders. First, in contrast to the legal rights discussed in Part V.C, immediately above—which are rooted in substantive and procedural due process formulations and statutory embodiments of those principles—the IDEA and ADA’s integrationist themes borrow from equal protection jurisprudence. Second, the IDEA and ADA reflect weakening reliance on the medical model conceptualization of the challenges and needs of persons identified as having mental disorders. The medical model sees these conditions as manifestations of individual pathology, the disability model focuses on individuals’ specific functional impairments in particular settings and/or in performing particular life activities (such as learning, working, gaining access to a building).

The third shift is the replacement of themes of “custodialism” with themes of “integrationism” in American legal policy toward disabled individuals. 511 “Custodialism is the idea that persons with disabilities are to be sheltered—that they should be kept separate from the population at large and given charity to compensate for their inability to survive in the world on their own.” 512 Arguably, however, the separation of mentally

512. Id. at 899.
disabled persons from the rest of the community exists less for the protection of those with disabilities, and more for the comfort of those in the community.\textsuperscript{513} Furthermore, custodialism deprives mentally disabled individuals of countless opportunities to learn and to develop their capacities to the greatest extent possible and fuels stigmatization of those institutionalized as inferior, defective, dangerous, unfit for social interaction, and incapable of meaningful participation in society.\textsuperscript{514}

Integrationism, by contrast, views disabilities as "socially constructed"\textsuperscript{515} to the extent that places of learning, employment, and social discourse are structured in ways that allow the participation of non-disabled persons but exclude disabled individuals.\textsuperscript{516} Because the structure of these settings is not immutable, changes can be made to permit greater participation by disabled individuals. In addition, the integrationist perspective encompasses an equality principle mandating equal opportunities for disabled and non-disabled individuals to participate in society. In order to promote this latter goal, government intervenes less to protect disabled persons and more to enable their "independence and self-reliance."\textsuperscript{517} Within this framework, the failure of government and private actors to construct settings in a manner that promotes disabled individuals' adaptive functioning is characterized as discrimination because "government and society facilitate the able-bodied population's achievement of the good life and refuse the same treatment to people with disabilities."\textsuperscript{518}

The first major move in American legal policymaking toward the integrationist model for children with mental disabilities occurred in the 1970s. In 1972, a federal district court interpreted \textit{Brown v. Board of Education}'s\textsuperscript{519} desegregation mandate to require that public school

\textsuperscript{513} Id. at 899-900.
\textsuperscript{514} See, e.g., \textit{id.} at 899-901; John V. Jacobi, \textit{Federal Power, Segregation, and Mental Disability}, 39 HOUS. L. REV. 1231, 1241-45 (2003). For a general discussion of what Perlin refers to as "sanist" biases, see \textit{PERLIN, HIDDEN PREJUDICE, supra note 481, at 3-58.}
\textsuperscript{515} Weber, \textit{supra} note 511, at 901-04; Jacobi, \textit{supra} note 514, at 1244-46.
\textsuperscript{516} See also, Laura L. Rovner, \textit{Disability, Equality, and Identity}, 55 ALA. L. REV. 1043, 1051-55 (2004) (referring to this model as the "socio-political model of disability").
\textsuperscript{517} Jacobi, \textit{supra} note 514, at 1244.
\textsuperscript{518} While the integrationist or equality model has become increasingly influential in formal American legal policy, many unsettled questions remain, such as what types of accommodations are required, by which government and private entities, and with respect to which types of disabilities. \textit{Id.} For further conceptualizations of "models" within disability law, and discussion of the limitations of the modern formulations, see generally Weber, \textit{supra} note 511; Rovner, \textit{supra} note 516, Samuel R. Bagenstos, \textit{Subordination, Stigma, and "Disability"}, 86 VA. L. REV. 397 (2000); Samuel R. Bagenstos, \textit{The Future of Disability Law}, 114 YALE L.J. 1 (2004).
\textsuperscript{519} 347 U.S. 483 (1954).
districts provide a free and appropriate public education to children with special educational needs. Brown's mandate was grounded in the Equal Protection Clause of the federal Constitution. The court in Mills v. Board of Education quoted with approval the following language in Brown:

In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the state has undertaken to provide it, is a right which must be made available to all on equal terms.

According to the Mills court, children with special educational needs could not be excluded from public schools entirely, nor could they be unnecessarily segregated from the mainstream of the student population. Special needs children, according to the court, have the same rights to equal educational opportunities as the Brown plaintiffs, whose access to an equal education had been denied on account of race. This case and Pennsylvania Association for Retarded Children v. Pennsylvania led to important settlement agreements that paved the way for a new conceptualization of children with mental, learning, and emotional difficulties. These two cases were followed by many others.

Congress acted in response to a growing understanding of the role that discrimination plays in denying those individuals with disabilities equal opportunities in our society. Congress passed the Rehabilitation Act of 1973, Section 504 of which prohibited discrimination against disabled persons by programs or entities that receive federal funding. Two years later, Congress passed the Education for All Handicapped Children Act to assist the states with the economic burden of meeting children's special educational needs and to create consistent policies.

520. See Mills v. Board of Education 348 F. Supp. 866, 868, 874-75 (D.C. 1972) (ordering relief for a class of children labeled as having "behavioral problems, mentally retarded, emotionally disturbed or hyperactive").

521. 348 F. Supp. at 875.

522. Id. at 874-76.


524. Forty-six such cases were pending or resolved by the time Congress passed the Education for All Handicapped Children Act in 1975. See, e.g., Daniel H. Melvin II, The Desegregation of Children with Disabilities, 44 DePaul L. Rev. 599, 608 & n.64 (1995).


nationwide for the implementation of students' substantive and procedural special education rights. As discussed in Part III, prior to the passage and implementation of the Education for All Handicapped Children Act in 1975, substantial numbers of children with disabilities were excluded from the public school system; still others were in public schools, but excluded from the regular classroom. This Act, like its successors, such as IDEA, sought to integrate disabled children into the public educational system and into regular classes to the greatest extent possible. Its goals were several. First, Congress sought to insure that disabled children would not be deprived of a free, appropriate, public education, an obligation owed by government to all American children. In addition, however, Congress recognized that exclusion of children from public schools and regular classes within those schools was a form of segregation that deprived these children of more than just a formal education. It also deprived them of the opportunity to participate in society. This integrationist perspective spawned its own variant on the mandate for service provision in the least restrictive alternative; the "least restrictive environment" requirement.

School participation constitutes children's earliest and most significant connection with the larger community. It serves as the training ground in which basic skills for working cooperatively in the larger society develop. Children are schooled not only in the formal curriculum, but in how to interact and work with others who are part of a potentially diverse and large student body. School is, therefore, an important tool in the state's achievement of its police power interests in preparing children to be citizens in a democracy. Inclusion of children who are "different" in the mainstream of public education also promotes our educational goals for non-disabled children, who will emerge from their exposure to disabled peers with greater understanding of, and tolerance for, such differences.

528. See supra Part III and accompanying text.
529. For a discussion of the concept of the least restrictive environment, see, for example, Patrick Howard, supra note 217; Monserud, supra note 211, at 695-97; Melvin, supra note 524, at 623-24. For specific language in the governing legislation, see supra note 217 and accompanying text.
530. In school, in addition to the formal subject matter, children learn to "speak articulately, to listen carefully; [and] to learn to participate in the give-and-take of group discussion . . ." AMY GUTTMAN, DEMOCRATIC EDUCATION 13 (1987) (quoting Diane Ravitch, A Good School, in THE SCHOOLS WE DESERVE: REFLECTIONS ON THE EDUCATIONAL CRISIS OF OUR TIME 277 (1985)).
531. GUTTMAN, supra note 530, at 13 ("A democratic society is responsible for educating . . . all children for citizenship.").
In 1990, Congress passed the Americans with Disabilities Act. The purpose of this legislation was to provide a "national mandate," "enforceable standards," and federal leadership in eliminating and redressing the pervasive discrimination against persons with disabilities existing in the United States. The ADA, like the Rehabilitation Act, is a nondiscrimination statute. It is broader, however, in its application to various non-educational contexts (such as employment settings, public buildings, transportation providers) and to private as well as public schools, irrespective of whether the non-public entities receive federal funds.

The ADA's definition of disability is sufficiently broad to include mental disorders if the condition and its effects meet certain criteria.
Recognizing that "historically, society has tended to isolate and segregate individuals with disabilities," and citing "institutionalization" as a context in which discrimination against those with disabilities has manifested itself, the legislation sought to promote "equality of opportunity, full participation, independent living, and economic self-sufficiency for" persons with disabilities. The ADA was lauded as offering "breathtaking promise" for persons with mental disabilities because of its mandate to provide equal opportunities to disabled individuals in a broad spectrum of contexts of community life, and because of the sheer power of the message conveyed in Congressional findings and the statutory language.

Title II of the ADA prohibits discrimination against disabled individuals by governmental entities. In 1999, in *Olmstead v. L.C.*, the Supreme Court interpreted the reach of Title II in adjudicating the claims of two mentally disabled women. Specifically, according to the Court's report of the facts, L.C. and E.W. were both diagnosed as mentally retarded, and L.C. had also been diagnosed as schizophrenic. Both women had been admitted voluntarily to Georgia Regional Hospital, where they had received treatment. After a period of hospitalization, the treating professionals determined that each woman's condition had improved sufficiently to justify her transfer to a community-based program. Yet, there were no appropriate community-based services available for either woman, and thus, both remained institutionalized for substantial periods of time beyond the

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540. Specifically, the prohibition reads: "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132 (2005).
point at which their discharges had been recommended.\textsuperscript{545} The women filed suit in federal court, claiming that their continued confinement in institutions, after they were determined to be capable of functioning in community-based programs, constituted impermissible segregation, and thus discrimination, under the ADA.\textsuperscript{546}

Delivering the opinion for the Court, Justice Ginsburg agreed with the plaintiffs, holding that: "Unjustified isolation... is properly regarded as discrimination based on disability."\textsuperscript{547} The Court cited the regulations promulgated to implement Title II, noting that each state is required to administer its services and programs "in the most integrated setting appropriate to the needs of... individuals with disabilities."\textsuperscript{548} The regulations further specify that "the most integrated setting" means "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."\textsuperscript{549} It cited language from the ADA noting that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."\textsuperscript{550} The Court further elaborated upon the judgments inherent in Congress' passage of these provisions of the ADA:

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.... Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.... Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable

\textsuperscript{545} Specifically, LC.'s discharge was recommended in May 1993, yet she was not released until February 1996. E.W. remained in the hospital for approximately a year after her discharge was recommended. \textit{id.}
\textsuperscript{546} \textit{See id. at 593-94.}
\textsuperscript{547} \textit{Id. at 597.}
\textsuperscript{548} \textit{Id. at 592 (citing 28 CFR § 35.130(d)(1998)).}
\textsuperscript{549} \textit{Id. (citing 28 CFR pt. 35, app. A450 (1998)).}
\textsuperscript{550} \textit{Id. at 600 (citing 42 U.S.C. § 12101(a)(5)).}
accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.\textsuperscript{551}

The Court noted that the state’s obligation to provide community-based services to persons such as L.C. and E.W. however, exists only if the individuals in question are judged to be capable of managing in appropriate community-based settings.\textsuperscript{552} In the instant case, this criterion had been met. Furthermore, the individuals in question must not oppose their discharge to community-based settings.\textsuperscript{553} Neither woman had opposed the transfer in \textit{Olmstead}. Finally, the Court underscored that the obligation of the state to provide community-based services for institutionalized persons is not limitless. Consistent with the language of the governing regulations, the Court emphasized that the state is required to make “reasonable modifications” but not “fundamental alterations” in its programs in order to avoid discrimination.\textsuperscript{554} Of course, the question of what constitutes a reasonable modification as contrasted with a fundamental alteration is open to debate, and the Court’s guidance on the distinction leaves room for varying interpretations. Specifically, the Court held that:

\begin{quote}
the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities . . . . [T]he ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk.
\end{quote}

\begin{quote}
If, for example, the State were to demonstrate that it had a comprehensive, effectively working 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
\end{quote}

\textsuperscript{551} \textit{Id.} at 600-01 (citations omitted).
\textsuperscript{552} \textit{Id.} at 601-03.
\textsuperscript{553} \textit{Id.}
\textsuperscript{554} \textit{Id.} at 592. The pertinent regulation reads: "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR § 35.130(b)(7) (2004).
to keep its institutions fully populated, the reasonable-modifications standard would be met.\textsuperscript{555}

Following the \textit{Olmstead} decision, President George W. Bush issued an Executive Order reinforcing the principles of the ADA and of its interpretation by the Supreme Court in \textit{Olmstead}, and calling for federal agency cooperation with the states in implementing these mandates.\textsuperscript{556} Cognizant of their liability under \textit{Olmstead}, some states have enacted legislation to respond to their \textit{Olmstead} obligations and many have developed “state plans” for \textit{Olmstead} implementation (that is, the transfer of qualified persons from institutions to appropriate community-based services).\textsuperscript{557} Yet, in the several years since the \textit{Olmstead} decision, very little progress has been made nationwide in moving appropriately institutionalized individuals to appropriate community placements.\textsuperscript{558} Lawsuits have been filed in many states by those individuals seeking to obtain appropriate community-based services under \textit{Olmstead’s} mandate.\textsuperscript{559} Litigation—which is both costly and slow—appears necessary to prod states to comply with the mandate.\textsuperscript{560} This is perhaps not surprising, given the public’s historic preference to avoid those who are different, and the state’s intransigence in the face of innovative policy approaches and initial outlays of funds. There exist, however, many sensible proposals as to how states and the federal government can restructure existing service programs to comply with \textit{Olmstead} while not unduly burdening state coffers.\textsuperscript{561}

\textsuperscript{555} \textit{Olmstead}, 527 U.S. at 604-06.
\textsuperscript{558} See, e.g., MATHIS, supra note 257 at 582; see also NAT’L COUNCIL ON DISABILITY, supra note 557.
\textsuperscript{559} For a summary of these lawsuits, see Jennifer Mathis, \textit{Where Are We Five Years After Olmstead?}, CLEARINGHOUSE REV., Jan-Feb. 2005, at 561, 562-64.
\textsuperscript{560} See MATHIS, supra note 257.
\textsuperscript{561} Much attention is focused on the need to restructure the Medicaid program, which has traditionally favored institutional rather that community-based services for persons diagnosed as having mental disorders. For a discussion of proposed changes in the structure of Medicaid funding and their importance to the success of \textit{Olmstead} implementation, see, e.g., NAT’L COUNCIL ON DISABILITY, supra note 557, at 3; Sara Rosenbaum et al., \textit{Olmstead v. L.C.: Implications for Medicaid and Other Publicly Funded Health Services}, 12 HEALTH MATRIX 93 (2002); Jacobi,
Together, the IDEA and ADA hold promise for troubled and troublesome youth who, with appropriate community services, could avoid institutional placements.\(^\text{562}\) There is no question that high rates of juvenile placement in detention centers, psychiatric hospitals, and other institutions is inconsistent with these statutes' recognition that unnecessary isolation of these individuals from their communities is stigmatizing,\(^\text{563}\) in that it deprives institutionalized persons of "everyday life activities" including "family relations."\(^\text{564}\) From a practical standpoint, however, the promise of both of these statutes is as yet unrealized for troubled and troublesome youth. As noted in Part III, many such youth, particularly those with conduct disorders and other behavior problems, are excluded from IDEA coverage in many jurisdictions, and the types of services delivered often fall short of those needed to meet the complex demands of troubled and troublesome youth and their families.\(^\text{565}\) And, as noted immediately above, states are making slow progress in their implementation of *Olmstead's* mandate. That said, these legislative enactments clearly disfavor unnecessary removal and exclusion of youth from the community.

### E. The Spirit of These Core Legal Traditions

In summary, the spirit of these legal traditions is clear. The family is the setting of first resort for the upbringing of children, including, and perhaps even especially, for children with special needs. Removal from family and home should be a last resort, limited to circumstances when a family environment or a child's conduct requires removal in order to protect the welfare of the child or others. Even then, removal should be

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\(^{562}\) One interpretive question regarding the reach of *Olmstead* is: When is a state obliged to offer community-based services to those who are not yet institutionalized, but are at risk of institutionalization? Courts addressing this issue in the past several years typically interpret the ADA's mandates as creating rights to avoid institutionalization in those who are not yet institutionalized. Mathis, *supra* note 257, at 562-64. There remain, however, a range of unresolved issues regarding the scope of that right. *Id.* For a discussion of the ADA's "promise" for those with mental disabilities, see Michael L. Perlin, “Their Promises of Paradise": Will *Olmstead v. L.C.* Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law?, 37 Hous. L. Rev. 999 (2000); Milstein et al., *supra* note 539.

\(^{563}\) “[I]nstitutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in the community life.” *Olmstead*, 527 U.S. at 600.

\(^{564}\) *Id.* at 601.

\(^{565}\) *See supra* Part III.
short term, unless it is determined that the family home will never be a suitable place for the child. The tradition of favoring a family upbringing for children derives not only from parents’ constitutional rights, but also from the psychological and sociological importance of supporting and strengthening the family and encouraging healthy and stable parent-child relationships. Furthermore, the states’ *parens patriae* and police power interests in children’s welfare are most likely to be promoted through creation of a stable, adaptive, and functional family unit. State investment in helping problem families achieve such functioning is in the interest of the children, the families, and the greater society. Unnecessary restrictions of children’s liberty, and unnecessary separation of the child from the broader community are also inconsistent with core American legal traditions. Some policymakers have already recognized the importance of bringing policies toward American children in line with these legal traditions. During the twentieth century, various policy initiatives were implemented with the goal of reducing institutional use in the child welfare, juvenile justice, and mental health systems. Yet, these initiatives have had limited success with respect to troubled and troublesome youth. An analysis of these trends is in Part VI below.

VI. UNDERSTANDING THE FAILURES OF AMERICAN RESPONSES TO TROUBLED AND TROUBLESOME YOUTH

In this Part, I examine the limited success of policy reforms in achieving the deinstitutionalization of troubled and troublesome youth and persons with mental disorders. Although most deinstitutionalization policies did strive to create alternative mechanisms to meet the underlying social needs traditionally served by institutions, few did so successfully. Sometimes, the alternatives were poorly funded, sometimes they were poorly conceived, and sometimes they were no more faithful to the core legal traditions discussed in Part V than were institutional options. In Part VII, I present proposals for more effective deinstitutionalization policies. But formulation of effective deinstitutionalization policies requires an understanding of the forces that promoted the creation and use of institutions, as well as those that interfered with the success of reforms. The functionalist perspective, described immediately below, aids both of those inquiries.
A. The Functionalist Perspective

The functionalist perspective advanced by various sociologists underscores the importance of examining the functions that particular aspects of the social system—in our case, institutions—serve. In applying this perspective to policies leading to the construction, use, and attempted depopulation of various institutions, it is critical to distinguish between “manifest functions” (that is, those functions that are intended and acknowledged by policymakers and social participants) and “latent functions” (that is, those functions that are unintended, unanticipated or unacknowledged by policymakers and social participants). Policymakers may devise and implement strategies to achieve particular manifest policy goals, such as treating mentally disordered individuals and protecting those individuals and others in the community from those persons’ dangerous conduct. At the same time, however, the institutions may serve the latent functions, such as removing persons who behave in odd or disturbing manners from public view, or shifting the cost of sustaining such persons from one governmental entity to another. Manifest and latent functions can operate concurrently. Sometimes, the line between these functions blurs. Policy reforms directed at those institutions, however, cannot succeed without confronting the institutions’ latent functions. Whether we call functions manifest or latent, if these institutions serve important social functions, such as providing food and shelter to those incapable of meeting these needs independently, or temporarily removing an adolescent from a violent home, policy reforms must create alternative mechanisms to meet these needs. Failure to do so dooms the reforms to whole or partial failure and may lead to various unintended consequences.

566. For elucidation of the functionalist approach in sociology, see generally ROBERT K. MERTON, SOCIAL THEORY AND SOCIAL STRUCTURE 73-138 (rev. 1968). For an application of this perspective to deinstitutionalization, see LEONA L. BACHRACH, DEINSTITUTIONALIZATION: AN ANALYTIC REVIEW AND SOCIOLOGICAL PERSPECTIVE 18-21 (1976).
567. See BACHRACH, supra note 566, at 18-19; see also MERTON, supra note 566, at 114-15.
568. See BACHRACH, supra note 566, at 18-19.
B. The Creation and Perpetuation of Child Care and Control Institutions in the United States

The story of troubled and troublesome youth in American society is a story of the proliferation of a variety of child care and control institutions, and of children’s removal from their homes and placement in these facilities. It is also the story of several waves of policy initiatives aimed at deinstitutionalizing some subsets of children from these facilities. Institutions were not always America’s preferred response to troubled and troublesome children, or for any persons perceived to be deviant or dependent. The use of institutions was fairly limited in the Colonies and United States prior to the nineteenth century. Only then did the country experience a substantial boom in the growth of specialized total institutions intended to address the perceived needs of various groups. During the nineteenth century, use of total institutions was widely embraced, with some measure of this enthusiasm continuing well into the twentieth century. Institutionalization was no longer a last resort for exceptional situations; it became a favored response to manifest dependence and deviance. Institutionalization was seen as a preventive intervention to socialize children whose life circumstances were less than optimal, or as a form of early intervention when adults evidenced the first symptoms of mental disorder. In the words of one historian: “A cult of asylum swept the country.”

