

Representing Institutionalized Children: Issues and Strategies for Protection and Advocacy
Agencies

Prepared for ATTAC of NAPAS

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Representing Institutionalized Children: Issues and Strategies for Protection and Advocacy Agencies

I.

Introduction

Institutionalized children and adolescents with disabilities are among the most forsaken and forgotten individuals in our society. Like adults who are confined, they are deprived of their liberty, their friends, their families and their community. Unlike adults, they are denied educational opportunities and the formative social and developmental experiences that are part of going to school and of growing up. Their age, their lack of experience, their level of maturity and their vulnerability combine to intensify the institutional experience. Ironically, the law often provides them with less protection from harm and guarantees them fewer substantive and procedural rights than are afforded to institutionalized adults. (See footnote 1) Regrettably, institutionalized children and adolescents are among the “most underrepresented of individuals,” (See footnote 2) thereby exacerbating the problems which are inherent to their institutionalization.

Protection and Advocacy organizations, which have a strong tradition of representing students with disabilities in special education cases, are increasingly asserting an interest in representing institutionalized youth. (See footnote 3) However, the inherent character and customs of juvenile institutions, their treatment (or correctional) paradigms, the fact that the law delegates most of a minor's decision making authority to adults, and the ethical difficulties intrinsic to the representation of minors, (See footnote 4) can make the provision of legal services to institutionalized youth a difficult affair. This paper, intended as a guide for P&A staff, will address some of the most significant issues which may arise as a P&A first seeks access to facilities and then, once access has been accomplished, when the P&A staff undertake the demanding job of advocating for children and adolescents.

A. Types of institutions

Children in America are held in an impressive array of institutional (See footnote 5) models. The most common, for purposes of this memorandum, are psychiatric hospitals, psychiatric wards and units for children and adolescents, juvenile correctional facilities and juvenile detention facilities. Of course, minors are also held in adult hospitals and, increasingly, in adult jails and prisons (See footnote 6) and some children with mental disabilities are even kept on medical units of hospitals. (See footnote 7)

Numerous commentators and the popular press have lamented a recent significant rise in the admission of youth to mental hospitals. (See footnote 8) On average, children stay in mental hospitals longer than adults and, indeed, some believe the federal payment formulas encourage longer stays. (See footnote 9)

Although we do not specifically address representation of minors in adult facilities,

many of the issues discussed are equally problems in those facilities. Likewise, although we do not specifically discuss “residential schools” which house special education students, many such schools have some, even many, of the characteristics of institutions and the legal issues facing students and their advocates are analogous to those we will discuss. (See footnote 10)

In the following sections we will distinguish where necessary between hospitals and “juvenile justice facilities.” By hospitals we mean both private and public facilities whether they are freestanding or are units or wards of general hospitals. Most of the information and suggestions regarding “hospitals” will also apply to restrictive, that is “secure,” (See footnote 11) community-based mental health or mental disability programs.

Juvenile justice facilities, which house children without disabilities as well as those with disabilities, include detention centers (usually used to denote places where children are kept prior to adjudication) and post-adjudication treatment programs or correctional centers. The latter programs may have any one of a variety of names, for instance “secure treatment program,” “juvenile hall,” or “juvenile correction center.” Except where necessary, we do not distinguish between adjudicated delinquents and status offenders. (See footnote 12)

Throughout this paper we keep in mind that the juvenile justice system, despite popular myth, is hardly coddling youth. One recent article notes:

As tempting as it would be to think that draconian sentences for children are part of a bygone era, children today are still threatened by severe and disproportionate sanctions. For example, the *New York Times* reported that a young boy in Louisiana was sentenced to serve five years in a training school for fishing without a license. A Department of Justice investigation of Georgia's juvenile justice system in 1997 revealed that extremely young children were frequently jailed or detained. In one instance, a small eleven-year-old boy was detained for threatening his fifth-grade teacher, while in another instance a twelve-year-old boy with a seizure disorder was incarcerated for making a harassing phone call. In Michigan, incarcerated children were sent to out-of-state facilities as far away as Colorado and Pennsylvania, without notice to their parents. (See footnote 13)

The horrendous events at Littleton, Colorado are not likely to decrease the calls to “get tough” on juvenile crime, on students or on juvenile offenders.