569. Paul Lerman refers to those residential facilities relevant to our analyses as “care and control institutions.” LERMAN, DEINSTITUTIONALIZATION, supra note 20, at 1-12. Lerman proposes the following definition of a care and control institution:

A civilian institution is a private or public establishment which furnishes (in single or multiple faculties) food and shelter to about four or more persons unrelated to the proprietor and, in addition, provides one or more of the following:

1. Medical and/or personal and/or social care.
2. Treatment and/or skills training and/or habilitation.
3. Supervision and/or custodial control.
4. Protection and/or social welfare.
5. Diagnostic assessment and/or background investigation.

Excluded from this definition are: [foster family homes]; all military establishments; educational dormitories and rooms, except for schools for the mentally and developmentally disabled; and religious training institutions.

Id. at 8. Lerman distinguished between “traditional” and “nontraditional” institutions, and intentionally swept nontraditional institutions into his definition, despite the relatively small size of facilities housing as few as five or six persons. Traditional institutions, such as mental hospitals, state institutions for the developmentally disabled, juvenile detention facilities, and prisons, have often housed hundreds of persons at any given time, are self-contained, and are typically set off
from the community so as to minimize—or completely prevent—interaction of the residents with community members. Such facilities, referred to by sociologist Erving Goffman as “total institutions,” are characterized by separation from the community, restrictive conditions of custody regulating the activities and movement of residents, requirements of conformity and attendant reduction in individuality, and a lack of privacy. “Their encompassing total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, . . . .” Goffman, supra note 27, at 4.

First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member’s daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution.

Id. at 6. See also David J. Rothman, The Discovery of the Asylum xxiv (3d ed. 2002) [hereinafter Discovery of the Asylum]. As contrasted with total or traditional institutions, nontraditional institutions are typically smaller and are not necessarily set apart from the community. Examples of such facilities are nursing homes, shelter-care facilities, or newer juvenile correctional facilities such as “ranches, camps and schools.” Although these nontraditional living arrangements are often regarded by observers and residents as “freer places to live than traditional institutions,” some are quite large, custodial in nature, and introduce significant restrictions and limitations on the residents’ privacy and activities. Lerman, Deinstitutionalization, supra note 20, at 8-11. Lerman also included halfway houses and group homes in the category of nontraditional institutions. Id. It is noteworthy that some of these latter facilities, depending upon size, location, program, and level of integration into the community, may maximize the opportunities for social participation for some individuals for whom residence with a family is not possible. The various options available for those who cannot reside with their families are examined below. See infra Part VII.C.2.b.

570. The terms “dependent” and “deviant” refer to different social characterizations that might lead to institutionalization. Those persons who are viewed as both dependent and deviant are particularly likely to be candidates for institutionalization. Dependency in this context refers to one’s reliance on others for care or support. Such reliance may derive from an individual’s actual psychological or physical limitations, or from the limitations imposed by social roles. Thus, while many adolescents could engage in some adult-like daily tasks relatively independently, their socialization and the legal restrictions on their activities allow for—and at times require—greater dependence during the teen years than may be required strictly by an assessment of their intellectual and physical capabilities.

Deviance can be viewed primarily as a statistical variation from a norm of some type, which does not carry with it positive or negative connotations, or it can derive from the perception that an individual is violating some social norm or rule. Some deviance designations are formally defined by the law. For further discussion of sociological perspectives on deviance, see generally Howard S. Becker, Outsiders: Studies in the Sociology of Deviance 1-39 (1963); Edwin M. Schur, The Politics of Deviance: Stigma Contests and the Uses of Power 1-25 (1980).


572. See supra Part V.B.

573. Discovery of the Asylum, supra note 569, at 130-31.
The development of institutions serving children was part of larger “systemic attempts to purify the environments of the young, to withdraw them from debasing community temptations, and to immerse them in networks of good influence.”\textsuperscript{576} The institutionalization movement focused on youth with deceased, absent, ill, or impoverished parents, as well as those whose parents had allegedly failed in adequately socializing their children.\textsuperscript{577} Orphanages and houses of refuge became increasingly common ways of dealing with these children.\textsuperscript{578} Although the name orphanage implies that these facilities served children whose parents were deceased, admission policies were flexible, casting a relatively wide net that extended beyond parentless children. From the perspective of these facilities’ administrators, “there was no reason to penalize the unfortunate child for the fact of his parents’ survival.”\textsuperscript{579} Thus, children were removed from parents ostensibly to reduce their chances of becoming “pests to society” or future “tenants of . . . prisons.”\textsuperscript{580}

What motivated this urge to place children and those adults labeled as insane in institutions? Historians quarrel as to the particular contributions of various humanitarian, sociopolitical, economic, or other influences. But it is fair to say that a complex range of factors converged to promote the development and use of these facilities in the United States.\textsuperscript{581} The manifest functions of the institutions included treatment,
rehabilitation, education, reform, and achievement of other benevolent
goals. Yet, as is often the case with attempts at social engineering,
altruistic agendas are only part of the story. Grossberg emphasizes the
“fundamental tension in American beliefs and policies toward the young,” as we are “torn between a fear for children and a fear of
children.” Americans wished to inculcate children with “American”
values, not only because they expected that doing so would benefit the
children—they also expected that doing so would benefit the general
welfare.

Rothman suggests that a sense of desperation in the first half of the
nineteenth century propelled reformers to take dramatic steps by
constructing networks of “well-ordered” institutions:

Americans experienced a crisis of confidence in the social organization
of the new republic, fearful that the ties that once bound citizens
together—the ties of community, church, and family—were loosening
and that, as a consequence, social disorganization appeared imminent.
Their fears were confirmed and exacerbated by the extent of the crime,
poverty, delinquency, and insanity that they saw around them. In
response to these perceptions, to an anxiety about the stability of the
social order and an alarm about the extent of deviancy and
dependency, they discovered the asylum.

Ironically, despite this nation’s historical roots—which had often
led it to be cautious about broad-based unchecked state authority over
individuals—the Progressive Era ushered in even greater expansions
of governmental power. The public placed “unbounded trust” in the
“benevolence of the state.” What made these expansions palatable—
even welcome—was that these interventions were not focused on the
general populous, but rather, on dependent and deviant subgroups.

who view social intervention in children’s lives as either a product of humanitarian or social control
objectives).

582. Michael Grossberg, Changing Conceptions of Child Welfare in the United States, 1820-
1935, in A CENTURY OF JUVENILE JUSTICE 3, 3 (Margaret K. Rosenheim et al. eds., 2002)
[hereinafter Grossberg, Changing Conceptions].

583. Id. at xxiv.

584. Historians have generally referred to the period of time between 1885 through 1915 as the
Progressive Era. During these years, “reformers” expressed pervasive concerns about social and
economic conditions in the United States, and particularly those that affected children, and sought
comprehensive social and legal change. For a thoughtful and balanced historical analysis of this era,
see Cohen, supra note 103; Hamilton Cravens, Child Saving in Modern America, 1870-1990s, in

585. JOHN Q. LA FOND & MARY L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF
Grossberg characterizes social reforms of this era as propelled by a kind of “moral panic”—that is, fear “that urbanization, industrial capitalism, and massive immigration were undermining the nation’s homes and thus, the republic itself.” Adults worried about children—everyone’s children, not just their own—for their own sake and also out of fear for the country’s future. Thus, the public was unwilling to challenge seemingly benevolent governmental action in the face of its overwhelming concerns. And, indeed, the ideology of this era and the language of humanitarianism made it almost impossible to disentangle the myriad of functions served by the highly intrusive governmental interventions given ever-increasing legitimacy.

The creation of the juvenile court was the single most dramatic development relating to institutionalization in the twentieth century. While the establishment of the juvenile court was an extension of the organized child welfare and child reform interventions commenced in the prior century, it was, in many ways, more far-reaching. The child welfare movement, with its proliferation of orphanages, was the product of private, nonprofit organizations and societies, which operated with tacit legal approval. By contrast, the juvenile court at once

587. See Cohen, supra note 103, at 274.
588. See DAVID J. ROTHMAN, CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA 10 (rev. 2002) [hereinafter CONSCIENCE AND CONVENIENCE]. Rothman suggests that state actors and others working in the service of state goals asserted full confidence about the correctness of their approach:

[T]hey were convinced that...the same person and the same institution could at once guard and help, protect and rehabilitate, maintain custody and deliver treatment. They perceived no conflict between these goals, no clash of interest between the deviant and the wider society, between the warden and his convicts, between the hospital superintendent and his patients, between the keeper and the kept. The “friend” or social worker who did probation work could simultaneously be an “officer”; the juvenile court judge who was charged to protect society could also be a parent to the delinquent. This belief was among the most fundamental in the reformers’ canon, and in retrospect, perhaps the most dubious.

Id.

589. For a discussion of the growth, power, and functioning of these private, nonprofit child welfare agencies as sort of “quasi” agents of the state, see Weithorn, Protecting Children, supra note 77, at 45-51. While the state did not oppose, and often ratified, these private efforts, these interventions were not formal state actions. The advent of the juvenile court, therefore, expanded the reach into the family by outside forces and formalized the role of the state as the intervener. Grossberg notes that, given the “relatively weak state and decentralized and underdeveloped bureaucracy” in the United States of the nineteenth century, the nation “became a fertile host for an expansive and expanding civil society.” Grossberg, Changing Conceptions, supra note 582, at 9. He defines “civil society” as “the social space between the family and state—a space of public
consolidated legal authority over all children perceived to be in need of some extrafamilial intervention in one state agency. Beginning with the initiation of the first juvenile court in Illinois in 1899, the juvenile justice movement formalized state intervention in the lives of troubled and troublesome youth and their families. 590

The state—acting through the juvenile court and under the authority of its parens patriae authority—substituted itself for those parents who were absent or perceived to be inadequate or harmful. 591 These reforms incorporated a treatment philosophy, emphasizing the needs of each individual child, rather than the acts or circumstances that triggered the court’s authority, as determinative of the court’s disposition. 592 Thus, in theory, a child falling into any of the three primary categories of youth within the court’s jurisdiction—delinquents, noncriminal disobedients (today’s status offenders), or dependent children 593—could, and often did, receive similar dispositions. 594 The numbers of children institutionalized in child welfare and juvenile justice facilities under the authority of the juvenile court mushroomed during the twentieth century. 595 By contrast, admission of children to mental hospitals, while not unheard of, was less common until the 1970s.

Placement of adults in mental institutions, however, continued to expand throughout the twentieth century, despite awareness of discourse and action carried on by individuals who band together in nongovernmental or quasi-governmental organizations, institutions, and movements.” Id. 590. Most writers cite 1899 as the date of the juvenile justice system’s creation because in this year, the Juvenile Court Act in Illinois became effective, marking the first formal appearance of the juvenile court model in a state statute. See Anthony M. Platt, The Child Savers: The Invention of Delinquency 9-10 (2d ed. 1977); Mack, supra note 102. 591. See LaMar T. Empey, Introduction: The Social Construction of Childhood and Juvenile Justice, in THE FUTURE OF CHILDHOOD AND JUVENILE JUSTICE 1-4, 16-28 (LaMar T. Empey ed., 1979). 592. See Weithorn, Protecting Children, supra note 77, at 48; Mack, supra note 102, at 107. 593. During the Progressive Era, and even up until the 1960s, most children classified as dependent were children perceived to be neglected. Although cases of child abuse were part of the juvenile court’s docket, such cases typically constituted a small proportion of the caseload. Some scholars attribute this phenomenon to the agendas of those in the child welfare and juvenile court movements and to historically contingent evaluations of which family circumstances were most problematic rather than the prevalence of different forms of child maltreatment. For an analysis of these historical developments and summary of relevant commentary, see, for example, Weithorn, Protecting Children, supra note 77, at 48-50, 52-60. 594. Lerman, Deinstitutionalization, supra note 20, at 107, 113-14. For example, in 1923, 50% of the minors in secure detention facilities in this country were labeled “dependent.” Id. The author of a 1923 census noted: “The dividing line between dependency and delinquency is often so vague that in practice both types of children may be found in the care of organizations intended primarily for the care of a single class.” Id. at 114. 595. Lerman, Twentieth-Century Developments, supra note 20, at 82-87.
overcrowding, abuses, and poor conditions within most such facilities.596 While there was clearly enthusiasm and optimism regarding new perspectives in medicine and psychology on the part of many, there was also a willingness to accept the system’s failings in exchange for the benefits to the community of segregating the mentally disordered. Over time, these facilities admitted and sustained increasing numbers of chronic and severe cases.597

Despite all of the enthusiasm for the use of mental hospitals to treat the afflicted, most observers agree that conditions were often deplorable.598 Given inadequate appropriations by state legislatures, conditions deteriorated to the point that custodial care was all that was offered by the end of the nineteenth century, notwithstanding Progressive attempts to tinker with the way in which the institutions functioned.599 Furthermore, reports revealed that patients were frequently physically abused, neglected, and subjected to a range of experimental procedures, such as drugs, electroshock therapy, and lobotomies.600 Despite several sustained efforts to create alternatives to mental institutions in the early twentieth century, these institutions remained. Indeed, they admitted increasing numbers of patients and became the cornerstone of American mental health policy, a testament to society’s reliance on the latent functions served by these facilities. In other words, total institutions housing the deviant and dependent served a popular sense of social order, achieved by controlling the day-to-day lives of persons from certain undesirable segments of society.601 Thus, even after optimism regarding the curability of insanity and the ability to reform wayward children waned and the idealism of the institutions’ founders gave way to disillusionment, institutional populations increased. This occurred despite scandals revealing repressive practices, overcrowding, and deteriorating conditions within these facilities, a phenomenon historian Michael Grossberg cites as “testimony to an unflagging readiness to keep the deviant out of sight and out of mind.”602

596. ROCHEFORT, supra note 59, at 30 (noting that between 1880 and 1940, the number of residents in state mental hospitals increased almost five times as fast as the general population). Officials often justified the continued existence of these facilities by comparisons to the past. For example, asylums were certainly preferred over approaches that chained and confined the “insane” in attics and cellars. CONSCIENCE AND CONVENIENCE, supra note 588, at 29-31, 40.

597. See generally DISCOVERY OF THE ASYLUM, supra note 569.

598. See id.

599. See CONSCIENCE AND CONVENIENCE, supra note 588, at 293-375.

600. Id.

601. DISCOVERY OF THE ASYLUM, supra note 569.

602. Id. at xxxix; xlvii. Grossberg states that by the 1850s and 1860s, “overcrowding and mismanagement had undermined the therapeutic goals of the Houses of Refuge.”
Rothman concludes that the "convenience" of total institutions allowed them to continue well past society's belief in their rehabilitative potential: "The promise of reform had built up the asylums; the functionalism of custody perpetuated them."\(^603\)

Overwhelming proportions of institutional residents were immigrants or from the lower socioeconomic classes.\(^604\) Some historians argue that institutions were tools used by the dominant classes to maintain social control over other groups.\(^605\) Or, perhaps these less powerful groups simply were less able to repel the state's authority than were those with more secure standing in the community mainstream.\(^606\) Possibly, the institutionalization of substantially greater proportions of the poor and immigrant classes reflected a more generalized "[f]ear of community disintegration and . . . social pollution [magnified by an] increasingly visible class of cultural strangers and destitute and dirty children [in the city and country]."\(^607\)

Finally, any functional analysis of the growth and use of institutions housing dependent and deviant persons must examine financial incentives. At the level of the family, the financial and human cost of caring for dependent and deviant members was often overwhelming. These individuals tax the financial and social capital of their families. Not only are they frequently not contributing to the financial assets of the social units that maintain them, but they also drain communal resources by occupying the time and services of those who would be engaged in remunerative activities but for the demands on their time to

\[^{[T]}\]he institutional movement spread across the republic . . . in various states for the rest of the century. Institutionalization had acquired its own appeal; if nothing else, it took children off the streets and out of failed families. The reformatories became a fundamental way of dealing with disorderly and other dependent youths. Grossberg, Changing Conceptions, supra note 582, at 18.

603. DISCOVERY OF THE ASYLUM, supra note 569, at 240. While some subgroup of incarcerated persons might have been dangerous to themselves or to others, many more were not. But, to the extent that Americans feared, or were otherwise disturbed by, contact with members of various dependent and deviant groups, containment of these groups in institutions added value to these facilities and perpetuated their existence.

604. For example, Rothman reports that in 1890, 40% of state mental institution residents were either immigrants or children of immigrants, with higher percentages in the cities. Most patients were of working-class backgrounds, and others were impoverished. CONSCIENCE AND CONVENIENCE, supra note 588, at 24.


606. DISCOVERY OF THE ASYLUM, supra note 569, at 286-87. Those with greater financial resources, those with stronger ties to the community, those whose unconventional conduct might be interpreted as "eccentricity" rather than "insanity" were more likely to avoid institutional solutions to their problems.

serve as caregivers. In addition, the family must often expend funds to obtain needed professional services. In the decades before governmental financial assistance to the poor, ill, or the emotionally disturbed, family members bore the cost of care. Many reluctantly shifted the cost of care of their dependents—their young, aged, physically infirm or emotionally disturbed family members—to the state. Making use of the institutional system may have been the only palatable response to the harsh circumstances in which many working class and impoverished families found themselves. And while government subsidies do assist some people today, many families still find themselves in a situation analogous to those nineteenth century and early twentieth century families whose energies and financial resources were depleted by the demands and expense of caring for relatives with special needs. Cost-shifting in the care of certain dependent and deviant individuals also occurred among levels of government during the eighteenth, nineteenth, and twentieth centuries. Historian Gerald Grob points out that local communities, which bore the cost of almshouses, were only too glad to shift the responsibility and expense of caring for dependent and deviant individuals to the specialized institutions developed and financed by the states. The depopulation of state-funded mental institutions during the twentieth century was assisted by the availability of federal subsidies for the daily sustenance of the mentally infirm in the community or in private residential facilities. Other economic considerations, such as the provision of local employment opportunities, also promoted the use of certain facilities. To the extent that these latent functions and the benefits of particular patterns of institutional use are not addressed in reform efforts, such efforts are likely to have only limited success.

608. Martha Fineman discusses this theme in a more generalized way when examining the impact of caring for dependent persons on those who care for their children or their elder or ill relatives. See generally Martha Albertson Fineman, The Inevitability of Dependency and the Politics of Subsidy, 9 STAN. L. & POL'y REV. 89 (1998).

609. For example, Grob points out that families of severely disturbed individuals suffered two forms of financial hardship in that the “afflicted individual was usually unable to work,” and someone in the family was required to provide intensive care, removing that individual partially or fully from the labor market. GERALD N. GROB, MENTAL ILLNESS AND AMERICAN SOCIETY, 1875-1940, at 10 (1983). For a discussion of some of the psychological conflicts experienced by families around the decision to commit a relative to an institution, see NANCY TOMES, A GENEROUS CONFIDENCE: THOMAS STORY KIRKBRIDE AND THE ART OF ASYLUM-KEEPING, 1840-1883, at 90-128 (Charles Webster & Charles Rosenberg eds., 1984).

610. GROB, supra note 609, at 116-24.

611. Cost-shifting may also occur between sectors of the same governmental entity, as when the closure of state mental hospitals leads to increased use of correctional facilities.

612. DISCOVERY OF THE ASYLUM, supra note 569.
Furthermore, such failure may lead to unintended consequences that create new and equally or more challenging policy dilemmas.  

C. Understanding the Failures of Deinstitutionalization Movements

The term "deinstitutionalization" can refer to a fact, that is, an actual reduction in the use of particular institutions, effected either by discharge of persons confined in those facilities and/or by discontinued use of such placements for persons not yet confined. Or deinstitutionalization can refer to a policy, process, or goal. Sociologist Leona Bachrach defines deinstitutionalization as involving two key components: "(1) the eschewal of traditional institutional settings . . ., and (2) the concurrent expansion of community-based services for [care of and intervention with] these individuals." Her definition implies intentionality, such as that often sought through purposive lawmaking, and envisions the development of alternative services or interventions in noninstitutional settings to address the needs that fueled the establishment and maintenance of the institutions. Policies that go no further than preventing or discouraging continued use of the institutions and do not serve the needs of the institutionalized, their families, and their communities are incomplete. Needs, be they individual, familial, or societal, do not evaporate at the will of policymakers. Policymakers must plan to meet the underlying social needs in an alternate manner that is sufficiently accessible and attractive to be preferred over institutions. Thus, a formal policy of deinstitutionalization with a promise of success is likely to involve: (1) discharge of persons from institutional settings; (2) reduction or prevention of new admissions and readmissions to institutional settings; and (3) creation or expansion of suitable alternative interventions or services in noninstitutional settings.

Yet, deinstitutionalization, as a fact, may also occur in the absence of legal policies directed at achieving depopulation of institutions. For example, many circumstances other than formal policymaking have been cited as promoting the deinstitutionalization of adult psychiatric patients from mental hospitals in the latter half of the twentieth century, such as

613. See supra Parts IV-V.
614. See, e.g., LERMAN, DEINSTITUTIONALIZATION, supra note 20, at 3 (stating that "a broad view of [deinstitutionalization] would refer primarily to reduced reliance on . . . traditional institutions [as] counted institutions . . . [as] counted by the U.S. Bureau of the Census").
615. BACHRACH, supra note 566, at 1. Professor Bachrach's definition was specific to the use of mental hospitals; it was modified above to serve as a more generic definition suitable also to child care and control institutions.
the development of antipsychotic medications.\textsuperscript{616} More recently, the advent of managed care and its attendant restrictions on availability of third-party payment for inpatient psychiatric treatment has further reduced rates of hospital use.\textsuperscript{617} Historian Gerald Grob points out that deinstitutionalization can be an \textit{unintended consequence} of a policy that was enacted for other reasons.\textsuperscript{618} For example, Social Security disability insurance and Medicaid have played a major role in the deinstitutionalization of psychiatric patients from mental hospitals, even though this result was not the purpose of those policy innovations.\textsuperscript{619}

Deinstitutionalization, as a phenomenon, cannot be discussed without also examining the associated phenomenon of \textit{transinstitutionalization}, that is, the movement of persons or groups from one institutional system to another.\textsuperscript{620} While policymakers may, at times, seek or encourage transinstitutionalization,\textsuperscript{621} most commonly transinstitutionalization is an unintended result of \textit{incomplete} deinstitutionalization policies. It typically results from insufficient attention to the third prong of the definition of deinstitutionalization—that is, the creation or expansion of suitable alternative interventions or services in noninstitutional settings. Frequently, therefore, transinstitutionalization is predictable. And while it is not always possible to predict precisely what needs formerly institutionalized individuals or their families and communities will have once deinstitutionalization policies are implemented, transinstitutionalization has occurred frequently enough throughout the history of institutional

\begin{footnotes}
\item[616] \textsc{La Fond} \& \textsc{Durham}, \textit{supra} note 585, at 128.
\item[617] \textsc{See} David S. Mechanic, \textit{Key Policy Considerations for Mental Health in the Managed Care Era, in Mental Health, United States, 1996,} at 1, 1 (Ronald W. Manderscheid \& Mary Anne Sonnenschein eds., 1996).
\item[618] \textsc{Grob, supra} note 609, at 265-69.
\item[619] \textit{Id.}
\item[620] Sociologist Carol Warren introduced the term “transinstitutionalization” into the scholarly literature. \textsc{See, e.g.,} Carol A.B. Warren, \textit{New Forms of Social Control: The Myth of Deinstitutionalization, 24 Am. Behav. Scientist} 724, 726-30 (1981). For a discussion of the origins of the term “transinstitutionalization,” see Weithorn, \textit{Skyrocketing Admissions, supra} note 16, at 805 \& n.198. Paul Lerman’s classic 1982 work, \textit{Deinstitutionalization and the Welfare State,} is the first text to describe and demonstrate, theoretically and empirically, processes of transinstitutionalization at work across a range of institutional settings in twentieth century American society. No better exposition of this phenomenon, as it relates to children, older Americans, or persons identified as mentally disabled, exists in the professional literature. \textsc{See generally Lerman, Deinstitutionalization, supra} note 20.
\item[621] For example, they may seek to move a population from a more restrictive to a less restrictive institution, or from a less appropriate to a more appropriate setting. Thus, policymakers sought to remove juveniles adjudicated as delinquents from adult correctional facilities and to place them instead in juvenile correctional facilities.
\end{footnotes}
use to place policymakers on notice as to the possibility or probability of its occurrence. And, not surprisingly, trends in the use of the three primary systems of care and control affecting troubled and troublesome youth in the twentieth century confirm a strong relationship between formal policies promoting and achieving some level of deinstitutionalization of one system’s facilities and the increased use of those of another system.

There were five key deinstitutionalization movements in the twentieth century which affected the placement of troubled and troublesome youth. Two involved child welfare facilities (removal of first impoverished children, and then maltreated children, from child care institutions), two involved correctional facilities (removal of juvenile offenders from adult correctional facilities and status offenders from juvenile justice facilities), and one involved mental health facilities (removal of adult patients from mental hospitals).

From their outset, the primary child service and intervention systems justified their forays into the lives of children and families on the basis that they were serving the state’s parens patriae and police power interests in promoting the welfare of the child—for the child’s own sake and for the welfare of the society in which these children would ultimately take their place as adults. These were the manifest functions that the institutional placements were to serve. And yet, a review of the policies governing institutionalization of children and the mentally disabled over the eighteenth, nineteenth, and twentieth centuries reveals that various latent functions were served as well.

1. Deinstitutionalization and the Child Welfare System

During the nineteenth, and to some extent, the early twentieth century, there remained enthusiasm for placing in institutions large numbers of children perceived to be in need of governmental aid or intervention. Not only were delinquent, disobedient, “wayward,” homeless, neglected, abandoned, abused, and orphaned children placed

622. One of the harshest critics of this institutionalization trend was Charles Loring Brace, a New York City minister who created the Children’s Aid Society. Priscilla Ferguson Clement, *The City and the Child, 1860-1885*, in *AMERICAN CHILDHOOD: A RESEARCH GUIDE AND HISTORICAL HANDBOOK* 235, 257-62 (Joseph M. Hawes & N. Ray Hiner eds., 1985). Loring did not question the appropriateness of intervention in these children’s lives but argued that what these children needed was not placement in institutions, but in homes with Christian families in the rural Midwest. Schene, supra note 578, at 25. Reportedly, over 150,000 such children were sent by train to live and work on family farms. *Id.* In the late nineteenth century, states also developed programs for reimbursing farm families for caring for these wards. *Id.* These models were precursors to modern concepts of foster care. Yet, apart from Loring’s objections, institutionalization was the norm.
in these facilities, but children of impoverished families were placed in these facilities as well. The Progressive movement, however, introduced new notions about child development, including the importance of mothers to the healthy upbringing of their children. The Progressive reformers were concerned about those children separated from their mothers and placed in institutions solely because of maternal poverty. Encouraged by a 1909 report of the White House Conference on Dependent Children, which emphasized the importance of maternal care, twenty states enacted what were referred to as "mothers' pension" or "widows' pension" laws by 1913, and another twenty did so by 1920. These laws provided meager stipends to "respectable poor" mothers, that is, generally "white widows," to enable them to support themselves and their children, thus avoiding their children's removal from the home. This policy evidenced a partial return to the colonial and eighteenth century practice of providing relief to those in need within the community. Yet, despite these goals and state subsidies to the "deserving" poor, almost half (43%) of children referred for out-of-home care were referred by their parents.

Even more significant than the state subsidies, however, was the passage of the federal Social Security Act of 1935, which established the Aid to Dependent Children program, the forerunner of the AFDC federal "welfare" program. This development not only signaled the federal government's assumption of responsibility for support of certain needy families, but further demonstrated a shift in ideology: children from destitute families should be raised in their own homes, by their own mothers, and not in institutions. These policies were among several measures designed to dismantle residential institutions for children by returning the inmates of orphanages to their birth families.

623. See Grossberg, Changing Conceptions, supra note 582, at 32.
624. Id.; see also Lerman, Twentieth-Century Developments, supra note 20, at 75.
625. LAWRENCE M. FRIEDMAN, AMERICAN LAW IN THE 20TH CENTURY 179 (2002); see also Grossberg, Changing Conceptions, supra note 582, at 33.
626. See FRIEDMAN, supra note 625, at 179; see also Grossberg, Changing Conceptions, supra note 582, at 32-33.
627. See FRIEDMAN, HISTORY OF AMERICAN LAW, supra note 571, at 212-18.
628. Lerman, Twentieth-Century Developments, supra note 20, at 76. Lerman emphasizes that while these child welfare institutions were used by impoverished parents as a means of supporting their families, others may have used them as a way of coping with disobedient and difficult youth. Id. at 77.
629. 42 U.S.C. §§ 601-687 (repealed 1996). In 1962, this program was renamed Aid to Families with Dependent Children to reflect a broadened focus on providing support to the parents or other relatives caring for the child. Public Welfare Amendment of 1962, Pub. L. No. 87-543, §§ 104(a)(1)-(3), 76 Stat. 185 (1962).
or, where these families were absent or unfit, by distributing them among family homes by indenture or payment of board. In effect, the reformers were building a disembodied orphanage—a set of policies that would accommodate the healthy, non-delinquent inmates of orphan asylums without resorting to the asylum itself.630

Although mothers’ pensions and federal welfare subsidies made it possible for one subset of the residents of children’s institutions to remain in their homes, “countless children continued to be placed in reformatories, orphanages, and other public and private asylums.”631 The child welfare system, arising out of the hodgepodge of private and public institutions and policies of the nineteenth century, and increasingly centralized in the juvenile courts, retained control over the day-to-day lives of large numbers of children.632

The next ideological shift was one that disfavored traditional institutional placements for most of the remaining children in the child welfare system.633 For those dependent children without special needs, placements with foster families became a preferred option, offering children the benefits of a family environment.634 Beginning in the 1960s, federal policy initiatives sought to promote these ideals, encouraging foster family placements, adoption, and, when necessary for children with special needs, smaller child welfare facilities. The federal government committed increasingly substantial infusions of funds to promote these goals.635 And, indeed, Lerman’s analysis of national out-of-home placement rates reveals that use of child welfare institutions did plunge 73.4% between 1923 and 1985.636 The rate increased again between 1985 and 1997, narrowing the overall reduction (between 1923 and 1997) to 65.6%.637 Yet, despite the decrease of children in child

631. Grossberg, Changing Conceptions, supra note 582, at 36.
632. Id. at 36-39.
633. Lerman, Twentieth-Century Developments, supra note 20, at 76.
634. Id. at 76-77.
635. See id. at 76-78. Lerman points out that many of these new facilities, labeled residential treatment centers for emotionally disturbed children, were renovated versions of former child welfare institutions. Id.
636. See id. at 80. The 73.4% figure was obtained by this author by comparing the rate of 88 per 100,000 youth in these facilities in 1985, reported in Lerman’s Figure 3.1, with the rate of 331 per 100,000 youth in 1923.
637. This figure was obtained by this author by comparing the rate of 114 per 100,000 youth in these facilities in 1997, reported in Lerman’s Figure 3.1, with the rate of 331 per 100,000 youth in 1923. Id. at 79 fig.3.1. While 520 youth per 100,000 resided in the combined categories of out-of-
welfare institutions as a result of these policies, national data sets suggest that a greater proportion of American youth overall are in out-of-home placements under the jurisdiction of the child welfare system today than prior to these two deinstitutionalization movements.638

What accounts for this increase? In part, as the system contracted its reach, excluding many children of impoverished families, it expanded its reach as well. The parameters defining maltreated children shifted, particularly in the latter half of the twentieth century, ultimately broadening the system mandate. Thus, these figures reflect increasing awareness of the toll that various forms of child maltreatment take on the well-being of children, as well as actual increases in the numbers of children exposed to dangerous circumstances.639 In addition, however,
the figures may also include many families for whom the necessity of state intervention can be, and has been, debated.\textsuperscript{640} These two deinstitutionalization movements might be viewed as partial successes, in that the overwhelming proportion of out-of-home placements are with foster families, that is, the child is living in someone's home, rather than in an institution. Yet, the current rate of removals to noninstitutional settings is inconsistent with the core American legal traditions discussed in Part V. Not only does it deprive the child and her family of their familial relationship, but there is substantial evidence that the lack of continuity and dislocation process takes a heavy toll on children removed from their homes.\textsuperscript{641} The conditions in some foster homes are substandard and unsafe, and may be more dangerous to the child's well-being than those in their parents' homes.\textsuperscript{642} Removal from one's own community, including school, neighborhood, and extended family, all deprive the child of important connections and developmental opportunities.\textsuperscript{643} Thus, the population served by the child welfare system has shifted, with certain categories of children replaced by others. In the final analysis, however, the existing foster care system is not the dramatic improvement over child care and control institutions that we once thought it would be.

There is no question that many children are far better off in foster homes than in large institutions. But, homes and caregivers are not fungible. The relative superiority of foster homes over childcare institutions therefore misses the point in terms of big-picture policymaking. The critical inquiry should be whether, if the state provided families with appropriate support and services so as to prevent removal, children would be better off remaining with those families than maltreatment rose sharply over the following years and decades, as did the involvement of the child welfare system in families. \textit{Id.} at 58. The widespread use of crack cocaine has been blamed as well for an increase in formal intervention of the child welfare system in families in which parents are substance users. Lewit, \textit{supra} note 638, at 198. According to one source, reports of child abuse had increased from 10,000 annually in 1962 to almost three million in 1992. DUNCAN LINDSEY, THE WELFARE OF CHILDREN 8 (1994). According to another, the number of children reported nationally rose by over 347% between 1976 and 1993. Schene, \textit{supra} note 578, at 29.

\textsuperscript{640} See, e.g., LINDSEY, \textit{supra} note 639, at 3-5; LELA B. COSTIN ET AL., THE POLITICS OF CHILD ABUSE IN AMERICA (1996).


\textsuperscript{642} Austen L. Parrish, \textit{Avoiding the Mistakes of Terrell R.: The Undoing of the California Tort Claims Act and the Move to Absolute Governmental Immunity in Foster Care Placement and Supervision}, 15 STAN. L. \\& POL'Y REV. 267, 268-70 (2004).

\textsuperscript{643} Harden, \textit{supra} note 641, at 33-39.
they would be if removed from them. 644 Most experts believe that the system, in its present form, has failed miserably, 645 and many argue that there is no empirical evidence that the system’s intervention actually benefits those children for whose benefit it allegedly exists. 646 Thus, despite the best intentions of those who “deinstitutionalized” the child welfare system, we have replaced an institutional system with other out-of-home placements that may arguably be little better than the institutions they replaced in their long-term impact on the child’s welfare.

2. Deinstitutionalization and the Juvenile Justice System

The juvenile justice system was created, in part, to remove juvenile offenders from adult correctional facilities. Incorporating new notions of adolescence as a phase of child development during which children need rehabilitative, rather than punitive intervention, the juvenile justice system was formally grounded in the state’s parens patriae authority. 647 Furthermore, adult correctional facilities were characterized by harsh conditions and exposure to adult inmates endangered the physical and psychological well-being of juveniles placed with them. Data reveal that reformers succeeded in reducing the number of juveniles in adult facilities, but this result was achieved at the “cost of having many more youth incarcerated in juvenile detention than were held under the traditional system.” 648 Short-term and long-term juvenile correctional

644. Intervention in today’s child welfare system consists of little more than “investigation” of reports of suspected child abuse or neglect and removal of children where suspicions appear justified. See U.S. ADVISORY BD. ON CHILD ABUSE & NEGLECT, U.S. DEP’T OF HEALTH & HUMAN SERVS., NEIGHBORS HELPING NEIGHBORS: A NEW NATIONAL STRATEGY FOR THE PROTECTION OF CHILDREN 9-10 (1993). Little in the way of organized service provision to the families or children occurs. U.S. ADVISORY BD. ON CHILD ABUSE & NEGLECT, U.S. DEP’T OF HEALTH & HUMAN SERVS., CREATING CARING COMMUNITIES: BLUEPRINT FOR AN EFFECTIVE FEDERAL POLICY ON CHILD ABUSE AND NEGLECT xi (1991). Furthermore, little is done to monitor placements, train and support foster parents, or assist children and families if the family is subsequently reunified.

645. See, e.g., U.S. ADVISORY BD. ON CHILD ABUSE & NEGLECT, supra note 83, at vii. Among the Advisory Board’s conclusions were that “child abuse and neglect in the United States now represents a national emergency,” in part because “in spite of the nation’s avowed aim of protecting its children,” there is an absence of effective preventive and intervention strategies. Id. at vii-xv.

646. See, e.g., Melton, supra note 83; Thompson & Wilcox, supra note 83.


648. Lerman, Twentieth-Century Developments, supra note 20, at 82, 84. Ironically, however, the last two decades have witnessed a resurgence of policies that lead to the mingling of juvenile and adult offenders in the same population, as jurisdictions process increasing numbers of offenses committed by juveniles in the adult criminal justice system. See supra note 93.
facilities experienced steady increases in rates of admission, residence, and episodes throughout the twentieth century. 649

The overall data, however, mask certain trends, such as the deinstitutionalization of status offenders and nonoffenders from juvenile justice facilities. In 1974, Congress passed the Juvenile Justice and Delinquency Prevention Act ("JJDPA"). 650 A key provision of this legislation conditioned federal grants to state juvenile justice programs on a state's compliance with requirements to deinstitutionalize status offenders 651 from secure short- and long-term juvenile justice facilities. 652 The JJDPA and several state-level predecessor acts were the products of many years of dissatisfaction with the high rates of detention of status offenders in juvenile correctional facilities with delinquents. 653 The juvenile courts' jurisdiction over these youth did not seem particularly problematic when observers still held out hope that the system could provide individualized and non-punitive treatment for those in need. 654 Yet, by the 1960s and 1970s, acknowledgement of and disillusion with the gap between the system's ideals and the reality was widespread. 655 The basic premise of characterizing minors who engage in status offender conduct as offenders at all was questioned by the IJA-ABA Joint Commission on Juvenile Justice Standards in its report

649. Lerman, Twentieth-Century Developments, supra note 20, at 88 fig.3.5. Lerman's data reveal that residence rates increased 128.9% during this period and that admission rates increased over ten-fold during this period. Admission rates climbed even more rapidly, rising over ten-fold between the 1920s and 1990s. Id. at 87 fig.3.4, 88 fig.3.5. In 1923, the episode rate per 100,000 youth in private and public correctional facilities was 226; by contrast, the rate in the mid-1990s was 1,726, yielding an increase of 663.7%. ("Episodes" of juvenile placement are derived by combining the one-day residency count on a given day of a year and all additional admissions throughout the remainder of that year.) Id.


651. For a definition of status offender, see supra notes 95-101 and accompanying text.


654. See Costello, supra note 443, at 234-36.

655. See, e.g., Zatz, Historical Overview, supra note 653, at 25-29 (discussing the Supreme Court's conclusion that the juvenile justice system fails to provide minors either with due process or care and treatment).
recommending Standards Relating to Noncriminal Misbehavior. The Joint Commission recommended that the juvenile court be divested of status offender jurisdiction, and that states focus on providing a range of community-based voluntary intervention services geared toward helping youths and their families resolve their conflicts.

Congress, in enacting the JJDPA, attempted to respond to various concerns, although it did not adopt the IJA-ABA recommendations. Critics of the juvenile justice system condemned “the excessive intrusiveness of the juvenile justice system into the lives of youth whose offenses were noncriminal in nature.” At the time of JJDPA’s enactment, minors charged with status offenses were twice as likely as those charged with delinquent offenses to be placed in secure detention, despite the noncriminal—and relatively nondangerous—nature of their conduct. Reformers sought to prevent the “commingling” of status offenders and delinquents in detention, given that many of the latter group have committed serious crimes and might victimize or influence status offenders. Furthermore, observers argued that the experience of institutionalization and the stigmatizing effects of the “offender” label would increase the likelihood that status offenders will recidivate or move on to more serious offenses. By the 1960s, it was clear that the

656. INST. OF JUD. ADMIN. – AM. BAR ASS’N JOINT COMM’N ON JUV. JUST. STANDARDS, STANDARDS RELATING TO NONCRIMINAL MISBEHAVIOR (1977); see also Costello, supra note 443, at 242-43 & nn.44-45 (citing various objections in the literature).

657. Standard 1.1 reads: “A juvenile’s acts of misbehavior, ungovernability, or unruliness which do not violate the criminal law should not constitute a ground for asserting juvenile court jurisdiction over the juvenile committing them.” INST. OF JUD. ADMIN. – AM. BAR ASS’N JOINT COMM’N ON JUV. JUST. STANDARDS, supra note 656, at 23. Parts II and III of the Standards address limited circumstances in which the court or law enforcement can take custody of such juveniles, such as placement or temporary placement of runaways in nonsecure detention. Id. at 23-26. Parts IV through VI address the role of the state in offering a range of voluntary services to juveniles and their families. Id. at 26-34.

658. Zatz, Historical Overview, supra note 653, at 26. The procedural informality of the juvenile court, already a concern as it related to the incarceration of those accused of violating criminal statutes, was even more disturbing relative to noncriminal offenders. Id.

659. SNYDER & SICKMUND, supra note 100, at 207 (revealing that in 1975, approximately 40% of status offense cases involved the use of secure detention, compared with approximately 20% of delinquency cases).