II.

Access Issues

A. Generally

The Center for Public Representation has drafted an annotated model access agreement for ATTAC of NAPAS for use by P&As seeking to represent clients in facilities which serve children and adolescents. Some of the material in this section appears in slightly different form in the annotations to that document. The model access agreement also discusses in more detail than is possible here discrete access issues. P&A staff are encouraged to consult the model agreement as well as this issues paper when confronted with questions about the right to access to facilities, clients and records. ATTAC's Protection and Advocacy System Access Manual: Authority to Access facilities that Serve People with Disabilities, Facility Residents and

Records (ATTAC 1996)(“*Access Manual*”) is also a very helpful, comprehensive and periodically updated resource.

B.

Access to facilities

There can be no debate that if all other eligibility requirements are met, P&As may represent minors. The regulations governing the PAIMI program make no reference to age in the definition of the eligible clients. However, an “individual with mental illness” includes someone with a “significant...emotional impairment.” [\(See footnote 14\)](#) “Emotional impairment” is a term often used to describe a mental disability, other than, for example, mental retardation, in a minor. Also, the facility access provision regarding private meetings with residents of facilities, includes the statement that “[r]esidents include minors...” [\(See footnote 15\)](#) “Juvenile detention facilities” are listed in the definition of “facility.” [\(See footnote 16\)](#) Also, the preamble to the PAIMI regulations, [\(See footnote 17\)](#) makes repeated reference to children and adolescents as the potential clients of the P&A. At least two courts have had no difficulty finding that a P&A may represent minors. [\(See footnote 18\)](#) The regulations governing the PADD program also make no reference to age in the definition of the eligible clients. However, “juvenile detention facilities” are included in the definition of “facility.” [\(See footnote 19\)](#)

Most P&As and nearly all facility administrators prefer to have written agreements about the process of regular or periodic access by P&A staff. Some P&As have negotiated such agreements with government oversight and funding agencies and may also want to consider negotiating agreements with trade organizations which represent privately operated facilities. For example, the Center for Public Representation has an access agreement which applies to all members of an association which represents private free standing mental hospitals.

P&A staff should approach access negotiations from a position of strength. The statutes, regulation and case law provide powerful authority and support. [\(See footnote 20\)](#) Indeed, some P&As are graced by state laws which provide more even more authority to the than is afforded by federal law. These, and the ultimate threat of a lawsuit, can be potent ammunition in access negotiations. On the other hand, P&As should be cognizant of the concerns (both legitimate and imagined) of facility management. A willingness to compromise and make some reasonable concessions to facility routine and custom may alleviate the need for litigation [\(See footnote 21\)](#) and is likely to make the relationship more comfortable.

The Center for Public Representation has found that over time many restrictive protocols demanded by facilities simply melt away as the facility staff become accustomed to the presence of advocates and discover that some level of cooperation is in everyone's interest. [\(See footnote 22\)](#) Similarly, if agreements, or at least of those parts which restrict access, are periodically reviewed, there is often a softening of resistance, based on experience.

Also, of particular relevance to facilities holding children, for purposes of P&A access, it is not necessary that the primary purpose of the facility be to treat minors with mental illness or developmental disabilities or that all the residents of the facility be individuals with a mental or developmental disability. In *Michigan Protection & Advocacy Services, Inc.*, the defendant, trying to fence out MPAS, argued that because the “main” purpose of its facilities was to

provided education and rehabilitation, not treatment, the PAIMI access provisions did not apply. The Court disagreed. (See footnote 23)

Similarly, P&As should negotiate for access to the entire facility and resist any attempt to limit access to specific areas. The PAIMI statute supports this position. (See footnote 24) Nevertheless, particularly in juvenile justice centers, the facility will want to confine access only to common or administrative areas. The facility will almost certainly cite to security needs and concerns about the P&A staff's safety. Some facilities may also claim that it is a violation of the residents' privacy for P&A staff to visit them in their "living quarters." P&As should acknowledge the security concerns where appropriate. However, the statute and regulation do not make exceptions for "correctional" or detention facilities. Therefore, although some compromise to legitimate security concerns may be appropriate, the P&A should stand firm in its insistence that it have access to all areas of the facility to which the residents have access.