660. Zatz, Historical Overview, supra note 653, at 29, 31. Some worried that status offenders might become “hardened” as a result of their exposures to serious offenders. Costello, supra note 443, at 239.

juvenile justice system had failed to restrain the rising rate of violent crime by juveniles. In light of these statistics, the commitment of a substantial proportion of the system’s resources to incarcerate noncriminal offenders seemed misguided.662

In the decades following the JJDPA, there were substantial reductions in the number of status offenders placed in detention under the auspices of the juvenile justice system.663 By the year 1988, the GAO reported that states “had cumulatively reduced their status offender detention about 95 percent below their base years,”664 with 38 states in compliance with the legislation’s requirement that states reduce their status offender detention by at least 75 percent.665 Since 1988, the overall rates of incarceration of status offenders have continued to decline, with the exception of a slight increase between 1999 and 2001 (the last year for which data are available). Using the base-year data provided by the GAO as the point of comparison, there was a 94.7% reduction in the absolute numbers of incarcerated status offenders666 from 186,996 in the base year, to 9849 in 1988.667 The Office of Juvenile

Inst. of Just.: Youth Just. Program, Dec. 2004, at 1 (concluding that the status offender system “created to help parents, schools and communities get . . . disobedient, but not delinquent, children back on track” has had “the opposite effect,” when removing the child from the home, aggravating “family tension, reduc[ing] engagement in school, and increas[ing the] likelihood of . . . involvement in criminal behavior”). Furthermore, once labeled “offenders,” these minors are stigmatized in ways that may make it even more problematic for them to be treated normally and function adaptively in the community. See Jonathan C. Juliano, Detention of Persons in Need of Supervision: The Dilemma in Grounding the Flight-Footed Status Offender, 13 J. Suffolk Acad. L. 95, 113 (1999).


664. GAO, 1991, supra note 663, at 19. “When states enter the program, they are required to identify a ‘base year’ number of status offenders [and nonoffenders] held in secure detention for longer than 24 hours.” Id. at 19 & n.2. Thus, despite the enactment of the legislation in 1974, states commenced participation in the grant program during different years thereafter. It is the level of use of secure detention with status offenders during the base year against which changes over time are measured in order to determine the state’s compliance with the program’s requirements.

665. Id. at 20.

666. Id. at 20-21 tbl.2.1. Absolute numbers, rather than rates for 100,000 in the juvenile population are used because the variability in the base years in which particular states joined the program makes it difficult to estimate the population-based rate. The population of persons under the age of 18 in the United States did drop about 6 percent between 1975 and 1988. Thus, depending upon the years of entry into the program, the percentage of decline in status offenders may reflect a slight overestimate when corrected by changes in the population.

667. Id. at 21 tbl.2.1. The figure reported is 9,849, although this statistic is an underestimate because of missing data from North Dakota, South Dakota and Wyoming. Id. Subsequent data obtained by the Office of Juvenile Justice and Delinquency Prevention revealed the following absolute numbers in more recent years: 6,877 in 1997; 4,694 in 1999; and 5,116 in 2001. Melissa
Justice and Delinquency Prevention concluded in 1999 that “[f]ederal requirements to deinstitutionalize status offenders have been effective,” pointing to data comparing status offender incarceration in 1996 with 1975 statistics.\(^{668}\)

And while these data suggest that states have successfully implemented the Congressional mandate to deinstitutionalize status offenders from juvenile justice correctional facilities, a more cautious interpretation of the Act’s achievement is appropriate if we look at impact more broadly. The filing of status offender petitions by parents and law enforcement personnel is higher today than when the JJDA went into effect.\(^{669}\) In 1975, state status offense petitions were estimated to be at approximately 144,000 nationally.\(^{670}\) In the year 2000, the estimate was 165,000.\(^{671}\) This increase of 14.6% is slightly greater than the 8.0% increase in the national population of minors during that period of time.\(^{672}\) Yet, the changes over time have not been linear. Petitioned status offense cases dropped to 62,000 in 1982, down 56.9%, but then gradually increased throughout the 1980s, and began to rise rapidly in the 1990s.\(^{673}\) According to the Office of Juvenile Justice and Delinquency Prevention, “[b]etween 1987 and 1996, the juvenile court’s formal status offense caseload more than doubled.”\(^{674}\) Increases in all categories of status offenses were observed, with truancy and violations of liquor laws accounting for the highest number of cases.\(^{675}\)

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Sickmund, Juveniles in Corrections, NAT’L REP. SERIES BULL.: JUV. OFFENDERS & VICTIMS, June 2004, at 3 (reporting 1997 and 1999 data); Off. of Juv. Just. Delinq. Prevention, Detailed Offense Profile by Placement Status for United States, 2001, Census of Juveniles in Residential Placement Databook, available at http://ojjdp.ncjrs.org/ojstatbb/cjrp/asp/Offense_Adj.asp (last visited June 15, 2005) (reporting 2001 data). Thus, the numbers continued to decline until 1999, despite increases in the population of children in the United States. Adjusted for changes in the population, however, the 2001 rate reflects an increase above 1999 of 8%. The rate per 100,000 in 1999 was 6.52; the rate per 100,000 in 2001 was 7.04. It is not clear whether this increase is an indication of a trend toward greater use of residential placements for status offenders, or is merely a nonsignificant fluctuation; the next available data set—which is not available at the time of this writing—will likely provide insight as to this issue.

\(^{668}\) Snyder & Sickmund, supra note 100, at 207.

\(^{669}\) Hunter Hurst, Status Offenders: “Where Have They Gone and Who Cares?”, JUV. & FAM. JUST. TODAY, reprinted in Hunter Hurst, HUNTER OF DELINQUENCY, Winter 2003, at 1, 3.

\(^{670}\) Id.

\(^{671}\) Id.

\(^{672}\) These percentage increases were tabulated by this author, applying population statistics obtained from Figure POP1: Number of Children Under Age 18 in the United States, 1950-2001 and Projected 2002-20 found at http://www.childstats.gov/americaschildren/pdf/ac2003/pop.pdf.

\(^{673}\) Hurst, supra note 669, at 3.

\(^{674}\) Snyder & Sickmund, supra note 100, at 166-67.

\(^{675}\) Id. at 166.
juvenile justice expert attributes the rise in the 1980s to the Valid Court Order Amendment of the JJDPAct, discussed immediately below, and the rise in the 1990s, in part, to the “ravaged” public and private human service budgets, which dramatically reduced states’ abilities to provide alternate services to those who, without such assistance, would fall into the status offender category.676

Pressure from the states to provide a mechanism to incarcerate particularly recalcitrant status offenders led to an amendment to the JJDPAct in 1980 creating the “valid court order” exception.677 This amendment provided authority for a practice already in place in some jurisdictions.678 Under this provision, if a status offender is ordered by the court to do something (such as participating in counseling or attending school), or to stop doing something (such as running away), and she violates that order, the court is permitted to commit her to a secure placement.679 This, of course, opens the door fairly wide for incarceration of status offenders, since noncompliance and refusal to cooperate with authority are hallmarks of status offender conduct.680

In addition, several trends have emerged that suggest that law enforcement, court personnel, and parents have used alternate constructions of status offender behavior to find ways to remove these minors from their homes and communities. For example, some juveniles,

676. See Hurst, supra note 669, at 3. The other factor to which Hurst attributes the rise of status offender petitions in the 1990s is the proliferation and enforcement of curfew laws. Id.
679. See Costello & Worthington, supra note 678, at 58-60; Holden & Kapler, supra note 678, at 7; see also Donna M. Bishop & Charles E. Frazier, Gender Bias in Juvenile Justice Processing: Implications of the JJDPAct, 82 J. CRIM. L. & CRIMINOLOGY 1162, 1167 (1992). Observers are particularly critical of one variant of this procedure. In some states, courts have used the court’s criminal contempt authority to characterize a status offender’s defiance of the court’s order as a criminal and, therefore, delinquent offense. Costello & Worthington, supra note 678, at 58. This practice, described by authors as “nightmarish” or “vicious,” is referred to as “bootstrapping.” Costello & Worthington, supra note 678, at 58-59; Harry J. Rothgerber, The Bootstrapping of Status Offenders: A Vicious Practice, 1 KY. CHILD. RTS. J. 1, 1-2 (1991). Official interpretations of the JJDPAct’s Valid Court Order Amendment do not permit the court to transform the case from a status offense to delinquency adjudication on this basis. Holden & Kapler, supra note 678, at 7-8.
680. See Costello, supra note 443, at 237 (“[U]ngovernable, incorrigible, stubborn, and rebellious minors tend not to defer to authority—no surprise—including that of the courts. They frequently do not comply with the terms of probation, run away from nonsecure placements, and constantly test whatever rule or authority is asserted—but try to stop short of committing a true criminal offense.”); Costello & Worthington, supra note 678, at 58; see also Holden & Kapler, supra note 678, at 7.
who cannot be placed in secure confinement in compliance with the JJDPAct if labeled as status offenders, have been "relabeled" as delinquents. 681 Costello and Worthington observe that "[o]ften the facts available to the intake officer or police could be interpreted to support either a status offense or juvenile delinquency charge."682 They note, for example, that many runaways carry weapons to protect themselves and engage in conduct such as prostitution and sale of illegal drugs. These facts could support a finding of delinquency.683 Using the discretion inherent in their roles, law enforcement and court personnel can treat the case as a status or delinquency offense. The same is true when police find a runaway child sleeping at night in an unoccupied building. She could be treated as a status offender who has run away from home or violated a curfew, or as a delinquent who has violated a trespassing statute 684 because the facts fit either offense category.685 The juvenile court's status offender and delinquency jurisdictions represent alternate social constructions of the norm-violating conduct.686 Furthermore, evidence exists that many juveniles meeting the criteria of status offenders are admitted to psychiatric inpatient and residential facilities. Scholarly analysis and empirical investigation published in the 1980s indicated that reductions in rates of institutionalization of status offenders in juvenile justice facilities were offset by increased admissions of minors to mental hospitals, 687 and more recent data reveal

681. See Steinhart, supra note 323, at 91 (noting empirical research findings); Bishop & Frazier, supra note 679, at 1167 & n.19 (summarizing empirical research findings and commenting that "[t]he line between status offenses and delinquency offenses may be easily manipulated by justice officials"); Costello & Worthington, supra note 678, at 72-75; Malcolm W. Klein, Deinstitutionalization and Diversion of Juvenile Offenders: A Litany of Impediments, in 1 CRIME AND JUSTICE: AN ANNUAL REVIEW OF RESEARCH 145, 176-77, 183-84 (Norval Morris & Michael Tonry eds., Phoenix ed. 1980) (summarizing empirical studies); Wesley Krause & Marilyn D. McShane, A Deinstitutionalization Retrospective: Relabeling the Status Offender, XVII J. CRIME & JUST. 45, 51-62 (1994) (reporting empirical findings of relabeling patterns in California); MAXSON & KLEIN, supra note 119, at 34-35 (1997) (summarizing empirical studies).

682. Costello & Worthington, supra note 678, at 73.

683. Id.

684. Id. Other examples include children who have run away and engage in petty theft to sustain themselves while living on the streets, or who steal cash from their parents before leaving. Krause & McShane, supra note 681, at 51; Zatz, Historical Overview, supra note 653, at 47.

685. See Zatz, Problems and Issues, supra note 653, at 47.

686. See supra Part II.D.

that the admission rates to mental health facilities have climbed still higher during the late 1980s and the 1990s. The admissions of these minors may be initiated by parents or the juvenile court. The data have been interpreted as indicating that some proportion of potential status offenders has been transinstitutionalized—i.e., institutionalized in the mental health system when secure juvenile detention became unavailable—rather than deinstitutionalized.

Some status offenders may be relabeled as dependent (that is, abused or neglected). Prior to 1977, when the JJDPA was amended to specify that nonoffenders (such as "dependent, neglected, or abused" children) could not be placed in secure detention, law enforcement and court personnel sometimes relabeled status offenders "downward" as dependency cases in order to access secure detention. Furthermore, even today, a finding of dependency gives the courts jurisdiction over the child and substantial authority to order the child’s family to follow through with court-ordered intervention, and it permits the court to order any of a range of nonsecure out-of-home placements for juveniles. Thus, juveniles labeled as status offenders or dependents can be placed in foster care with families or, as is more typical with troublesome dependent children, in foster care facilities. Many formally adjudicated status offenders end up in private correctional facilities, most of which are defined as nonsecure placements that comply with JJDPA restrictions for such children. Youth in these facilities are a mix of adjudicated delinquents, status offenders, and several categories of nonoffenders; children found by the juvenile court to be dependent,

688. See Lerman, Twentieth-Century Developments, supra note 20; see supra Part IV.E.
689. See, e.g., Teitelbaum, supra note 95, at 167-68.
690. See, e.g., Costello & Worthington, supra note 678, at 62 & n.91, 64, 67.
692. See, e.g., FELD, supra note 94, at 177-79 (discussing the strategy, used in some states, to relabel status offenders, individually (by the courts), or collectively (by the legislatures) as dependents, thereby emphasizing "their vulnerability rather than offensivity"); Klein, supra note 681, at 176-77, 183-84 (discussing the "downward" relabeling of status offenders as dependent and reviewing empirical findings demonstrating such relabeling).
693. See Lerman, Twentieth-Century Developments, supra note 20, at 89-90. In a series of publications, Paul Lerman has demonstrated that many former child welfare institutions reinvented themselves when the deinstitutionalization of the child welfare system reduced their livelihoods and threatened their continued existence. Id.; see also LERMAN, DEINSTITUTIONALIZATION, supra note 20, at 126-30. See generally Paul Lerman, Child Welfare, the Private Sector, and Community-Based Corrections, 30 CRIME & DELINQ. 5 (1984) [hereinafter Lerman, Community-Based Corrections]; Lerman, supra note 119. Lerman has characterized these nontraditional institutions, such as community-based shelters, halfway houses, and group homes, as a "'kinder and gentler' type of correctional facility" serving a broader range of youth than public correctional institutions. Lerman, Twentieth-Century Developments, supra note 20, at 90.
children identified as emotionally disturbed or developmentally disabled, and youth "voluntarily" admitted by their parents for any of a range of reasons. Because these facilities are privately owned (despite receiving public funds for the placement of children who are in state custody), adjudicated delinquents can be placed with status offenders and nonoffenders, a blend that would not be permissible in public facilities under the JJDPA. And while such facilities certainly seem more appropriate for status offenders than do secure juvenile facilities, these nonsecure placements are still out-of-home and most likely require the child's removal from her school, her friends, her relatives, and her greater community as well.

There is also concern that increasing numbers of status offenders who would have been confined in secure facilities prior to the JJDPA's mandate are now on the streets, either as runaways or children evicted from their homes by their families. Thus, while the JJDPA's goal of deinstitutionalizing status offenders from juvenile justice correctional facilities has been implemented successfully from a technical perspective, minors who would likely have been placed in secure detention as status offenders prior to the passage of the JJDPA may still be securely detained, albeit under the authority of an alternative statutory provision. Or, these children may be in nonsecure correctional facilities, mixed with a range of other youth, may be in inpatient psychiatric facilities, or may be on the street. Although the JJDPA planned for and funded a network of community-based diversion programs, the services appear to have been inadequate to meet the underlying needs.

Consistent with the functionalist perspective, one would expect that, in the absence of incarceration as an accessible response to status offenders, various actors (parents, police, juvenile court intake personnel, and judges) would seek some alternative means of addressing

694. Lerman, Twentieth-Century Developments, supra note 20, at 90; Lerman, Deinstitutionalization, supra note 20, at 128-30; Lerman, Community-Based Corrections, supra note 693, at 11-13 & tbls.4-5.

695. Holden & Kapler, supra note 678, at 8; Steinhart, supra note 323, at 92-94; Teitelbaum, supra note 95, at 169; Juliano, supra note 661, at 96. For a discussion of empirical and policy analyses addressing these "runaway" or "thrownaway" children, see supra Part IV.D.

696. See Steinhart, supra note 323, at 91; Hurst, supra note 669, at 4; Neither Angels Nor Thieves: Studies in Deinstitutionalization of Status Offenders 209 (Joel F. Handler & Julie Zatz eds., 1982). It is beyond the scope of this Article to examine all of the reasons why the community-based services failed adequately to meet the needs of status offenders, their families, and their communities. For comprehensive evaluation of status offender deinstitutionalization policies, see Neither Angels Nor Thieves: Studies in Deinstitutionalization of Status Offenders, supra; Maxson & Klein, supra note 119.

697. See supra Part VI.A.
the underlying needs that had been addressed by secure incarceration. In particular, the status offender jurisdiction of the juvenile court has provided parents and law enforcement officials\(^{698}\) with a mechanism to deal with what they experienced as difficult, disobedient, and noncompliant children who violate rules in homes, schools, or communities.\(^{699}\) "While status offense jurisdiction and residential placement of youths who had not committed criminal acts were sharply curtailed [by the JJDPA], the social circumstances giving rise to such jurisdiction remained in place."\(^{700}\) Incorrigibility, also referred to as ungovernability, habitual disobedience, or being beyond parental control, says as much about parental needs for assistance and about the parent-child relationship as it says about the minors—an observation that is perhaps true of all of these categories of noncriminal misbehavior.\(^{701}\) In fact, there is substantial overlap in the home situations that constitute a finding of child abuse or neglect, and the family circumstances of status offenders.\(^{702}\) Many runaways are escaping family violence or

\(^{698}\) Data for the year 1996 reveal that 48% of petitioned status offense cases are referred by law enforcement, in contrast to 86% of delinquency cases. Snyder & Sickmund, supra note 100, at 166. The circumstances motivating parental referral are several:

In some families, parents resort to a status offense petition when they have few other resources to enforce compliant behavior by their children; in others, it serves as a vehicle for removing unwanted children from home; in yet others, it is the only available means of securing social and mental health services for parents who, unlike their wealthier counterparts, cannot afford to purchase those services in the private sector.

\(^{699}\) Status offender behavior has been viewed in a variety of ways. Some view it as one variation of the normal developmental process, requiring little more than appropriate parental guidance, structure, and support. Some view many forms of status offender conduct as a manifestation of normal adolescent rebellion which, with an appropriate parental response, would be merely transitory. See, e.g., Joel F. Handler & Julie Zatz, Introduction to Neither Angels nor Thieves: Studies in Deinstitutionalization of Status Offenders 3, 3 (Joel F. Handler & Julie Zatz eds., 1982) (citing classical personality development theorists such as Erik Erikson and Anna Freud for the proposition that "[s]ome people, feeling that a certain amount of adolescent turmoil is a necessary and desirable part of the maturation process, are inclined to endure youthful disobedience"). Others view it as a symptom of an emotional or a psychological disorder for which therapy is needed. Robert W. Sweet, Jr., Deinstitutionalization of Status Offenders: In Perspective, 18 Pepp. L. Rev. 389, 414 (1991). It has also been viewed as a precursor of more serious law-violating conduct that can be prevented or minimized with justice system intervention, or as merely one component of an already generalized pattern of law-violating conduct. See Maxson & Klein, supra note 119.

\(^{700}\) Teitelbaum, supra note 95, at 167.


\(^{702}\) See, e.g., Denise Read, Deinstitutionalization of Status Offenders: A Look at the Debate, 7 Child. Legal Rts. J. 1, 3-4 (1986) (stating that approximately half of runaways leave home because of maltreatment, or are "pushed out" or "thrown out" by their families); Michele Dubowy,
other dysfunctional family situations; some parents of status offenders may be absent or providing inadequate supervision. Others may be abandoned or ejected by their families.\textsuperscript{703}

Other conceptualizations of the core of the problem help explain the truancy of some status offenders. Some truants have undiagnosed learning disabilities which make academics sufficiently onerous to lead them to do anything in order to avoid school.\textsuperscript{704} Conceivably, with proper diagnosis and special educational assistance, these children’s needs might be adequately met, eliminating the need for juvenile justice system intervention. Or, a child may be truant to avoid bullying and teasing that occur at school. The child may stay home from school to provide care to a family member or to protect one family member from another. Again, intervention focusing on eradication of the underlying problems is more likely to be effective in obtaining the child’s compliance with mandatory attendance requirements than is involvement of a juvenile justice system that treats the child as the problem and seeks to coerce compliance through threats of penalties.\textsuperscript{705}

But what of the community-based services financed with federal grants to states that were in compliance with the JJDPA’s mandates? There is an extensive and complex literature analyzing the efficacy of these interventions.\textsuperscript{706} In the final analysis, however, these interventions can be faulted on a number of bases that undercut efficacy. One team of authors points out that while the “negative” mandate under the JJDPA was clear (that is, \textit{not} to place status offenders in detention or correctional facilities), the “positive” mandate regarding what was to

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\textsuperscript{703} See Teitelbaum, \textit{supra} note 95, at 169; Costello, \textit{supra} note 443, at 238; see also Loken, \textit{supra} note 19.

\textsuperscript{704} Gordon Bazemore et al., \textit{Boundary Changes and the Nexus Between Formal and Informal Social Control: Truancy Intervention as a Case Study in Criminal Justice Expansionism}, 18 \textit{NORE DAME J.L. ETHICS \& PUB. POL’Y} 521, 539-40 (2004); Costello, \textit{supra} note 443, at 238; Steinhart, \textit{supra} note 323, at 94.

\textsuperscript{705} See infra Part VII.

\textsuperscript{706} See, e.g., Maxson \& Klein, \textit{supra} note 119; Klein, \textit{supra} note 681; \textit{NEITHER ANGELS NOR THIEVES: STUDIES IN DEINSTITUTIONALIZATION OF STATUS OFFENDERS}, \textit{supra} note 653.
replace institutionalization was anything but clear. Individual jurisdictions were on their own to develop alternative services, funded in part with the federal grants available under the JJDPA. The variability among and within jurisdictions in post-JJDPA responses to status offenders was dramatic, and many interventions were not grounded in theory or in empirical research. In some instances, the articulated alternative policies consisted of placing youth in foster family and group homes. Sometimes the youth were referred to another system (i.e., mental health or child welfare) and sometimes simply returned to parents. And, as demonstrated above, often the de facto policies included a variety of relabeling strategies that allowed for either secure detention and incarceration in the juvenile justice system or a confinement in a mental health facility.

In the implementation of the JJDPA, there were few evaluative loops put in place to determine what was working and what was not, so that jurisdictions had no real mechanism to self-correct ineffective policies. This problem reflected the overall lack of a coordinated, well-planned intervention strategy: there was little “official” agreement across and within jurisdictions as to what alternatives were essential or important parts of the noninstitutionalization policy. In fact, it wasn’t even clear in most instances what outcomes would constitute “success.” Was the case a “success” if the child didn’t run away from the foster home in which she was placed, if she seemed relatively “happy and reasonably adjusted,” or if she stayed off the juvenile court’s radar for some predetermined period of time?

Typically, to the extent the interventions were grounded in theoretical models, the approaches were characterized by the theories of the day, which viewed these youth as mentally disordered, as products of inadequate or problematic family and social circumstances, or as disobedient youths requiring justice system intervention to prevent escalation of their conduct to criminal violations. Programs placed

707. NEITHER ANGELS NOR THIEVES: STUDIES IN DEINSTITUTIONALIZATION OF STATUS OFFENDERS, supra note 653, at 202-04.
708. Id. at 200-07.
709. Id. at 219-22.
710. Id. at 205.
711. Id.
712. Id.
713. Id.
714. Maxson and Klein characterize the dominant models around which community diversion programs were framed as falling into these three broad categories. See MAXSON & KLEIN, supra note 119, at 42-58.
little emphasis on discovering and addressing the problems that might
underlie or accompany status offending conduct such as family
dysfunction, emotional trauma, academic challenges, or substance abuse.
Programs did not focus on strengthening and supporting the family
members or developing a child’s ability to function adaptively within her
multiple social systems. The community-based programs developed to
divert delinquents and status offenders from detention had “minimal
impact” and often “miss[ed] their mark in selecting appropriate
youngsters,” frequently serving youth who would not have been
candidates for detention prior to the JJDPA.\textsuperscript{715}

In the absence of community-based interventions that met the
underlying needs of the children, their families, and the larger
communities, deinstitutionalization policies may have reduced the
number of children officially labeled as status offenders who were
placed in secure detention and correctional facilities, but the problems
triggering the status offending conduct were rarely addressed. The
employment of alternate mechanisms to remove these children from
their homes and communities, as discussed in this section, betrays the
inefficacy of the interventions in meeting the underlying social needs
that had led to pre-JJDPA policies of detainment for these youth.

3. Deinstitutionalization and the Mental Health System

Psychiatric hospitalization of minors was not common until the
mid- and late-twentieth century. Thus, \textit{most} of the history of
institutionalization and deinstitutionalization of the mental health system
focuses on adults. There are lessons we can learn from these trends,
however, that apply to juveniles, whose hospitalization became more
typical in the last quarter of the twentieth century. There is vast and
diverse literature on the deinstitutionalization of the mental health
system.\textsuperscript{716} While it is beyond the scope of this Article to review this

\textsuperscript{715} Id. at 40.

\textsuperscript{716} See, e.g., BACHRACH, supra note 566; PHIL BROWN, THE TRANSFER OF CARE:
PSYCHIATRIC DEINSTITUTIONALIZATION AND ITS AFTERMATH (1985); DEINSTITUTIONALIZATION:
PROMISE AND PROBLEMS (H. Richard Lamb & Linda E. Weinberger eds., 2001); GERALD N. GROB, FROM
ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA (1991); Gerald N.
Grob, Deinstitutionalization: The Illusion of Policy, in HEALTH CARE POLICY IN CONTEMPORARY
AMERICA 48 (Alan I. Marcus & Hamilton Cravens eds., 1997) [hereinafter Grob, Illusion of Policy];
Gerald N. Grob, Mental Health Policy in Late Twentieth-Century America, in AMERICAN
PSYCHIATRY AFTER WORLD WAR II (1944-1994) 232 (Roy W. Menninger & John C. Nemiah eds.,
2000) [hereinafter Grob, Late Twentieth-Century]; CHARLES A. KIESLER & AMY E. SIBULKIN,
MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS (1987); LERMAN,
DEINSTITUTIONALIZATION supra note 20; DAVID A. ROCHEFORT, FROM POORHOUSES TO
HOMELESSNESS: POLICY ANALYSIS AND MENTAL HEALTH CARE (2d ed. 1997); E. FULLER
literature in depth, I will make a few observations that help in the analysis of institutionalization and deinstitutionalization of minors in psychiatric facilities.

In the second half of the twentieth century, several phenomena converged to create an environment favorable to deinstitutionalization of adults from inpatient mental health facilities. After World War II, there was increasing dissatisfaction with the dominant role of institutions in American mental health policy. Shifts had occurred in social attitudes and professional perspectives on mental health problems and treatment. Not only was there increasing concern about the deplorable conditions in these institutions, but mental health professionals expressed optimism about their ability to effect positive changes in mental disorders with outpatient therapy and the new psychotropic drugs that controlled some of the most disabling symptoms of serious conditions such as schizophrenia.

The National Mental Health Act was passed by Congress in 1946, which established the National Institute of Mental Health and introduced the federal role in mental health policy. Congress created the Joint Commission on Mental Health in 1955. The Commission issued its report, Action for Mental Health in 1961, which recommended the development of a broad spectrum of mental health services, including noninstitutional services such as outpatient clinics and aftercare. In 1963, President Kennedy signed the Mental Retardation and Community Mental Health Centers Construction Act, which led to a profusion of federal funds in the form of state grants for the purpose of developing a community-based infrastructure of mental health services. The Community Mental Health Centers Act of 1963 followed, providing for federal funding for the staffing of the community mental health centers. Congress hoped that the legislation would lead to the development of a wide network of services providing humane and


717. See Grob, Late Twentieth-Century, supra note 716, at 232-35; Grob, Illusion of Policy, supra note 716, at 48.

718. Grob, Illusion of Policy, supra note 716, at 51.

719. BROWN, supra note 716, at 149-58.


721. Id. at vii-xxiv.

722. GROB, supra note 134, at 257-58.

723. See Grob, Illusion of Policy, supra note 716, at 52.
effective care in the community for those who would otherwise spend their lives in overcrowded state institutions. Lawmakers aspired to "render traditional mental hospitals obsolete." 724

In one of the many offshoots of the civil rights movement, legal advocates in the 1960s and thereafter sought to extend certain rights to the mentally disabled, such as rights to treatment for those individuals committed to inpatient settings. 725 Other lawsuits focused on the procedural and substantive requirements due to patients prior to the restriction of liberty that accompanies commitment to mental hospitals. 726 Still, others addressed the rights of patients to refuse various forms of treatment. 727 During the 1970s and 1980s, in response to these suits, states developed statutory protections for patients for whom civil commitment was sought. The ultimate schema adopted in most jurisdictions is one that allows commitment of individuals to psychiatric facilities only when the patient is either an imminent danger to herself or others, or is gravely disabled so as to be unable to care for herself, and that limits the length of hospitalization to that period of time essential to serve the state's parens patriae and police power goals. 728

While some ascribe responsibility for deinstitutionalization of mental patients to these cases and subsequent statutory changes, 729 historian Gerald Grob suggests that these "[j]udicial decisions, however significant, merely confirmed existing trends by providing a legal sanction for deinstitutionalization." 730 Playing a much greater role in the deinstitutionalization movement, he argues, were social welfare programs which allowed the states to shift financial responsibility for chronic psychiatric patients to the federal government. 731 Many older chronic psychiatric patients qualified for Medicaid, which paid much of the cost of the community-based nursing homes to which thousands of

724. Id.
728. See Winick, supra note 486, at 41-97.
729. The most famous articulation of this position is found in the title to one article: Darold A. Treffert, Dying with One's Rights On, 224 J. AM. MED. ASS'N 1649 (1973).
730. Grob, Illusion of Policy, supra note 716, at 55.
731. Id.
patients were transferred. Medicare, Social Security Disability Insurance, and Social Security Income for the Aged, the Disabled, and the Blind further allowed states to shift the cost of care of many chronically mentally disabled individuals from state-funded institutions to federally subsidized community-based living. Sadly, the quality of care in many of these facilities was not much better than that which they had left in state institutions.

Most observers agree that this deinstitutionalization movement did not turn out precisely as hoped as most who left or avoided the institutions never obtained adequate community-based services. Grob points to certain inaccurate assumptions embedded in the community services model. In particular, he argues, the policy presumed that “patients had a home... [and] a sympathetic family or other person willing and able to assume responsibility for their care” when, in fact, few patients had families that could or would serve this function.

Furthermore, the intervention community mental health centers typically provided, traditional psychodynamically- or “insight”-oriented psychotherapy, is more appropriate for highly functioning individuals with mild psychological difficulties than for the severely and chronically disabled patients who were the more typical residents of mental institutions. Grob argues that the community-based services created during this era and subsequently never provided “for the basic human and medical needs of the severely mentally ill.” By the 1970s, the federal government began to scale back its leadership role and investment in mental health policy, and since that time, there has been gradual erosion of public funding for mental health services of all types.

One final glimmer of hope had accompanied the President’s Commission on Mental Health, created by and issuing its report to

733. Grob, Illusion of Policy, supra note 716, at 56.
734. Id. at 55.
735. Id. at 52-53. Grob points out that “[i]n 1960, however, 48 percent of the mental hospital population was unmarried, 12 percent were widowed, and 13 percent were divorced or separated. A large proportion of patients, in other words, may have had no families to care for them.” Id. at 53.
736. See id. at 53.
737. Id. at 53-54.
President Jimmy Carter.\footnote{739} The Report served as the blueprint for the Mental Health Systems Act ("MHSA"), passed by Congress in 1980.\footnote{740} The MHSA would have provided federal grants to fund a range of community-based mental health programs, with an emphasis on underserved or poorly-served populations such as the chronically mentally ill and children, and it encouraged innovation in service delivery. Unfortunately, upon taking office in 1981, President Reagan's administration succeeded in repealing the MHSA,\footnote{741} thus short-circuiting a program that might have led to the development of community-based services appropriate for severely emotionally disturbed individuals and special populations such as children. Since that time, few initiatives, state or federal, have prioritized mental health funding. In fact, governmental expenditures on mental health services have not increased in the past two decades, when the figures are corrected for inflation.

So what has happened to those individuals who would have been hospitalized in mental institutions in prior eras? Many of them still spend time in mental hospitals, but most cycle in and out, with shorter stays than in previous years.\footnote{742} Some appear in hospital emergency rooms during emotional crises and, like the children discussed above, board on medical wards until a psychiatric bed becomes available.\footnote{743} Others live in nursing homes, board and bed homes, and a variety of community-based living situations, some of which offer "treatment" and others of which are primarily custodial in nature.\footnote{744} Still, others have turned up in relatively large numbers in the criminal justice system.\footnote{745} Many individuals who would have been institutionalized in former
decades now live on our streets. 746 And, some are cared for by family members or friends, often without the types of support services that would help these loved ones to provide such care without suffering devastating financial or psychosocial consequences.

Although there is debate as to whether community life under present circumstances is "better" than long periods of institutionalization in psychiatric facilities for those with chronic mental disorders, most observers agree that the aftermath of deinstitutionalization of psychiatric patients is both disappointing and disturbing. And yet, the failures make sense within the functionalist perspective, in that the deinstitutionalization process was incomplete. That is, many patients were discharged from mental hospitals and others never entered or did not re-enter. The underlying social needs of these individuals, their families, and their communities did not evaporate along with the inpatient beds. Thus, many of these individuals have gone without formal care; others have entered alternative and arguably less appropriate service and intervention systems, while still others cycle in and out of mental hospitals.

During this first wave of deinstitutionalization of mental health facilities in the late 1960s through the 1980s, while adult admission and residency counts dropped, the rates of use for minors increased, a phenomenon discussed elsewhere in depth. 747 Troubled and troublesome youth who had been deinstitutionalized from other systems appeared in mental health facilities in greater numbers during these decades. A second "wave" of deinstitutionalization of mental hospitals began in the 1990s and continues today. This latter wave followed restrictions in the availability of private and public insurance for inpatient treatment of children and adults. Private insurance companies and state Medicaid programs have either adopted managed care policies or created managed care "carve-outs," in which they subcontracted mental health services and/or administrative management to a managed care agency. 748 The


747. See Weithorn, Skyrocketing Admissions, supra note 16.

748. Ray & Kanapaux, supra note 738, at 12 (noting that the initiation of managed care in public programs was expected to promote the development of more cost-effective alternatives to hospitalization, but that "cost concerns more frequently than not overrode any well-intentioned designs to reinvest savings in further development of community services"); see also E. Clarke Ross, The Promise and Reality of Managed Behavioral Health Care, in MENTAL HEALTH, UNITED STATES, 2000, at 73 (Ronald W. Manderscheid & Marilyn J. Henderson eds., 2000), available at
changes thus implemented often limit the types and locus of mental health intervention available, the length of treatment, and a range of "qualifying" factors. These restrictions have contributed as well to closures of (primarily public) inpatient facilities.

The financing of mental health care in the United States relies more heavily upon out-of-pocket expenditures by consumers than is the case for most industrialized nations. These out-of-pocket expenditures are supplemented by private insurance for some, by public insurance for those in particular income, age, or disability categories, and by scattered public services. Research reveals that this method of financing frequently "leads to denial of access and a two-tiered system of care where higher socioeconomic groups and more therapeutically promising patients are served by the private sector and the lower socioeconomic groups and patients and families requiring multisectoral interventions are served by the public sector." The relegation of the structure and organization of mental health services to market forces, supplemented by a relatively small safety net, certainly has contributed to the "de facto" (or "nonsystem") nature of the system and its failure to meet the needs of many whose functioning is deleteriously affected by a mental disorder.

Mental health needs receive only a small proportion of health care expenditures in the United States each year. According to one estimate, only 7% of the combined private and public dollars spent on health care in the United States in 1996 were spent on mental health care. Yet, epidemiological data reveal that in any given year, one in five adult Americans suffers from a mental disorder. In general, about half of those people "experience some significant functional impairment." While researchers have only recently begun to study the prevalence of childhood mental disorders, data suggest that a similar proportion of

MANAGED MENTAL HEALTH CARE IN THE PUBLIC SECTOR: A SURVIVAL MANUAL (Kenneth Minkoff & David Pollack eds., 1997).
750. Id. at 140.
751. Saxena and colleagues emphasize that "[h]ealth and social markets do not function like business markets; the supply and demand fundamentals of the business world may actually threaten effective and equitable health care and may prove especially harmful to mentally ill patients with high degree of need and limited resources." Id. at 136.
752. SURGEON GENERAL'S REPORT, supra note 22, at 416 tbl.6-6.
753. Id. at 46.
754. Id.
children—about 20%—have diagnosable conditions, and that between 5% and 9% of children ages 9 to 17 experience severe functional impairment, known as "serious emotional disturbance," as a component of these conditions. Despite these statistics, and other data that reveal the substantial level of disability experienced by many persons with mental disorders, mental health service delivery in the United States occurs in a splintered and haphazard manner, with little or no coordination among entities or professionals. These deficiencies in the mental health "nonsystem" contribute significantly to the overuse and inappropriate use of institutional interventions with troubled and troublesome youth, who are unable to access less restrictive and more appropriate interventions. Existing avenues to access appropriate services are confusing and create multiple obstacles for families. Eligibility requirements for appropriate services often exclude large segments of children or place onerous burdens upon families, such as requiring relinquishment of custody in order to access services. Furthermore, few providers offer the newer evidence-based therapies which focus on strengthening the family and equipping the child to function more adaptively in her natural environments.

In summary, while deinstitutionalization in the mental health system has succeeded in depopulating public and, to a lesser extent, private mental hospitals, there is no evidence that patients, be they adults or children, are receiving appropriate services. Rather, these individuals are populating our juvenile and criminal justice system facilities, our medical emergency rooms, our child welfare placements, our streets, and are, at times, cycling in and out of the remaining psychiatric units which operate much like a revolving door. Not only are these patterns inconsistent with several core legal traditions discussed in Part V, they also increase the short- and long-term burden on society and on local, state, and federal governments. As each level of government and particular agencies within each jurisdiction shift costs in various directions, the overall costs to society are enormous. While the financial burden of providing ineffective services only after problems have reached crisis-like proportions is great, the human cost is incalculable. Potentially productive lives are wasted as hundreds of thousands of individuals who could have contributed to society are unable to participate meaningfully; individuals suffer emotionally, despite the existence of a range of effective treatments that are inaccessible; families are burdened to the point of dysfunction and destruction; and, in the case

755. Id.
of those individuals whose conduct is harmful to others, members of the community are needlessly injured in one way or another. Ironically, all of this occurs at a financial cost far greater than that of a comprehensive well-planned, well-coordinated, well-implemented, and well-funded mental health system.

VII. REFORMING LEGAL POLICIES AFFECTING TROUBLED AND TROUBLESOME YOUTH: ENVISIONING SECOND-ORDER CHANGE

At the outset of this Article, I distinguished between first-order and second-order change. While first-order change "occurs within a given system which itself remains unchanged," second-order change "changes the system itself" and is thus a change in the goals and process by which change occurs, that is, "change of change." Obviously, one needs to investigate the possibilities for stimulating second-order change only if attempts to generate first-order change are unsuccessful. This is indeed the case with respect to our nation's legal responses to troubled and troublesome youth. Hundreds of thousands of such youth and their families experience serious emotional crises annually. These crises reverberate within their larger communities—in schools, in hospitals, in the juvenile and criminal justice systems, in the welfare system, and in the streets—and ultimately in all of our lives. The suffering of all affected can be enormous, as are the social and financial costs to society.

Throughout the twentieth century, policymakers have experimented with a variety of responses to troubled and troublesome youth. The dominant modalities of intervention employ strategies of removal, confinement, and segregation. As we have seen, these approaches are inconsistent with core traditions in American law, and have been unsuccessful in ameliorating the difficulties they were intended to address. Despite the best intentions of reformers seeking to reduce use of specific institutional systems, each of the targeted systems has expanded rather than contracted its overall reach into American families. Clearly, the mechanisms by which policymakers have sought to promote change are themselves in need of change. While determining what constitutes second-order change is not easy, the first step is to examine what has been tried in the past and evaluate the shortcomings of failed approaches.

Below, I propose several changes to the ways in which we have approached change. First, I argue that past efforts have focused on

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756. See supra notes 23-24 and accompanying text.
757. See WATZLAWICK ET AL., supra note 2, at 10-11 (emphases added).
negative rather than positive mandates. While policies have successfully depopulated identified institutions or subgroups, they have failed at serving their target populations adequately. I propose that policymakers begin with the positive mandates, with negative mandates following only after an effective alternative service system is in place.

Second, the compartmentalization of children’s and families’ behavior and needs into the artificial and rigid conceptual categories reflected by multiple service and intervention systems ignores the overlap in the populations served by these systems, and the multifaceted nature of these children’s and families’ problems and needs. Working in isolation, the several service and intervention systems inadequately serve children’s and families’ needs, operating quite inefficiently. States must develop “metasystem” capabilities that transcend traditional system boundaries and coordinate system efforts, transforming unintended boundary crossings into formal interagency coordination, cooperation, and cross-referral. One model for achieving such capabilities is described.

Third, the philosophies guiding the primary child service and intervention systems have not generated a nucleus of successful intervention strategies. Traditional strategies have emphasized removal from family, confinement in institutional settings, and segregation from the mainstream of the community. These approaches have the dubious distinction of blending their inefficacy with their disconnection from core American legal principles. Below, I argue that it is possible to intervene with troubled and troublesome youth and their families in a manner that is substantially more effective in meeting underlying individual and social needs and that supports families, minimizes unnecessary restrictions of liberty, and promotes social inclusion. This approach focuses on the commonalities in the interests of parents, children, and the state, rather than on the conflicts, and devises interventions that advance those shared goals.

Finally, attempts to serve troubled and troublesome youth and their families in the community will not be successful if there are latent functions served by institutions that are not addressed by the reforms. The proposals below strive to confront the gamut of functions served by institutions. In addition to those goals just enumerated, the scheme must also address our society’s fear of and intolerance for people who are different or who violate social norms, even when those individuals are not dangerous. While overcoming this obstacle is particularly challenging, various groups have begun to lay the groundwork.
A. Putting the "Horse Before the Cart": Focusing on Positive Before Negative Mandates

While there is no constitutional right to governmental services, once the government establishes a statutory right to a particular category of services or benefits, it must fulfill those obligations in a manner prescribed by that or other legislation such as the ADA, which mandates nondiscrimination. There are federal programs relevant to troubled and troublesome youth which have provided funding to enable the states to provide certain services, accompanied by negative, as well as positive, mandates.