C.

Access to clients

P&A staff have a right to have unaccompanied access to residents, which includes the opportunity to meet and communicate privately with them, both formally and informally, by telephone, mail and in person. (See footnote 25) The right of informal access applies to all residents of a facility, including those who may eventually be found not to meet the P&A eligibility criteria. Permission of a parent or guardian of a resident is not necessary for P&A staff to meet informally with any resident (See footnote 26) or to meet with a resident in the course of a full investigation. (See footnote 27) However, the P&A staff must honor a resident's request to terminate an interview. (See footnote 28) A request to terminate an interview should not mean, however, that the P&A never again approaches the individual. Most advocates have worked with clients who will not talk with them one day, but welcome a respectful approach on the next.

The regulations require the P&A to make an effort to ensure that the parents and guardians of residents are informed that the P&A will be monitoring activities at the facility and may in the course of such monitoring have access to the residents. The facilities should provide reasonable assistance to the P&A to so notify parents and guardians. The PAIMI regulations offer no guidance to P&As as to how to carry out the notification mandate. The task will be considerably easier if the P&A is able to secure some cooperation from the facility. For example, the facility might be willing to enclose a P&A brochure in the information packet provided to parents upon admission of their child. Such notice may result in calls from parents and guardians for assistance.

Although a P&A may meet informally with a resident, except in an emergency as defined in the applicable regulations, P&A staff may take no "formal" action on behalf of the resident or initiate a formal attorney-client or advocate-client relationship without appropriate consent. (See footnote 29) The provision is problematic and warrants some extended discussion here.

1.

Guardians include parents

Both the PAIMI and PADD regulation define “guardian” and the definitions are similar, though not identical. (See footnote 30) In brief, a legal guardian is an individual who is appointed by appropriate state powers to be a legal guardian for an individual and who has the authority to consent to health and mental health care or treatment for the individual with mental illness. The Center for Mental Health Services (CMHS) says that “natural or adoptive parents are legal guardians unless the State has appointed another legal guardian under applicable State law.” (See footnote 31) The Supreme Court has held that, at least in the context of admitting children to mental hospitals, the law will assume that the child's parents will act in the child's best interest. (See footnote 32)

There is no mention of “mature minor” or “emancipated minor” in either set of regulations. Some states have processes through which an adolescent may be emancipated. In other states minors may be considered “mature” for certain purposes – particularly to make decisions about health care. (See footnote 33) P&A staff should be aware of the mature minor law in their state. It may be possible to assert that a particular adolescent is “emancipated” and, therefore, can make certain decisions, including to enter into an attorney–client relationship. In such cases, the “appropriate consent” referred to in the regulations may be the minor's consent.

2.

When a state agency is the guardian

Some P&A staff have found it singularly challenging to obtain access to and to represent minors who under guardianship of a state agency. If the agency is recalcitrant, the P&A should look to the federal regulation and to state law for assistance. (At least in the sections regarding access to records, both the PAIMI and DD regulations appear to at least acknowledge the potential difficulties when a state agency is the guardian. (See footnote 34))

In cases in which the guardian is “an official[] responsible for the provision of health or mental health services” to the individual, the guardian is not a “guardian” for the purposes of the regulations. (See footnote 35) Therefore, if the state agency with guardianship is also the agency which is responsible to provide mental health or habilitation services, it may be permissible for the P&A to proceed as if the agency is not the guardian. Local statutory schemes may be helpful in making an argument, if necessary, that an agency is not a guardian within the meaning of the federal regulations. This argument may be unavailing in states in which one agency is a custodial agency, but another provides services. For example, in Massachusetts, the children services agency, the Department of Social Services, may be the court appointed legal custodian of a youth, but the Department of Mental Health may be responsible for providing mental health services in one of its programs or facilities. Also, P&As should keep in mind that CMHS has said that it does not intend for its regulation “to supercede State laws regarding which agency may appoint and review guardianships nor will [CMHS] mandate for States whom they shall name as guardian.” (See footnote 36)

3.