In their attempts to deinstitutionalize various institutional systems, policymakers have gone about their efforts a bit backwards—putting the proverbial "cart before the horse." In their analysis of the shortcomings of the JJDPA's implementation, Handler and Zatz distinguish between positive and negative mandates. Deinstitutionalization policies of all types typically focus on their negative mandate—that is, reducing numbers of admissions or residents in particular types of institutions. Positive mandates to create alternative services are frequently an afterthought. Policymakers recognize the need for such alternatives but rarely craft sophisticated blueprints for those services guided by thorough assessment of needs and grounded in carefully developed intervention philosophies. Where plans for positive mandates exist, they frequently do not incorporate a program evaluation component allowing for program modification as feedback regarding efficacy and other effects is integrated.


760. See supra note 652 and accompanying text (discussing JJDPA); see supra Part III.B.5. (discussing IDEA).

761. NEITHER ANGELS NOR THIEVES: STUDIES IN DEINSTITUTIONALIZATION OF STATUS OFFENDERS, supra note 653, at 202-04.

762. Consistent with functionalist theory, see supra Part VI.A, if important social functions are served by institutions, policymakers must provide alternative mechanisms to serve the social or individual needs met by the institutions; otherwise, the reforms are destined to fail, wholly or partially.

763. One notable exception to this more typical neglect in the formulation of the positive mandate is the Mental Health Systems Act, developed as a result of several years of deliberation and reports analyzing needs and proposing a particular intervention approach. See supra note 740 and accompanying text.
Examining the failures of the past, it seems clear that a successful response to the problems of troubled and troublesome youth must turn this traditional approach on its head. In other words, rather than beginning with a negative mandate to deinstitutionalize and hoping that the community-based services ultimately developed meet the underlying social needs, we should begin with the positive mandate to develop the network of appropriate community-based services. If these services truly meet the underlying social needs of troubled and troublesome children, their families, and their communities, decreasing demand for institutional interventions—whether those services are provided in mental health, juvenile justice, child welfare, or medical settings—should follow naturally. Gradually, layers of clientele of various institutional systems will peel away from the institutional systems, and many other individuals and families will be referred directly to these new services.

Thus, in Phase One of the policy reform effort, funding with strings tied tightly to particular models of service delivery would be dispersed so that the infrastructure can be built and tested. If effective, the service system will act like a magnet, attracting clientele away from institutional and other inappropriate services. In Phase Two, once the community-based service system is well established, additional clients for whom these services are appropriate can be coaxed from institutions through the use of negative mandates, such as providing incentives to states for reductions in institutional use. Of course, the success of this approach is tied closely to the degree to which the alternative services and interventions meet the underlying individual and social needs served by institutional systems. In Sections B and C below, I sketch some essential components of a successful governmental response.

B. Taking Charge of Boundary Crossings Through Development of Metasystem Capabilities

In this Article and elsewhere in the scholarly and policy-based literature, we hear much of the unintended and unanticipated consequences of failed deinstitutionalization policies. While many...
have written about these phenomena more generally, one of the most useful expositions is a 1936 article by sociologist Robert Merton in *The Unanticipated Consequences of Purposive Social Action*.\(^{766}\) Unintended and unanticipated consequences are not always undesirable, but to the extent that they are, it is useful to understand what factors contribute to their occurrence for the purpose of taking preventive or corrective actions.\(^{767}\) Clearly, the failure of policymakers to develop, fund, and implement service and intervention systems that meet the underlying social needs served by institutions contributed to the unintended consequences that accompanied deinstitutionalization.

Understanding the nature of these unintended consequences, however, is also quite revealing, and helps us to envision how we might anticipate and reduce future policy failures. When underlying needs of troubled and troublesome youth are not met by one institutional system, individuals, families, and social agencies often try to meet those underlying needs by crossing permeable intersystem boundaries. This tendency, which has been repeated countless times in a range of deinstitutionalization contexts, is now a fairly predictable result of deinstitutionalization policies, and should no longer be thought of as unanticipated. But intersystem boundary crossing by troubled and troublesome children and their families is informative as well. It reveals the complex and multidimensional character of the problems requiring attention. Presently, our legal system compartmentalizes the services it provides into the niches defined by the mental health, educational, juvenile justice, and child welfare systems. While there is indeed some overlap among these services, and many children and families are served concurrently or consecutively by more than one system, the services provided typically reflect the formulations of the child’s or family’s behavior characteristic of the system through which the child or family happened to enter.\(^{768}\) Yet, as discussed in Part III of this Article, children and families do not fit neatly into the boxes that constitute the formulations and turf of each of these systems. Rigid adherence to system-specific notions of this population’s problems often bears little relation to the lives and needs of these multi-problem children and

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\(^{766}\) Robert K. Merton, *The Unanticipated Consequences of Purposive Social Action*, 1 AM. SOCIOLOG. REV. 894 (1936). Merton cites to a range of other writers who have addressed the phenomenon: "In some one of its numerous forms, the problem of unanticipated consequences of purposive action has been treated by virtually every substantial contributor to the long history of social thought." *Id.* at 894.

\(^{767}\) *Id.* at 896-97.

\(^{768}\) *See supra* Part III.B.5.
families, who often require services that might only be available across systems.

This conclusion leads directly to the next facet of my proposal. Rather than *discourage* intersystem boundary crossings, we should *facilitate* such crossings. Each system reflects a lens through which the child and family are perceived. Rather than to use only one lens, thereby locking families into one system, we should look at the children and families from the range of relevant perspectives, and insure that families have access to the full spectrum of services, easily accessing those that are most appropriate. Permeability of boundaries can be a desirable component of a total service network—when formally coordinated and managed—using the multiple systems' resources in a logical, planned, and productive way. In other words, the best way to address the problems of *unintended* boundary crossing is by structuring positive opportunities for *intentional* boundary crossing, thereby maximizing the chances that each child and family will receive appropriate services in response to the unique range of needs they manifest.\(^769\)

Clearly, however, it will be difficult to effect such planned, purposive boundary crossings with the current structure of the various systems. The lack of coordination that is endemic to the various child service and intervention systems presents a major obstacle. Not only does the right hand not know what the left hand is doing, but also the financing structure within these rigid administrative entities provides incentives for shifting costs from one agency to the next. There is no overall accountability mechanism to encourage the educational system, for example, to provide a child with less expensive and more appropriate services that are likely to prevent the subsequent, and far more expensive, incarceration of the youth in the juvenile justice system years later. Each agency operates independently of the others, and there is no motivation on the part of agency personnel to consider the totality of expenses the state will incur as a result of short sighted intra-agency policies. For these reasons, I propose the legislative creation of metasystem capabilities within state government. I use the term "metasystem," to emphasize the need for an administrative structure that sits *above*, and *transcends*, the individual systems, and has the capacity to build into these systems a workable, interactive structure.

What might such metasystem capabilities look like in practice? Depending upon the state, its agency structure, and who the players are

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\(^{769}\) For further discussion of analogies to this somewhat paradoxical approach to altering a undesired course of conduct by "prescribing" it, see Watzlawick et al., *supra* note 1, at 120-24.
at any given point in time, different approaches may make the most sense. The "Systems of Care" model, which is federally-funded, and on which child mental health programs around the country have been based, stresses the provision of "services that are integrated, with linkage between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services."\(^770\) The Systems of Care model does not dictate what form that linkage and coordination should take, although various approaches have been proposed and implemented.\(^771\) The need for collaboration among governmental agencies and systems is not unique to troubled and troublesome youth.\(^772\)

As a first step, the Legislature or Governor's Office can create a working commission, committee, board, or panel, with representation from each of the agencies and professional groups involved in the policymaking and service delivery to troubled and troublesome youth. The presence of scholars and researchers who can assist the group in grounding their investigations on a solid empirical base is important as well. This group would develop proposals for development and maintenance of a metasystem response to the needs of troubled and troublesome youth and their families. In order to maximize the likelihood of success, however, there are three key components that are essential: (1) establishment of an office in the upper levels of state


\(^771\) See, e.g., Gary Macbeth, A Statewide Approach to System Development, in CREATING SYSTEMS OF CARE, supra note 770 at 131; SHARON HODGES ET AL., U.S. DEP'T OF HEALTH AND HUMAN SERVS., Promising Practices: Building Collaboration in Systems of Care, Promising Practices in CHILDREN'S MENTAL HEALTH: SYSTEMS OF CARE VI (1998), available at http://cecp.air.org/promisingpractices/1998monographs/vol6.pdf. Elsewhere, I examined a range of state-based approaches to developing interagency coordination of responses in the context of childhood exposure to domestic violence. See Weithorn, Protecting Children, supra note 77, at 100-51. In Protecting Children, I examined the ways in which states were responding to the exposure of children to domestic violence perpetrated by one parent or parent figure on another. Two of the central agencies charged with responding to these problems—that is, providers of child protection and domestic violence services—functioned with distinct philosophies and divergent service models. Id. at 26-41. Substantial mistrust had pervaded interagency interactions over the years. In recent years, there have been substantial efforts in several jurisdictions to bring about productive interagency collaboration focusing on their common concerns, with promising outcomes in those jurisdictions that have gone about their policy reform in a thoughtful manner, examining and planning strategies to tackle the various challenges they must confront. See id. at 109-31 (discussing implementation of new policies in Alaska, Massachusetts, and Michigan).

\(^772\) See, e.g., Bradford C. Mark, Protecting the Environment for Future Generations: A Proposal for a "Republican" Superagency, 5 N.Y.U. ENVTL. L.J. 444, 460-65, 488-96 (1996) (discussing the general role of the federal Office of Management and Budget in cross-agency policy planning and program implementation, and arguing for a distinct "superagency" that will oversee and coordinate environmental policies.)
administration to develop and implement policy directives that coordinate services of the various child service and intervention systems (i.e., the health, mental health, child welfare, juvenile justice, and educational systems) to troubled and troublesome youth; (2) establishment of triage or assessment centers within each county to coordinate the implementation of the program at the county level, insuring that the needs of troubled and troublesome youth and their families are appropriately assessed, and referred to appropriate services; (3) financial incentives to discourage cost-shifting and encourage assumption of responsibility by those governmental agencies within those systems charged with provision of appropriate services to troubled and troublesome youth; and (4) training and development of expertise and cross-agency linkages so that front-line workers are motivated and capable of implementing the new approaches to service provision to troubled and troublesome youth.

1. Establishing a Statewide Office to Coordinate a Multisystem Response to the Needs of Troubled and Troublesome Youth and Their Families

An administrative office at the highest level of state government must be created and staffed by a team of experts familiar with the workings of the various child service and intervention systems. These individuals must be committed to developing a coordinated system of service delivery to troubled and troublesome youth grounded in empirically-supported or evidence-based practices. This office, referred to here as the Office of Multisystem Services to Child, Youth, and Families (hereinafter the “Multisystem Office”) would coordinate a

773. There is fairly broad agreement among scholars that the coordination of cross-agency policies, planning, and funding must be in the executive branch, and must sit at a high level of government, given the likely intransigence of agencies to alter traditional patterns of operation. See, e.g., Stroul and Friedman, supra note 770, at 11 (referring to “executive-level interagency entities”); Macbeth, supra note 771, at 13, 143-45 (citing several interagency coalitions, including a State Executive Council to formulate program and fiscal policies and a State Management Team to oversee implementation of the policies; Mark, supra note 772, at 455-496 (discussing the need for and functions of a “superagency”); Shelly Hara & Theodora Ooms, Children’s Mental Health Services: Policy Implications of the New Paradigm 19 (1995), available at http://www.uwex.edu/ces/familyimpact/reports/pin35.pdf (stating that an agency, consisting of executives from all of the concerned agencies, would assume “responsibility for new policies, joint planning, priority setting, service development, financing, resource allocation, and system management”). An administrative agency is far more likely than is the legislature to maintain continuity of staff and goals from year to year. Mark, supra note 772, at 455-96.

774. For discussion of the concepts of evidence-based or empirically supported treatments, see infra Part VII.C.2.
variety of functions. First, the Multisystem Office would examine epidemiological and other statistical data regarding the numbers and types of troubled and troublesome youth served in the state in order to guide programmatic, training, and budgetary planning for future service delivery. The population of relevance would be consistent with the general definition set forth in Part III of this Article: Children who are at risk for out-of-home placement, who are appropriate for community-based interventions of the types described in Part VII.C below. Second, using these prevalence data and scientific knowledge of the efficacy of various interventions, the Multisystem Office would develop a plan for the delivery of services to the range of troubled and troublesome youth and their families within the various service and intervention systems. Third, the Multisystem Office would determine the staffing and training needs within these systems, and direct these operations. Fourth, it would design ongoing data collection, including program evaluation, to insure that policy is informed by empirical inquiries, allowing for ongoing reforms to better meet the needs of the relevant populations. Fifth, and most importantly, this agency would control a portion of the state budgets for each of the five systems, in a manner discussed in Subsection 3 below. Sixth, it would plan and implement permanent linkages among the five systems’ personnel, as discussed in Subsection 4, below. And seventh, the Multisystem Office would plan and coordinate preventive interventions for those children and families deemed to be at risk for future problems, as discussed in Section VII.C below. The Multisystem Office, therefore, would develop and implement policy, and serve as the conduit for the coordinated delivery of appropriate services to troubled and troublesome youth in a manner consistent with the principles set forth in this Part.

2. Establishing Triage Centers

Once a worker in a child service and intervention system encounters a child or family deemed to be at risk of out-of-home placement, that case should be referred to the local Triage Center775 (alternatively, the Evaluation, Assessment, or Intake Center; hereinafter referred to as the “Center”). Staffed by personnel with expertise in each of the areas of relevance (that is, pediatrics, mental health, child welfare,
juvenile justice, and education), the Center’s role is to insure that each child and family receive a thorough evaluation in order to develop an Intake Plan. Depending upon the local organization of services, staff at the Center might play a supervisory role only, insuring that the proper evaluation is conducted at other sites (for example, the school, by child protective services). Or, the Center staff might conduct some of the assessment functions, particularly where centralizing the expertise is the most sensible and cost-effective way of insuring completion of a comprehensive assessment with a multisystem focus. Assessment staff (at the Center and other agencies) will be guided by protocols that require evaluators to consider a range of issues relevant to these children and families. Macbeth refers to such entities as Family Assessment and Planning Teams, local panels that assess the needs of troubled and troublesome youth and their families, and refer these individuals to appropriate services. 776

The evaluation will be multifaceted, so as to discern which services are required in order to avoid out-of-home placement and to promote the child’s and family’s adaptive functioning. Only in this context will professionals learn which of the many possible explanations for truancy, for example, underlies a particular child’s school absence. Is a truant child staying home from school because his father will not assault his mother if someone else is in the house, because he has an undiagnosed learning disability and associates school with failure, because he has become involved with a peer group that socially rewards norm violations of this type, or because he was being teased and assaulted at school? The evaluation findings will guide the nature and type of interventions and which systems will become involved in providing services.

Staff at the Center will also make an initial determination as to whether family-based or home-based intervention is sensible, given the family circumstances. As noted at the outset of this Article, some families are beyond repair, at least within a time frame that is necessary to avoid an out-of-home placement. Based on the Intake Plan set forth by the Center, funding would follow the child and family to the various systems in which services are delivered. 777 In addition, depending upon

776. Macbeth, supra note 771, at 144.

777. States have begun to experiment with an innovation aptly named “Money Follows the Person.” Under this model, money that would have been available if an individual would have received the “default” services under the auspices of one service and intervention system can use those funds to access either different services in that system, or services in another system. Legislation under consideration by Congress would permit greater access to community-based options by those persons whose care is funded by Medicaid. See, e.g., S. 528, 109th Cong. (2005);
the specifics of the case, the Center staff would identify periodic intervals for reassessment.

One problem with existing service delivery to these multi-problem children and families is the unavailability of the full range of voluntary services at all points of entry.\textsuperscript{778} If a child like Donny is served solely in the educational system, little can be done about the child abuse he experiences, his assaultive conduct, or his mental health problems unless he is transferred to another system. In the traditional model, a child is likely to lose continuity of educational services as a result of an out-of-home placement either because his move from one neighborhood to another makes continuity impractical, or because the type of placement, such as secure juvenile detention, denies him the opportunity for a comprehensive school program. By contrast, the Intake Plan would provide access to the full range of services \textit{at any point of entry}. Whether a child's or family's problems become evident to the child's school, to a pediatrician, to an emergency room physician, to a mental health professional, to child protective services, to juvenile justice authorities, or to the police, the full range of appropriate services would be easily accessed. Thus, \textit{the needs of the particular child and family} would determine the nature of the intervention, not the particular system through which the child or family first entered. Entering through the "wrong" portal would not create barriers that lead to the provision of inappropriate services or no services at all.

3. Discouraging Cost-Shifting and Encouraging Assumption of Responsibility for Service Provision to Troubled and Troublesome Youth

As noted throughout this Article, and emphasized in Part V, cost-shifting is a significant problem in the delivery of services to troubled and troublesome youth and their families. Given the separate lines in state budgets for services in the different child service and intervention systems, there are no financial incentives for personnel and administrators in the educational system, for example, to provide relatively inexpensive early intervention services to a troubled and

troublesome child, potentially averting the need for ongoing and far more expensive services in the juvenile justice system, and even the criminal justice system, in the future. Furthermore, in an era of tight budgetary constraints, personnel may seek to avoid the expense of serving a child whose problems are not yet severe, despite the possibility or probability that those problems will escalate and result in higher costs within that same system at some undetermined future time. Thus, it is unlikely that administrators and personnel will eagerly increase their caseloads to provide more appropriate services to these children without financial incentives to do so.

An alternative way to structure the financing of these services could promote the provision of more appropriate services within particular systems. Based on existing data, state financial personnel would estimate the approximate proportion of each service and intervention system’s budget that should be dedicated to serving troubled and troublesome youth. That portion of each system’s budget would be isolated and extracted from that system’s appropriation from the state. Those funds would be pooled and channeled instead to the Multisystem Office. Once a child and/or family has been evaluated for services and a plan developed at the Triage Center, the funds estimated to be necessary for service delivery to that child and family would become available in appropriate proportions to the systems that provide those services. Thus, service and intervention system personnel would be motivated to serve youth identified by the Center because referrals would be accompanied by funds. Ideally, service and intervention systems would mobilize to develop services appropriate for this population, in the hope of receiving a larger portion of the pooled funds—in effect, competing with other systems for these children. If a case proved to require more or different services once the child and family proceeded through the system(s), procedures would exist to facilitate additional directives and requests for funding through the Center.

4. Developing Expertise, Cross-Agency Linkages, and Commitment Among Front-Line Workers

Without the commitment of front-line workers in all of the systems and the development of expertise in the intervention modalities discussed below, interagency coordination and improved service delivery will not occur. The capacity for such a response must be built. Successful capacity building, therefore, focuses on personnel and includes, at the minimum: (1) cross-training (i.e., substantial opportunities for personnel across agencies to share knowledge and
experience, build liaisons and relationships, and practice working together in interdisciplinary teams); and (2) training of all personnel in the theoretical models and innovative practices that will be the cornerstones of service provision, as described in Section C below.

Most critical to the success of interagency collaboration are the people who serve as the links between and among the systems. There are a variety of models that may be applied in conceptualizing the roles of these "linkage" personnel. For example, the Massachusetts Department of Social Services, upon recognizing that domestic violence in families is detrimental to the children they seek to protect, created an in-house position for a domestic violence advocate to serve as a consultant within its agency.779 The advocate worked collaboratively with the case management teams, assisting in assessments, formulation of recommendations in individual cases, and linking families to appropriate resources in the community.780 Clearly, the placement of a trusted and respected individual with training and expertise divergent from that of most staff members within the agency can serve as a critical component in the promotion of an interagency approach.

Henry Steadman emphasizes the role of "boundary spanners" in promoting interagency cooperation.781 He defines boundary spanners as individuals whose positions "link two or more systems whose goals and expectations are likely to be at least partially conflicting." At each organizational boundary there is a person whose role it is both to interact with the people inside their own organization and to negotiate system interchanges with the other organization.782 Steadman describes a range of models of boundary spanning, as well as examples relevant to the mental health and criminal justice system interactions. In addition, he points out that boundary spanners may be entire organizational units, rather than individuals.783 Others have pursued the boundary spanner concept, as did Steadman, with respect to the criminal justice-mental

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779. Weithorn, Protecting Children, supra note 77, at 119.
780. Id. at 119-20.
782. Id. at 77.
783. Id. at 77-86.
health interface, or other contexts, such as with respect to school-based mental health services.

In the final analysis, the newly structured network of service systems will be a purposefully, rather than haphazardly, interconnected groups of agencies. And, indeed, there is a growing consensus among experts that a broad continuum of coordinated, easily-accessible, affordable, appropriate, and primarily noninstitutional services provided within restructured service-delivery systems is most likely to


785. See also John Kastan, School-Based Mental Health Program Development: A Case Study of Interorganizational Collaboration, 25 J. HEALTH POL‘Y & L. 845, 848-51 (2000).

786. The concept of a continuum of services reflects the notion that a responsive service and intervention system provides options for a range of treatment interventions, depending upon the needs of the individual children and families. There are many variables of relevance to the continua. For example, interventions may be more or less intensive (e.g., 24-hour individual or family-based intervention at one end of the continuum and one hour of counseling weekly at the other); may use any of a range of modalities (e.g., biological interventions such as psychotropic medication at one end of the continuum and intensive family-based psychosocial intervention at the other); may be provided in any of a range of settings (e.g., at a clinic, in the home, at school, in a foster family home, in a community-based residential facility, and so on).

787. The concept of coordination refers not only to interagency coordination, as discussed above, but coordination among the various professionals and agencies within each service and intervention system. Frequently, services provided today constitute disparate and isolated interventions, typically provided without regard to services provided previously or expected subsequently. It is critical that there be a coordinated plan of intervention that follows each individual or family as they move both among and within service and intervention systems.

788. The current service systems are not user-friendly, in that families and others must typically struggle with a range of challenges. They must wait for extended periods of time for services, they must confront eligibility restrictions, limitations on types and lengths of service delivery, and they must negotiate the complexities of the maze of pathways to access care.

789. As discussed earlier, many services are not available unless one has extensive financial resources or exceptional insurance coverage. Otherwise, there are maximums, limits, eligibility requirements, and so forth, most of which do not match the needs of those children and families who are the focus of this Article. While it is beyond the scope of this Article to discuss proposals for universal health coverage more generally, there is no question that troubled and troublesome youth will continue to cycle through the systems that cannot reject them, that is juvenile justice, child welfare, and eventually criminal justice, if we do not implement a system of universal coverage of the types of interventions discussed below. See infra Part VII.C.2.a-c.

790. Interventions are appropriate when they are effective in addressing both the underlying needs and the overt manifestations of the problem conduct, and when they do so in a manner least destructive to family relationships, least restrictive of liberty, and least restrictive of the individual's opportunities to interact with others. Efficacy is determined with reference to the relevant body of empirical studies.

791. The term noninstitutional reflects the preference for interventions that permit individuals to remain in their natural settings.
meet the needs of most troubled and troublesome children and their families.

C. Responding to Underlying Individual and Social Needs

In Part V, I addressed the discontinuities among our society's responses to troubled and troublesome youth and several core traditions in American law. Empirical data reveal that these traditional modes of intervention do not achieve results that contribute to the well-being of minors or their families. The absence of such a positive impact suggests that highly-intrusive governmental and quasi-governmental agencies have failed to accomplish many of the purposes that provide much of the justification for their existence.

Ironically, based on an increasingly robust body of empirical data, it appears that those modes of service intervention that are likely to be the most effective in achieving a range of ameliorative goals are also those that are most consistent with our society's core legal traditions. I say that this is ironic because, to some extent, the legal frameworks of parent-child-state jurisprudence presume that adverse interests necessarily exist. Yet often, interests conflict solely because the absence of appropriate services constricts the choices of the parties and channels them into adversarial, rather than cooperative, interactions. There are ways to frame the interests of parents, children, and the state so as to reveal the underlying commonalities. Indeed, the unities of interest among parents, children, and the state can create the cornerstone or foundation on which intervention approaches are based. While we give lip-service to preserving and strengthening families in our nation, our money is rarely "where our mouth is." Below, I assert that, in order to serve the common interests of children, families, and the state, we must (1) address children's needs within their natural environments of home, school, and community and (2) rely on evidence-based/empirically-supported interventions. These approaches are grounded in psychological theory and research and are also consistent with core American legal values disfavoring interventions grounded in policies of

792. See the summary and analysis provided in SURGEON GENERAL'S REPORT, supra note 22, at 169-72.
793. See id. at 168-79.
794. In a similar vein, Professor Barbara Bennett Woodhouse observes that the "traditional paradigm pitting parents against the state" in a contest for control over children's development may be less useful than one viewing parents and the state as partners in promoting children's welfare. Barbara Bennett Woodhouse, Reframing the Debate about the Socialization of Children: An Environmentalist Paradigm, 2004 U. CHI. LEGAL F. 85, 85-86.
removal, confinement, and segregation. In addition, I argue that logic and available data indicate that such approaches are no more expensive than are current modes of intervention with troubled and troublesome youth, and they are probably less expensive. Given the overall benefits to children, parents, and society of shifting approaches, even a cost-neutral approach reflects a dramatic improvement over the status quo.

1. Addressing Children’s Needs within Their Natural Environments

In his book, The Ecology of Human Development, psychologist Urie Bronfenbrenner introduced his conception of children’s development, which extends beyond examinations of the influences of inheritance, parent-child interactions, or individual relationships between the child and others. He focused instead on the myriad of influences that derive from multiple social systems in which the child is directly involved or through which indirectly influenced, as well as the impact of the interactions and relationships of those systems with one another. Thus, for example, children engage in face-to-face interaction in a variety of microsystems, such as home, school, playground, and day care. Not only is the child’s development the product of her ongoing interactions within each of those systems, but also of the interactions among those systems. Thus, for example, how a child performs in school relates not only to her interactions with her parents and at school, but also to the interactions between her parents and the school. The next levels of systems conceptualized by Bronfenbrenner are that of mesosystem (which “comprises the interrelations among two or more settings in which the developing person actively participates,” that is, “a system of microsystems”) and exosystem (which constitutes “one or more settings that do not involve the developing person as an active participant, but in which events occur that affect ... what happens in the setting containing the developing person”). Thus, while relations between parent and school constitute a mesosystem, parents’ places of work—where a child does not participate directly—constitute an

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796. Id. at 3-12.
797. Id. at 22.
798. Id. at 7. Thus, the “principle of interconnectedness [applies] not only within settings but with equal force and consequence to linkages between settings, both those in which the developing person participates and those that he may never enter but in which events occur that affect what happens in the person’s immediate environment.” Id. at 7-8.
799. Id. at 25.
exosystem. Finally, Bronfenbrenner characterized as the *macrosystem* influences such as the culture, government, and other consistencies in one’s social environment, including predominant ideologies that have an impact on the ways in which microsystems, mesosystems, and exosystems function. 800 This definition is sufficiently broad to include various socio-economic, legal, ethnic, or religious factors that may have an impact on the functioning of the various “lower-order systems.” 801 Thus, Bronfenbrenner points out that parental efficacy is influenced not only by the skills and capacities an individual brings to parenthood, and not only by the child’s characteristics and needs, and the interaction between parent and child, but also by the parents’ interactions with other family members, with the “demands, stresses, and supports emanating from other settings . . . [with] flexibility of job schedules, adequacy of child care arrangements, the presence of friends and neighbors who can help out,” as well as the “public policies and practices . . . conducive to family life.” 802

Psychologist James Garbarino expounded upon and applied Bronfenbrenner’s social-ecological approach, providing a perspective within which we can understand some of the risks as well as the opportunities that affect children’s development in these various nested and interacting systems. 803 The writings of Bronfenbrenner, Garbarino, and others help us to appreciate the difficulties of intervention approaches in mental health, juvenile justice, or child welfare that do not seek to promote children’s adaptive functioning *within* their natural social environments, through practices that involve, coordinate, and where necessary, effect positive change in, those environments. Policies that lead to the incarceration of minors who run away from family violence for commission of a minor criminal offense on the streets fail to appreciate the importance of the child’s social system in affecting her conduct and are therefore highly unlikely to achieve positive effects. While some of these interventions do succeed in temporarily averting certain immediate problems (i.e., preventing a suicide attempt, avoiding an incident of child abuse, taking a runaway off of the streets), failure to intervene with the child in the context of her natural environments will fail to maximize the opportunity to effect positive, lasting change. Efficacy, which translates into improved familial, social, emotional, and

800. *Id.* at 26.
801. *Id.*
802. *Id.* at 7.
academic functioning, serves the states’ interests in promoting the welfare of children, serves children’s interests in maximizing their own potentials to attain satisfying and productive lives, serves families’ interests in their children’s well-being, and preserves family integrity and survival in the face of the sometimes overwhelming needs of their troubled and troublesome children.

Through the work of several task forces, the American Psychological Association ("APA") has pioneered a new way of looking at services delivered by its members to children and families. For decades, scholars have asserted that children should be viewed within their natural settings of family and community. Others have been advocating a positive, strengths-based approach. Others have been trying to promote interdisciplinary cooperation across services systems. Still others have been focusing the field on the need to disseminate information about treatment efficacy. Now these writers are no longer lone voices, drowned out by those who sustain the more traditional approaches. Scholars, researchers, and practitioners advocating these new directions now have center stage as they seek to promote their approaches within and beyond their profession.804

In 1992, the APA Task Force on Innovative Models of Mental Health Services for Children, Adolescents and Families published its Report, which consisted of a special issue of the Journal of Clinical Child Psychology.805 The Task Force examined the innovative service delivery models applicable to populations who are at risk of psychiatric hospitalization,806 who are processed by the juvenile justice system,807 whose families come to the attention of the child welfare system,808 who are seen by medical professionals,809 and who are served by the


806. Diane L. Sondheimer et al., Alternatives to the Hospitalization of Youth with a Serious Emotional Disturbance, 23 (Supp.) J. CLIN. CHILD PSYCHOL. 7 (1994).


The Task Force addressed the need to restructure the service delivery systems in order to provide support to families, and to emphasize preventive and early interventive approaches. Grounding their analysis on the body of research and theory accumulated thus far, the Task Force recommended: (1) adoption of "systems of care" principles; (2) reduced use of restrictive services, such as psychiatric hospitalization and many other forms of residential intervention; (3) increased use of home-based and community-based services; (4) approaches that strengthen, empower, and support families; and (5) availability of a comprehensive range of individualized and flexible services that are coordinated and integrated.

The Task Force's empirically-grounded evaluation of the range of new approaches to psychosocial intervention with children and families, as well as the virtual explosion of scholarship continuing the Task Force's work, has led the governance of the APA to adopt a formal Resolution on Children's Mental Health. After listing its key findings, the APA Council of Representatives resolved, among other things, that it would "take a significant leadership role to support and advocate that it is every child's right to have access to culturally competent, developmentally appropriate, family oriented, evidence-based, high-quality mental health services that are in accessible settings."

These general approaches have been endorsed by panels in reports such as those issued by the Surgeon General in 1999 and promulgated by the President's New Freedom Commission on Mental Health in 2003.

2. Relying on Evidence-Based/Empirically-Supported Interventions

Contemporaneous with the above developments, the Clinical Psychology Division of the APA set the ball rolling for a complementary process to inform professionals, consumers, policymakers, and others about the existing databases addressing the efficacy of various

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815. Id.
816. See, e.g., PRESIDENT'S NEW FREEDOM COMMISSION, supra note 22, at 52-54; SURGEON GENERAL'S REPORT, supra note 22, at 168-94.
psychosocial interventions. Based on the quality, scope, and findings of research addressing the efficacy of psychosocial intervention approaches for particular problems and with particular populations, the APA Division Panel, as well as individual scholars writing separately, have been publishing evaluations of the levels of evidence supporting the use of particular interventions with particular populations. Interventions have been characterized as (1) well-established (those with the strongest empirical support); (2) probably efficacious (those with less strong empirical support); or (3) experimental treatments (with no empirical evidence supporting efficacy as yet). As noted above, scholarly literature evaluating the empirical evidence for the efficacy of psychosocial interventions for children and adolescents has virtually exploded in the past several years. Thus, the timing is excellent to identify those intervention approaches most likely to be useful to troubled and troublesome youth.

And indeed, many of the approaches studied do focus on troubled and troublesome youth, although these children are more generally referred to in this literature by the relevant system-specific labels. A fascinating finding has emerged, which follows logically from the notion that there is substantial overlap in the populations of troubled and troublesome juveniles who come in contact with the mental health, juvenile justice, and child welfare systems. It appears that whether the children are identified as seriously emotionally disturbed, as status offenders or delinquents, or as victims of child maltreatment, the same cohort of intervention approaches appears to be useful. While not all approaches have been tested in all settings, empirical findings to date suggest that there is a core group of intensive intervention approaches

817. This trend was formally launched in 1995, with a report by a Task Force of the Division of Clinical Psychology of the American Psychological Association. See Task Force on Promotion and Dissemination of Psychological Procedures, Training In and Dissemination of Empirically-Validated Psychological Treatments, 38 CLIN. PSYCHOLOGIST 3 (1995).


that is effective in cases identified in different service and intervention systems. That is, the intervention approaches are not necessarily system-specific.

Common themes characterizing the range of innovative intervention models include: (1) a view of the child within her natural social environment; (2) a broad view of healthy psychological functioning as relating to many important spheres (including family, school, and peers); (3) a strategy of intervention that includes or emphasizes family functioning; (4) a focus on the development of strengths and capacities; (5) an individualization of the particular services selected for each child and family; and (6) an organized conceptual framework coordinating various levels and types of interventions. Furthermore, every one of these approaches seeks to avoid the child’s removal from the home, restriction of that child’s liberty, and segregation of the child from the community. In fact, most of these approaches rely on the opportunity to work with the child within the context of the family and community. Given that these approaches have been identified as those that are grounded in the strongest evidence of efficacy, it appears clear that effective intervention with troubled and troublesome youth can occur in a manner consistent with our nation’s core legal traditions. Those interventions inconsistent with those core traditions appear to be least likely to promote positive behavior change and healthy functioning in troubled and troublesome youth. I describe below, two of the approaches that appear to be the most effective.

While the primary emphasis of the interventions discussed immediately below is intervention with children already at risk for out-of-home placements, I briefly discuss the notion of early intervention as well. In addition, I touch on certain innovative approaches to addressing

820. My review of the empirical research is necessarily fairly cursory, and does not discuss the methodological designs of the studies other than to allude to their sophistication or general limitations. The process of evaluating the efficacy and cost-effectiveness of intervention programs is, by itself, complex, and has been the subject of volumes of scholarship. For the interested reader, I recommend the sources cited within for greater detail on the specifics of the empirical research briefly summarized here. In addition, for further discussion of the strategies and challenges in evaluating intervention programs, see, for example, CHILDREN’S MENTAL HEALTH SERVICES: RESEARCH, POLICY, AND EVALUATION (Leonard Bickman & Debra J. Rog eds., 1995); EVALUATING MENTAL HEALTH SERVICES: HOW DO PROGRAMS FOR CHILDREN “WORK” IN THE REAL WORLD? (Carol T. Nixon & Denine A. Northrup eds., 1997). Furthermore, Paul Lerman presents an excellent analysis of several model programs that were developed with an eye toward application in the mental health, child welfare, and juvenile justice systems. Lerman, Child Protection, supra note 84. Although this review was prepared over a decade ago, it is still instructive in the way in which it scrutinizes the programs examined within.
the needs of children who cannot go home, at least in the immediate future.

a. Serving Children in their Social Contexts

Multisystemic Therapy ("MST") is grounded in the notion that "the variables that influence the development and maintenance of [problem] behavior in children and adolescents" are many and that intervention approaches that narrowly seek to modify one variable or another are unlikely to promote adequate change. Among the facets of the child’s functioning and life that can be the focus of MST intervention if necessary in individual cases are: "individual youth characteristics (e.g., weak verbal skills, favorable attitudes toward antisocial behavior), family functioning (e.g., discipline, affect), caregiver functioning (e.g., mental health, substance abuse), peer relations (e.g., rejection, association with deviant peers), school performance, indigenous family supports, and neighborhood characteristics (e.g., criminal subculture)." Using a highly-individualized plan for each client, MST tailors a complex set of interventions to the particular child’s and family’s needs. Scott Henggeler and colleagues emphasize that the intervention plan is grounded in a “careful and ecologically based functional analysis of identified problems,” and that interventions incorporate strategies to develop strengths and protective factors relating to the emotional connections among family members, the family’s connections with a meaningful social support network, development of the youth’s social, academic, and vocational skills, as well as positive peer group alliances and patterns of interaction. Thus, while the approach is quite comprehensive in addressing the wide range of problematic facets of the child’s life, it is also individualized—that is tailored to each child’s specific needs. While initially developed to address the needs of serious juvenile offenders, MST has now been applied to other populations as well, and appears to have broader applicability to the entire gamut of troubled and troublesome youth. This finding is consistent with the likely flexibility of concurrent comprehensive, yet individualized, aspects of the model.

822. Id.
823. Id. at 5-6.
824. See also SCOTT W. HENGGELER ET AL., MULTISYSTEMIC TREATMENT OF ANTISOCIAL BEHAVIOR IN CHILDREN AND ADOLESCENTS (1998); SCOTT W. HENGGELER ET AL., FAMILY PRESERVATION USING MULTISYSTEMIC THERAPY: AN EFFECTIVE ALTERNATIVE TO INCARCERATING SERIOUS JUVENILE OFFENDERS.
MST has been subjected to substantial empirical evaluations, and is viewed as a "well-validated treatment model" by child treatment researchers.\textsuperscript{825} Studies have focused primarily on youth with antisocial behavior, including serious and violent juvenile offenders. When compared with traditional interventions, MST substantially reduced recidivism and out-of-home placements in the offender samples.\textsuperscript{826} More recently, studies have focused on children diagnosed with serious emotional disorders, including those at risk for hospitalization.\textsuperscript{827} Youth in the MST program were substantially less likely to be hospitalized or placed in other out-of-home placements than youth in traditional treatment, and those that were hospitalized had briefer hospital stays than the comparison group.\textsuperscript{828} Furthermore, MST participants demonstrated significantly greater improvement in symptomatology and missed significantly fewer days of school than the comparison group.\textsuperscript{829} One investigation examined the efficacy of MST with maltreating families, also with positive results.\textsuperscript{830} In those investigations that compared costs, MST was more cost-effective than the traditional interventions.\textsuperscript{831}

The Wraparound model was developed as an alternative to traditional mental health interventions. It presumes that children with severe emotional and behavioral problems will develop a more normal lifestyle if their services and supports are family centered and child focused, strengths based, individualized, community based, interagency coordinated, and culturally competent.

\begin{thebibliography}{10}
\bibitem{60} Consulting & Clinical Psychol. 953 (1992); Scott W. Henggeler et al., Four-Year Follow-up of Multisystemic Therapy with Substance-Abusing and Substance-Dependent Juvenile Offenders, 41 J. Am. Acad. Child & Adolesc. Psychiatry 868 (2002); Sonja K. Schoenwald & Melisa D. Rowland, Multisystemic Therapy, in Community Treatment for Youth, supra note 820, at 91.
\bibitem{825} Schoenwald & Rowland, supra note 824, at 113.
\bibitem{826} Id. at 113-14.
\bibitem{827} See Henggeler, Four-Year Follow-up, supra note 824; Melisa D. Rowland et al., Multisystemic Therapy with Youth Exhibiting Significant Psychiatric Impairment, in Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families: Program and Evaluation Best Practices 401 (M.H. Epstein et al. eds., 2d ed. 2005) [hereinafter Outcomes for Children and Youth].
\bibitem{828} Rowland et al., supra note 827, at 410.
\bibitem{829} Id.
\bibitem{831} Schoenwald & Rowland, supra note 824, at 114-15.
\end{thebibliography}
[Grounded in] psychosocial theories of child development... [such as] the social-ecological theory of Urie Bronfenbrenner... [behavior is seen] as developing in the context of multiple reciprocal interactions over time: The child, the family, the neighborhood, the school, and the community interact to affect one another in a continuous fashion. \(^{832}\)

This intervention approach focuses on the family unit, and seeks to provide the services and supports needed to promote that family’s adaptive functioning. The intervention is individualized and, as noted above, examines not only the child within the family context, but within other social contexts as well. Like MST, the Wraparound model has been expanded in its initial focus, and programs consistent with its theory have been provided for a range of problems brought to the attention of the mental health, education, child welfare, and juvenile justice sectors. \(^{833}\) Empirical investigations of Wraparound programs do not provide as strong a database as those of MST, in part because the inherent variability in the application of the program—which is highly individualized—makes it difficult to compare with other interventions. The program has become quite popular and has been adapted in a variety of locations in the United States and Canada. \(^{834}\) While initial studies are favorable, in terms of positive outcomes (e.g., reduced offending by delinquent youths) and cost savings in studies with populations of troubled and troublesome youth identified within various service and intervention systems, \(^{835}\) the research is weakest in providing data that compare this model of intervention with other approaches. There exist other promising interventions, as well. For some, findings regarding efficacy and cost-effectiveness are mixed. \(^{836}\)

\(^{832}\) John D. Burchard et al., The Wraparound Approach, in COMMUNITY TREATMENT FOR YOUTH, supra note 819, at 69-70.


\(^{834}\) Burchard et al., supra note 832, at 90.


\(^{836}\) For example, research on the Systems of Care model has yielded somewhat contradictory findings. Compare, e.g., Albert J. Duchnowski et al., Community-Based Interventions in a System of Care and Outcomes Framework, in COMMUNITY TREATMENT FOR YOUTH, supra note 819, at 16, 21-26 with Leonard Bickman, A Continuum of Care: More is Not Always Better, 51 AM. PSYCHOLOGIST 689 (1996). The term “systems of care” can refer to a range of program types that satisfy basic principles. Thus, research continues so as to identify successful program designs. The model is widely-regarded as “promising.” For example, see the monograph series published by the
b. Serving Children who Cannot Go Home Right Away (or at All)

Some children’s families are so dysfunctional, and some children’s behavior so difficult to manage, that remaining at home and/or returning home are not viable options for the child in the immediate future.