When a P&A may take formal action without consent of the parent or guardian.

In non–emergency situations the P&A may not take formal action on behalf of a

minor without “appropriate consent.” Except, perhaps, in the cases of emancipated minors or when the minor is in the guardianship of the state agency providing health or mental health services, in non-emergency situations that must mean the consent of a parent or guardian is necessary.

The preliminary draft of the PAIMI regulations was widely interpreted to forbid representation in all cases without a parent or guardian's permission. The preamble to the final regulations indicates that “many respondents” complained about that provision and, consequently, CMHS made some revisions. The essence of the revision is that the PAIMI program may act formally in certain emergency situations, if particular protocols are followed. (See footnote 37)

The relevant section, § 51.42(e), does not define an “emergency,” but instead refers back to § 51.41(b)(3), a provision that pertains to record access. That section allows P&A access to records of a person with a guardian under the following circumstances:

.
a complaint or report has been received by the PAIMI; *and*

.
the PAIMI has determined that there is probable cause to believe that the health or safety of the individual is in serious and immediate jeopardy; *and all of the following conditions also exist,*

.
the PAIMI has made a “good faith effort” to contact the guardian; *and*

.
the PAIMI has made a “good faith effort” to offer assistance to the guardian to resolve the situation; *and,*

.
the guardian has failed or refused to act on behalf of the individual.

Many adolescents and children whom P&A staff will meet informally will be in conflict with their care providers and, sometimes, with their parents or guardians as well. Even when the child and her parents are not in conflict, the parents may be understandably reluctant to authorize the P&A to advocate against a program which is providing care and treatment. In such situations, if the PAIMI program is to take some formal action, it will need to determine either that the minor has the legal capacity to consent or that an emergency situation exists.

Some complaints (ongoing abuse, failure to provide necessary medical care or unjustified restraint, for example) will obviously implicate an immediate risk to the minor's health or safety. A majority of the complaints which young people will bring to the attention of

a P&A staff person will not so clearly rise to the level of immediately jeopardizing health or safety. For example, complaints about access to reading materials or visitation rights may implicate important legal rights, but probably will not create an immediate threat to health or safety. Some complaints, perhaps most obviously requests from a minor for assistance in securing her discharge, will necessitate the careful exercise of the P&A's judgement in considering whether to find probable cause. The regulatory prerequisites to the provision of formal assistance or representation to minors when the parents or guardians refuse to consent or fail to respond are strict and should be carefully considered and observed.

4.

Whom does the P&A actually represent?

P&As should have policies on the representation of minors which are consistent with the federal regulation and with local ethical rules. (See footnote 38) The role of counsel in representing minors is discussed in more detail later in this memorandum. (See footnote 39)

Most P&As have a strong, if sometimes unwritten, policy that the agency's representational loyalty is to the minor, not to the parent or guardian. That loyalty will not create any problem if and as long as the goals of the minor and the parent are the same. Since the goals may diverge, however, it is crucial that the policy be made clear to the parent or guardian at intake, when a retainer is signed, and throughout the course of representation.

The PAIMI regulations require that the P&A, "consistent with State and Federal laws and canons of professional responsibility," involve family members "as appropriate" in the dispute resolution process. (See footnote 40)

5.

Meeting with clients on restrictions or in restraint.

P&A staff should insist that they may meet with residents who require 1:1 supervision and with residents in restraint. Interviewing residents who are subject to some sort of increased supervision or who are secluded or restrained is often difficult. While such access is essential, it is important to recognize what may be the facility's legitimate concerns about supervision and safety. The Center for Public Representation has always insisted that it has the right to speak with people in restraint, although we usually agree not to do so until the person has "quieted down." At Bridgewater State Hospital, a penal facility which has a discrete unit for residents in restraint, we have regular "office hours" in the unit. Occasionally, we have timed the office hours to coincide with the physician's "rounds." This enables our advocate to press the doctor to order that a client be released from restraints. At Bridgewater we speak to the client through the food tray opening in the door. At most state hospitals, we enter the restraint room.

On some few occasions, particularly when interviewing residents on close observation status, the P&A may have to agree to sacrifice some degree of privacy to enable the interview to happen at all. In adolescent facilities, when "room plans" are common, P&A staff should insist on the right to interview the youth in his or her room, with the greatest degree of privacy possible.

D.

Access to Records

1.

Generally

P&As have access to records of residents of facilities. (See footnote 41) The regulations implementing the PAIMI and DD Acts provide that access is not available to records, however, do not include records produced by medical care evaluation or peer review committees to the extent that such records are protected by state law. (See footnote 42)

Record access in juvenile facilities is complicated by the fact that most residents may not have the legal capacity to provide the P&A with consent to have access to the record. Many states and facilities will not recognize the right of a minor to authorize access to his or her records. Some state laws provide limited rights to older minors and those rights may expressly or implicitly include the right to authorize access to records. For example, Massachusetts law allows a person over 16 to sign in to or out of a mental hospital. Advocates have argued that if the youth is old enough to sign herself out, she is old enough to allow access to her record. A release from an emancipated or mature minor may also be sufficient if such concepts are recognized by state law. Some states have laws which provide more access to records than the P&A Acts. Many P&As seek authorization from the minor as well as the guardian as a matter of respect to the minor.

The regulations state that the P&A is entitled to be provided with reasonably prompt access to the records of

any resident if the parent or legal guardian or other legal representative of the resident has authorized such access;

any resident (including a resident who has died or whose whereabouts are unknown), who is without a parent or guardian or whose guardian is the state or one of its political subdivisions, with respect to whom a complaint has been received by the P&A or with respect to whom, as a result of monitoring or other activities there is probable cause to believe that such individual has been subject to abuse or neglect; (See footnote 43)

any resident who has a parent or guardian with respect to whom a complaint has been received by the P&A or with respect to whom there is probable cause to believe the health or safety of the resident is in serious and immediate jeopardy, the P&A has made a good faith effort to contact the parent or guardian, and where the P&A has made a

good faith effort to offer assistance to the parent or guardian to resolve the situation, and the parent or guardian has failed or refused to act on behalf of the resident. (See footnote 44)

Determining what happens when a minor consents to release of the records, but her guardian refuses and the case does not reach the threshold of an emergency, is difficult. In interpreting the D.D. Act's records access provisions, in a dispute involving an adult, the West Virginia Supreme Court of Appeals (See footnote 45) began with the premise that

there is no statutory requirement that if a disabled individual has a legal guardian or conservator, that the [P&A] system must first obtain the consent of said guardian or conservator prior to accessing the requested records or that the system must obtain the guardian's or conservator's consent in addition to the disabled person's consent prior to accessing the records. See 42 U.S.C. § 6042(a)(2)(I)(i).

The court held that the appointment of a guardian did not of itself render an adult incapable to consent to release of his records and noted the strong preference in the D.D. Act that, to the maximum extent feasible, individuals with disabilities should be afforded the opportunity to make their own decisions. The court remanded the case to the trial court for a determination whether the individual had the capacity to consent to the release of his records to the P&A.

If the court's analysis is correct, in non-emergency situations, where there is a dispute between the minor and his parent or guardian about the release of records to the P&A, it may be necessary to have a court determine if the minor has the level of capacity and understanding to authorize access. If the minor has a guardian, presumably a petition or motion seeking instructions to the guardian could be filed in the court which appointed and supervises the fiduciary. If it is apparent who is blocking access, however, it might be necessary to seek declaratory or injunctive relief in a case against the parent. Such an action would necessarily be undertaken only after careful thought and consideration.

2.

What can a P&A do with the record once it gets it?

Just what a P&A can do with a record once it has received it is not always entirely clear. There are restrictions which appear designed, first, to protect client privacy by ensuring P&As do not recklessly disclose confidential information and, second, to shield individuals from whatever harm may befall them if they know what has been written about them or others in their record. Since privacy concerns and, particularly, fears about the potential for harmful disclosure are likely to be more overt in juvenile facilities, these restrictions may present serious problems for P&A staff seeking to represent children and adolescents.