Federal Substance Abuse and Mental Health Services Administration on “Systems of Care: Promising Practices in Children’s Mental Health (available via links at: http://www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/practices.asp) and publications available at the University of South Florida’s Research and Training Center for Children’s Mental Health website (available via link at: http://rtckids.fmhi.usf.edu/). For general discussion of the Systems of Care model and implementation, see, for example, THE HANDBOOK OF CHILD AND ADOLESCENT SYSTEMS OF CARE (Andres J. Pumariega & Nancy C. Winters eds., 2003); CHILDREN’S MENTAL HEALTH: CREATING SYSTEMS OF CARE IN A CHANGING SOCIETY (Beth A. Stroul ed., 1996); STROUL & FRIEDMAN, supra note 812.

Similarly, evaluations of programs referred to generically as Intensive Family Preservation Services/Intensive Home-Based Interventions have led to mixed conclusions about efficacy. These approaches seek to prevent the removal from the home of children who might otherwise be placed in foster care, group homes, residential treatment centers, psychiatric hospitals, or juvenile justice facilities. Kathleen Wells, Family Preservation Services in Context: Origins, Practices, and Current Issues, in HOME-BASED SERVICES, supra note 119, at 1. The child’s family is the focus, with services provided in the family’s home “for as many hours as needed, over a relatively brief period of time,” and employing a wide range of interventions. Id. The model is grounded in four strands of theoretical and empirical work in psychology that developed over the last three decades of the twentieth century: social learning theory, which examines the reciprocal interaction between individuals and their environments; family systems theory, which examines the individual within the context of the family, and the family’s interactive patterns; and crisis intervention theory, which recognizes the unique characteristics of a crisis (as a situation in which there is “an imbalance between the perceived difficulty and significance of a threatening situation and the coping resources available to an individual”), and uses various strategies on a short-term basis, to assist the individual, including development of coping skills and provision of social supports; and the social ecological theory advanced by Bronfenbrenner, and Garbarino, which emphasizes the “interdependence of individuals and . . . the social world” and which focuses on “multiple contexts in which a child develops” and functions. Id. at 6-10. Yet, despite the intuitive attractiveness of this approach, and positive findings of efficacy and cost-effectiveness by those who developed and implemented these programs, see, for example, Jill Kinney & Kelly Dittmar, Homebuilders: Helping Families Help Themselves, in HOME-BASED SERVICES, supra note 119, at 29, 40-48, more methodologically-sophisticated empirical evaluations have not supported those findings, particularly in the child welfare context. See, e.g., WESTAT ET AL., EVALUATION OF FAMILY PRESERVATION AND REUNIFICATION PROGRAMS: FINAL REPORT SUBMITTED TO DEPARTMENT OF HEALTH AND HUMAN SERVICES (Dec. 2002) available at http://aspe.hhs.gov/hsp/evalfampres94/Final/index.htm; Duncan Lindsey, Preserving Families and Protecting Children: Finding the Balance, available at www.childwelfare.com/kids/fampres.htm. Paul Lerman uses family preservation programs to illustrate the importance of testing program innovations with randomized trial research designs. Lerman, Child Protection, supra note 84, at 355-57. Without the use of carefully-controlled comparison groups, researchers and others may attribute superiority to a program that has demonstrated positive gains in the target population over time, when those gains may not, in fact, be superior to those obtained with traditional interventions. For a discussion of the distinctions among predominant models of intensive family services, see Nelson, supra note 809, at 26-30; Beth A. Stroul, Home-Based Services, 1 COMMUNITY-BASED SERVICES FOR CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY-DISTURBED (Oct. 1988).
Ideally, even with this population, it is best not to abandon the preference for a family-based or home-based intervention strategy, even if the child must spend some time, or perhaps the remainder of her minority, in a setting other than her parents’ home. Several alternatives hold promise in such situations: Multisystemic or Wraparound treatment provided within the context of “kinship care,” Therapeutic Foster Care (also known as Multidimensional Treatment Foster Care) provided by non-relative or relative caregivers, and certain carefully-developed group care programs with demonstrated efficacy.

In recent years, the child welfare system has increasingly recognized the multiplicity of benefits of tapping the natural resources inherent in the extended families of children adjudicated as dependent. Kinship care relies on such family members when parents are unable or unwilling to provide safe and adequate home environments for their children. As an informal practice, primary care of children by extended family members, particularly grandparents, existed in many households long before the child welfare system began to formalize such arrangements. Estimates reported for 1994 indicate that 2.15 million children (approximately three percent of the nation’s children) live with relatives, primarily grandparents, without a parent present in the home. Most of these arrangements are informal; one study revealed that only 15.5 percent of these children were formally placed in relatives’ care through the child protection system. While kinship care as a formal alternative to either parental care or foster care placement with non-relatives in the context of child welfare intervention is not a panacea and certainly requires more study, the intuitive benefits of exploring such options seem clear. If kinship placements of troubled

837. See supra note 581.
838. See HARDEN ET AL., supra note 638, at 132-133; see also Moore v. City of East Cleveland, 431 U.S. 494, 504-05 (1977) (discussing the importance of extended family members in the upbringing of children in striking an ordinance that prohibited a grandmother from sharing a home with her adult son and two grandsons who were first cousins: “uncles, aunts, cousins, and especially grandparents sharing a household along with parents and children [is a tradition deserving] constitutional recognition”).
839. HARDEN ET AL., supra note 638.
840. Id.
841. For a discussion of the advantages, disadvantages, and risks of such placements, as well as of issues requiring further study, see, for example, Berrick, supra note 638, at 77-84; Geen, supra note 638, at 136-44. At the time of this writing, the Senate and House are considering bills that would provide: notice to relatives when a child is removed from parental custody; financial assistance to kinship foster caregivers; and grants to states study kinship foster care. See the Kinship Caregiver Support Act, S. 985, 109th Cong. (2005) and the Guardianship Assistance Promotion and Kinship Support Act, H.R. 3380, 109th Cong. (2005). For an incisive analysis of the “double-edged relationship” of kinship care to the child welfare system, see Roberts, Kinship Care, supra note 87,
and troublesome youth were supplemented by intensive intervention according to the principles guiding MST, as well as financial and other supports generally provided to foster parents, extended family members might be able to provide adequate home-based care for troubled and troublesome youth in some instances.

Finally, Therapeutic Foster Care provides an alternative to institutionalization for children who cannot live with their parents. This program has been implemented with samples referred from the juvenile justice, child welfare, and mental health systems. Research indicates its efficacy in improving functioning in a range of spheres, also reducing the number of subsequent institutional placements. In fact, a Task Force of the Centers for Disease Control has recommended adoption of Therapeutic Foster Care in a range of contexts as a way of preventing community violence. While some reviewers suggest that treatment effects may not be sustained over time, the Surgeon General’s Report evaluated the research findings quite positively, noting that “studies of treatment effectiveness showed that youths in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior. In addition, gains were sustained for some time [i.e., at a two-year follow-up] after leaving the therapeutic foster home.” Some researchers emphasize cost savings as well, in comparison to more restrictive interventions.

While the therapeutic foster care model is grounded on the same premises as generic foster care—that is, that youth removed from their

at 1622, 1642 (arguing that formal kinship foster care “exacts a high price for state assistance” in that it forces parents to relinquish custody of their children and submit to state supervision in order to obtain governmental aid).

842. See, e.g., Stephanie A. Shepard & Patricia Chamberlain, The Oregon Multidimensional Treatment Foster Care Model: Research, Community Applications, and Future Directions, in OUTCOMES FOR CHILDREN AND YOUTH, supra note 827, at 551; Patricia Chamberlain & John B. Reid, Comparison of Two Community Alternatives to Incarceration for Chronic Juvenile Offenders, 66 J. CONSULTING & CLIN. PSYCHOL. 624, 625 (1998). For more information about this model and its efficacy, see PATRICIA CHAMBERLAIN, TREATING CHRONIC JUVENILE OFFENDERS: ADVANCES MADE THROUGH THE OREGON MULTIDIMENSIONAL TREATMENT FOSTER CARE MODEL (2003); Beth A. Stroul, Therapeutic Foster Care, in 3 COMMUNITY-BASED SERVICES FOR CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY-DISTURBED (Sept. 1989).

homes will fare better if placed in a substitute family context than in an institution—Therapeutic Foster Care places a far greater premium on the training and special skills of those adults serving as the foster parents than does the traditional model. Like the other programs discussed above, however, the Therapeutic Foster Care model is grounded in social-ecological principles, and works with the child within each of the relevant social contexts, including attempts to improve the family situation. Whether improvement of the family situation occurs with the goal of the child’s eventual return home, or with the goal of promoting a positive non-custodial relationship between the child and parent, this orientation recognizes that families continue to influence children’s development even after day-to-day contact is severed or curtailed. It is therefore logical that this model could be applied in the context of kinship foster care. In other words, the non-parent caregivers are relatives rather than non-relatives, but otherwise all of the dimensions of the formal Therapeutic Foster Care model are unchanged. Clearly, future research is needed to address the promise of a range of variations on these models.

c. Intervening Early

The preceding types of interventions focus on the troubled and troublesome youth who are at risk of out-of-home placement, as well as many youth who are excluded from my definition of troubled and troublesome because they are serious or violent juvenile offenders. But, what of youth and families whose problems are less serious, at least initially? Early intervention provides the greatest likelihood of the most positive long-term outcomes for children and families, as well as the greatest cost-savings. Prevention programs, such as home visitation programs, appear to reduce the development of the types of individual and family dysfunction that lead to out-of-home placements for children. Furthermore, empirical research indicates that children

848. See Chamberlain, supra note 842, at 69-83; Shepard & Chamberlain, supra note 842, at 551-54.
849. See supra note 804 and accompanying text.
850. See supra Part III.
852. Despite several decades of urging by medical, mental health, and public health experts, policymakers and private insurers have failed to implement home-visitation programs. Council on Child and Adolescent Health, Am. Acad. of Pediatrics, The Role of Home-Visitation Programs in
experience long-term neurological effects from exposure to deleterious circumstances and experiences, and that early intervention, prevention-oriented, and family and individual health-promotion approaches are most likely to enhance children’s long-term social, emotional, and intellectual functioning.\textsuperscript{853}

\textbf{D. Addressing “Stigma”}

The Surgeon General’s Report identified “stigma” (that is, “prejudice and discrimination, fear, distrust, and stereotyping”) as a serious obstacle to the success of mental health initiatives.\textsuperscript{854} Children who become involved in the juvenile justice system are also subjects of negative stereotypes.\textsuperscript{855} Public education initiatives may help change such community attitudes.\textsuperscript{856} The most powerful weapon against such attitudes, however, is widespread availability of appropriate community-based resources for troubled and troublesome youth. The integrationist philosophy underlying statutes such as the ADA asserts that stigma results, in part, from policies of isolation and segregation that


\textsuperscript{853}. \textit{See, e.g., COMM. ON INTEGRATING THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT, NAT’L COUNCIL & INST. OF MEDICINE, FROM NEURONS TO NEIGHBORHOODS: THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT} (Jack P. Shonkoff & Deborah A. Phillips eds., 2000); \textit{COMM. ON PREVENTION OF MENTAL DISORDERS, INST. OF MEDICINE, REDUCING RISKS FOR MENTAL DISORDERS: FRONTIERS FOR PREVENTIVE INTERVENTION RESEARCH} (Patricia J. Mrazek & Robert J. Haggerty eds., 1994); \textit{6 PRIMARY PREVENTION WORKS: ISSUES IN CHILDREN’S AND FAMILIES’ LIVES} (George W. Albee & Thomas P. Gullotta eds., 1997); \textit{INVESTING IN CHILDREN, YOUTH, FAMILIES, AND COMMUNITIES} (Kenneth I. Maton et al. eds., 2004).

\textsuperscript{854}. \textit{SURGEON GENERAL’S REPORT, supra note 22, at 454 & 6-9; see also President’s New Freedom Commission, supra note 22, at 4 (“Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness”).}

\textsuperscript{855}. Elizabeth S. Scott & Laurence Steinberg, \textit{Blaming Youth}, 81 TEX. L. REV. 799, 806-11 (2003) (referring to perceptions of juvenile offenders as “superpredators” and contemporary juvenile justice policy as a response to “moral panic” not justified by the reality of the public threat).

\textsuperscript{856}. \textit{SURGEON GENERAL’S REPORT, supra note 22, at 9, 454; see also President’s New Freedom Commission, supra note 22, at 23 (asserting that public awareness education, including media initiatives may be helpful in reducing stigma).
communicate to the public that persons removed from the mainstream are unfit for community life.\textsuperscript{857} Fears and prejudices are permitted to flourish in the absence of real-life opportunities to interact with those who are removed from public view.\textsuperscript{858} Ineffective interventions also fuel such negative perceptions because the stigmatized individuals appear resistant or unresponsive to society’s attempts to help or change them. Furthermore, to the extent that the manifestations of troubled and troublesome youth’s difficulties (that is, their “symptoms” or conduct) fuel negative public attitudes, the remediation of those problems with effective interventions may allay such concerns. Clearly, society’s resistance to having these youth within its communities must be acknowledged and confronted if policies of the types proposed in this Article are to succeed.

\textbf{E. Financing the Reforms}

Readers who have made it through this lengthy Article may find these ideas interesting, but impractical in light of the current political climate in which human service expenditures are constricting rather than expanding. Thus, one should consider the possibility that implementation of the proposals articulated here will save, rather than increase, costs. The measurement of cost-effectiveness of interventions with children (and others) can proceed with any of a variety of premises.\textsuperscript{859} First, one can simply compare the program expenditures encountered in providing services with one type of intervention versus another. Along these lines, evaluations of the effectiveness and cost-efficacy of the various programs discussed immediately above reveal that the provision of the initial services leads to cost savings over traditional interventions. This makes sense when we remember that once

\textsuperscript{857} See supra Part V.D.

\textsuperscript{858} The President’s New Freedom Commission cites research findings as demonstrating that one of the most effective ways to combat stigma against those with mental disorders is personal contact between those individuals and others. See President’s New Freedom Comm’n, supra note 22, at 23.

a child is removed from the home, governmental interventions become quite expensive.

Second, if these programs are more effective in achieving their goals than are traditional interventions, the cost savings will proliferate as we consider the expense of future services necessitated by the ineffectiveness of traditional interventions. Lower 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 so on result in overall cost-savings.

Third, the higher the adaptive functioning of these youth, the lower the cost to society over the long haul, not only from a reduced need for governmental intervention, but from avoidance of a range of corollary expenses such as losses experienced by victims of crime, burdens on family members of these children, and avoidance of the maladaptive and destructive functioning of the adults these children will eventually become. The "payback" to society is likely to be dramatic when one contrasts, for example, the costs of having a law-abiding member of society versus one who violates the law, or the costs of having an individual who is productive and makes constructive contributions to her family's and community's financial lives versus one who is disabled by mental disorder and perpetually dependent on others for the basics of survival.

Recent studies conducted at the Harvard University School of Public Health, in collaboration with the World Health Organization and World Bank, have developed measures of the "global burden of disease," and have found that mental disorders account for a substantial component of disability-related burden of diseases. WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2001: MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE 25, box 2.2 (2001) (citing the work of researchers Christopher J. I. Murray and Alan D. Lopez, e.g., THE GLOBAL BURDEN OF DISEASE: A COMPREHENSIVE ASSESSMENT OF MORTALITY AND DISABILITY FROM DISEASES, INJURIES, AND RISK FACTORS IN 1990 AND PROJECTED TO 2020 (GLOBAL BURDEN OF DISEASE AND INJURY SERIES, VOL. I) (1996)). Mental disorders accounted for over 35% of the "years lived with disability" for persons in the age range of 15 to 44 years. Id. at 28, fig.2.3. These studies do take into account the financial burden on family members who must forego or limit income-producing employment, as well as missed employment opportunities of the disabled individual.

For analysis of the costs and benefits of various intervention programs for youth that take into account the larger benefits to society of successful interventions with children, see, for example, KAROLY, supra note 851; Juvenile Justice Evaluation Center, Cost-Benefit Analysis for Juvenile Justice Programs (May 2002), available at http://www.jrsa.org/jjec/about/publications/cost-benefit.pdf; Arthur J. Reynolds, et al., Paths of Effects of Early Childhood Intervention on Education Attainment and Delinquency: A Confirmatory Analysis of the Chicago Child-Parent Centers, 75 CHILD DEV. 1299 (2004); KAY JOHNSON ET AL., NAT'L CTR. FOR CHILDREN IN POVERTY, MAKING DOLLARS FOLLOW SENSE: FINANCING EARLY CHILDHOOD MENTAL HEALTH SERVICES TO PROMOTE HEALTHY SOCIAL AND EMOTIONAL DEVELOPMENT IN YOUNG CHILDREN, PROMOTING THE EMOTIONAL WELL-BEING OF CHILDREN...

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As for some of the other elements of the proposal: It is possible that the staffing of the Multisystem Office and the Triage Center can be implemented through shuffling of existing staff lines. While some staff may be replaced, others may be retrained. Training expenses as well are likely to be recouped fairly quickly in the renovated network of systems. It is possible that it will take time for savings to be realized. Early intervention and prevention programs will not have immediate cost savings. Furthermore, staff training must precede the system changes, and the positive mandate to develop and implement a broad spectrum of community-based and home-based approaches must precede the negative mandate to reduce institutional admission and residence counts.

The literature contains suggestions for addressing the challenges of funding these new services in a system that allows seamless intersystem boundary-crossings. For a discussion of some these financing strategies, see Judith C. Meyers, Financing Strategies to Support Innovations in Service Delivery to Children, 23 (Supp) J. CLIN. CHILD PSYCHOL. 48 (1994); Friedman, supra note 811, at 42-44; Lenore B. Behar, State-Level Policies in Children's Mental Health. An Example of System Building and Refinancing, in CHILDREN'S MENTAL HEALTH, supra note 820, at 21; Bruce J. Kamradt, Blending Funding Streams to Support System of Care Reform. 7 BEHAV. HEALTH TOMORROW 41 (1998); Bruce Kamradt, National Center for Mental Health and Juvenile Justice, Funding Mental Health Services for Youth in the Juvenile Justice System: Challenges and Opportunities (Dec. 2002).

See supra notes 259, 307.

See summary by the SURGEON GENERAL'S REPORT, supra note 22, at 182-83, 423-39.
Returning to the proverb with which I began this Article—"plus ça change, plus c'est la même chose"—much has changed over this century in our nation's responses to troubled and troublesome youth, and yet, much has stayed the same. Despite many cycles of reform aimed at the mental health, juvenile justice, and child welfare systems, we have not yet achieved most of the underlying goals articulated by these reform movements. The findings of recent governmental investigations that thousands of children for whom mental health services are sought are placed out of their homes under the auspices of the child welfare or juvenile justice systems illustrate that, depending upon the dominant constellation of legal policies, economic incentives, and social attitudes, the flow of children from one set of child care and control institutions to the others can occur in any of several possible directions. Policy responses that do not recognize this phenomenon are unlikely to have long-term success. Furthermore, policy 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. A troubled and troublesome child must learn how to live in the family and the community, and the family and community must learn how to incorporate the child within their midst.

The insights and recommendations emerging from the most recent cycle of government-sponsored reports and investigations are generally sensible and progressive. Yet, there is little indication that federal and state policymakers are planning to respond by enacting sweeping reforms. While establishing commissions, producing reports, conducting investigations, and holding hearings can be the first steps in shaping important changes in policy, these pursuits can also deflect attention from governmental inaction at a time when there is no genuine commitment to achieving real change. This leads us to one more step that is crucial to an effective and coordinated response to troubled and troublesome youth that is consistent with our society's core values. In the final analysis, none of the reforms addressed here will be possible without a financial investment in children.

865. See, e.g., supra note 22.
866. For example, President Bush's New Freedom Commission was instructed to "focus on those policies that maximize the utility of existing resources." See John K. Iglehart, The Mental Health Maze and the Call for Transformation, 350 NEW ENG. J. MED. 507, 508 (2004) (quoting Executive Order 13263 of April 29, 2002: President's New Freedom Comm'n on Mental Health, 67 FED. REG. 22337-8 (2002)). In other words, there are unlikely to be any new appropriations to implement the Commission's findings.
As noted above, it is highly likely that implementation of the innovative service models discussed here will result in direct and indirect cost savings by government and private parties. Yet even if these innovative interventions are cost-neutral, there is clearly added value in reducing the suffering of those engaging in troubled and troublesome behavior, of their families, and of those who would otherwise cope with the short- and long-term societal impact of these children’s difficulties. It is appropriate to return to the language in the frequently-cited 1944 Supreme Court case of *Prince v. Massachusetts*: “A democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies.”867 It is vital to our nation’s future, and to the future of all of us, that we maximize each child’s opportunity to develop into a well-adjusted, contributing member of society. In the final analysis, however, we must acknowledge the importance of investing in this nation’s children, so as to secure the future well-being not only of these children, their families, their offspring, and the like, but also the future well-being of all of us in this nation.868