To begin with, the statutes and regulations require P&As to treat records with the same level of privacy that applies to the record-providing agency. (See footnote 46) Some states have statutes which restrict the right of mental health consumers to have access to their own records. Massachusetts and Florida (See footnote 47) have such laws. Ironically, in Massachusetts, a person who has been denied access to her mental health records may authorize an attorney to have access. If the attorney is not affiliated with the Massachusetts P&A, the

attorney may then give the record to the individual. But, if the attorney is a P&A employee, she may not share the record because of the provisions of the PAIMI regulations. Similar problems may exist in other states.

Also, the regulations allow the mental health professional responsible for supervising the mental health services to a resident to provide the P&A, at the same time as access to the records is granted, a written determination that the disclosure of such information to the resident would be detrimental to the resident's health. In such cases, the P&A may disclose such information to the resident only upon the determination of another mental health professional that the disclosure of the information would not be detrimental to the resident's health. (See footnote 48) P&As which work regularly in juvenile facilities and which have no other right to access to records other than through the P&A statutes, may want to prepare for the eventuality that use limitations will be placed on the records.

III.

Representing Children and Adolescents – Ethical Issues

The ethical questions which arise in the representation of children are not new to P&A advocates. (See footnote 49) Particularly in cases in which the attorney is not court-appointed, perplexing questions arise: (See footnote 50)

.

How does one establish an attorney/client relationship with a minor?

.

When should the lawyer or advocate decide the goals of the representation and when should she defer to the child's decisions?

.

How can the attorney or advocate determine whether the child has the capacity to direct the representation?

.

How should the attorney or advocate proceed if the child is not capable to direct the representation?

.

How can the attorney or advocate effectively interview the child to ensure maximum participation?

P&A advocates need to resolve these questions both in order to effectively represent their minor clients and, not incidentally, to be able to respond to the inevitable challenges from others to that representation. Furthermore, P&A staff must come to their answers in the context of the P&A statutes and regulations.

A.

Representational models

Two basic representational models are familiar to disability advocates and have been debated for years. (See footnote 51) A familiar model — often called the “client autonomy” or “expressed wishes of the client” — is linked to our adversarial system of justice and sees the attorney as the “systemic promoter and facilitator of client autonomy.” (See footnote 52) Client autonomy is seen as a “fundamentally moral concept” because it promotes dignity and freedom, (See footnote 53) usually expressed as particularly high values in legal advocacy for people with disabilities. Because client autonomy has intrinsic worth, the attorney is absolved from the moral consequences of the client’s actions or the resolution of the dispute.

Disability advocates are familiar with this paradigm in, for example, the representation of a person with mental illness in the exercise of her right to refuse treatment with antipsychotic medication. The right itself has importance, (See footnote 54) as does the exercise of the right as an expression of the client’s autonomy, dignity and freedom to choose. That the outcome of the advocacy may be that the client’s right may be respected, but that her mental health may deteriorate or even that she may eventually be institutionalized, is of less consequence since the exercise of autonomy is a good in and of itself. (See footnote 55)

The other model — usually called the “best interest” or “attorney autonomy” model — accords the attorney “considerable autonomy over both the means chosen and the ends pursued on behalf of a client.” (See footnote 56) This model rejects the idea that a lawyer is merely a mouthpiece zealously advocating, without moral accountability, for a client’s wishes. Rather, its proponents argue, the lawyer has broader obligations including to “confront the client about the moral implications of the client’s actions and [to] actively seek justice by pursuing only those objectives deemed right and fair.” (See footnote 57) In the case of people with disabilities or minors, the proponents of this model may argue that the lawyer’s duty is to determine what is in the client’s “best interest” and to pursue that end, even if it varies from what the client says she wants. This is, of course, an inherently paternalistic model.

This model is also familiar to many disability advocates. Often we see it practiced by attorneys who represent our clients, for instance, in civil commitment cases, in which the attorney decides not to advocate for the client’s discharge, despite the client’s expressed wishes and even in the face of a weak case for the petitioner, in the belief that the individual will benefit from further hospitalization or that her plans upon discharge are “unrealistic.” (See footnote 58) Occasionally, the decision not to press for discharge is manifested in the lawyer’s feeble defense or in a manner, a metaphorical “wink” perhaps, which clearly conveys to the judge that

the lawyer is going through the motions for the client's benefit but that the court should not take the defense all that seriously.

B.

Competency

Both representational models, in their pure forms at least, have a serious limitation in their application to the representation of some people with disabilities and of many children — they assume a degree of competence on the part of the client. (See footnote 59) The person who is capable to make a choice is, in theory at least, an autonomous actor, able to exercise freedom. Indeed, the existence of a right may depend on the competence of the rights holder to compel others to perform some duty owed to the rights holder. (See footnote 60) Regardless which of the representation paradigms is adopted, therefore, there must be some initial determination of the child's capacity to make the choices which guide and inform the representation. Who, then, is to make that determination and how?

In some situations, state laws treat minors as adults — children 16 and over can decide to drop out of school in most states, children may be licensed hunters in some states, 16 is usually the age for a driver's license or learning permit, laws prohibiting minors from engaging in dangerous work often apply only to children under 16, and most states allow children over a certain age, perhaps 12 or 14, to nominate a guardian or state a preference in custody or visitation proceedings. States must provide procedures allowing a minor to show that she has sufficient maturity to consent to an abortion independent of the wishes of her parents or of the state. (See footnote 61) Increasingly, states consider children 14 and over to have sufficient competence to form the intent to commit serious crimes and, therefore, to be tried as adults. All of these activities and decisions would appear to be as serious as any involving the retaining of an attorney or the exercise of legal rights in a mental health program. (See footnote 62)

In the context of a P&A representation of an institutionalized child or adolescent, the decision about capacity will usually default to the advocate or attorney (See footnote 63) or to the child's "legal representative." (See footnote 64) Unlike adults, children are presumed to be incompetent. The determination whether a child client can overcome that presumption and be capable of making ultimate and important decisions about her own welfare may be a difficult matter. Although there is no generally accepted standard of child competence, there are some helpful guidelines and standards. However, their application may require the attorney to know more than a mere sampling of child developmental theory. (See footnote 65)

C.

Minors and contracts for legal services

Many courts have followed the Iowa Supreme Court's three prong test to determine when an attorney–adult client relationship has been established: first, when the person seeks advice; second, when the advice sought pertains to matters within the attorney's professional competence; and, third, when the attorney expressly or impliedly agrees to give the advice. (See footnote 66) The same formulation should probably apply to an attorney–child client relationship. Some courts have expressly recognized a minor's right to retain counsel. (See footnote 67) A few state bar ethics advisories have recognized a minor's right to control the course of representation. (See footnote 68)

Of course, although most states allow minors to contract, such contracts, often except those for “necessaries,” are voidable by the minor’s parents. (See footnote 69) “Necessaries” may include services “rendered in connection with the minor’s personal relief, protection or liberty.” (See footnote 70) Attorneys in states with similar statutory provisions may have an argument that a parent may not interfere with a legal services contract between a minor and an attorney. Furthermore, it may be unethical for an attorney to withdraw from representation of a client once representation has been undertaken if withdrawal will cause “material adverse effect on the interests of the client.” (See footnote 71)

Even if an argument that a minor has an independent right to retain counsel can be made under state law, P&A advocates will be confronted with the restrictions in the P&A statutes and regulations. (See footnote 72) Given the attorney’s ethical obligations, once a parent or guardian has consented to the attorney taking “formal action” on behalf of the child, it may be difficult for the parent to discharge the attorney. Indeed, the PAIMI regulations do give a nod to the rules of ethics, requiring the P&A, “consistent with State and Federal laws and canons of professional responsibility,” to involve family members “as appropriate” in mediation and other dispute resolution processes. (See footnote 73)

It is less clear, however, whether absent an emergency the P&A advocate can act in the first instance without consent of the legal representative.

D.

ABA Model Rules of Professional Conduct

Many states have adopted the ABA Model Rules of Professional Conduct. One of the most important of the rules for P&A advocates is Rule 1.14:

Rule 1.14 *Client Under a Disability*

(a) When a client’s ability to make adequately considered decisions in connection with the representation is impaired, whether because of abnormality, mental disability or some other reason, the lawyer shall as far as reasonable possible maintain a normal client–lawyer relationship with the client.

(b) A lawyer may seek the appointment of a guardian or take other protective action with respect to the client, only when the lawyer reasonably believes that the client cannot adequately act in the client’s own interest. (See footnote 74)

The commentary to the rules states that the fact of the client’s disability “does not diminish the lawyer’s obligation to treat the client with attention and respect.” (See footnote 75) If the client does not have a guardian, “the lawyer must often act as the de facto guardian,” and even where there is a legal representative, “the lawyer should ordinarily look to the representative for decisions,” but “should as far as possible accord the represented person the status of client, particularly in maintaining communication.” (See footnote 76) An attorney may also seek appointment of a guardian for her client if “it would serve the client’s best interest,” but must use “professional judgment” in evaluating whether such appointment might prove “expensive or traumatic” for the client. (See footnote 77)

Rule 1.14's approach has been both criticized and supported in the literature. (See footnote 78) Nearly all commentators agree, however, that the rule does not resolve many situations and difficulties that legal advocates for children with disabilities face in their day to day representation.

IV.

Interviewing Children and Adolescents

Children and adolescents are not adults. Although many of the basic rules of interviewing apply equally to adults and children, the P&A advocate should not forget that the child is less mature and may have less capacity and intellectual development than most adult clients. It is likely, for example, that a child will not have as clear an understanding of the legal system or of the lawyer's role as most adults. A child client may be more passive, more suggestible (See footnote 79) and less patient than other clients. The child's disability may add the difficulties of effective interviewing and counseling.

Emily Buss suggests that the hardest concept for the child to understand will not be that the lawyer wants to know what he or she thinks, but that the child's views will "amount to a direction of that lawyer's action." (See footnote 80) Not only is the advocate's role a mystery to some children, the advocate herself is almost always a stranger to the child. It is not unusual for the child client to distrust the advocate as just one more person who says she is there to help. Remember that many of the people whom the child may hold responsible for her incarceration or institutionalization also held themselves out as "wanting to help."

All meetings with child and adolescent clients, of course, should take place in as comfortable and confidential a setting as the institutional atmosphere will allow. Initial interviews should include a careful explanation of the lawyer's role and the rules of confidentiality. The P&A advocate should not assume that the client has an understanding of the process and should take care to explain it in as concrete terms as possible. The advocate should ask the client if she is taking medication and should take the possible effects of the medication into account throughout the course of the interview. (See footnote 81) Most advocates have learned that careful listening is the most important interview skill and sometimes the hardest. One cannot listen well if there is insufficient time. P&A advocates, despite the press of their work and the many demands on their time, must insure that there is sufficient time for each client meeting and interview. To elicit information, the attorney should ask simple and concrete questions and should avoid using legal and technical terms. Many institutionalized people will be surprised that anyone takes the time to listen carefully to them. Patience is most definitely a virtue. The advocate must be willing to work with the client to define the legal problem and seek a desired outcome. Several visits may be necessary to achieve this end. The advocate should advise the client of the potential consequences of the available choices, should feel free to advise about the wisdom of her choice and the possibility of success, without manipulating the discussion to insure the decision the advocate herself would make. (See footnote 82)

Interviewing young clients with disabilities takes care and skill. P&A advocates should approach this challenge with care and compassion.

V.

Working with Institutional Staff

The likelihood of successful advocacy for institutionalized children and adolescents is greatly enhanced if the P&A has a professional working relationship with the staff and management of the facility. However, as difficult as external advocacy may be in adult facilities the tensions between staff and advocates are likely to be even more pronounced in juvenile institutions. In part, this is because facility staff who might find an adversarial approach tolerable in an adult setting are extremely uncomfortable with it in a program serving children. Similarly, juvenile court lawyers have reported pressure from judges to repress adversarial tactics in that court. (See footnote 83) Paternalism, a belief that the staff know “what is best” for the child, and a fear that the child will be upset and may “act out” if she knows and tries to exercise her rights, all contribute to this attitude. Many advocates have had staff complain to them that “You come on the unit, tell kids their 'rights,' get them all worked up, and leave. We have to clean up the mess you started.”

It is important that advocates understand this perception and respond to it both by carefully counseling their clients and by taking opportunities to educate staff about the importance of legal rights.

Such “training” can take place on an individual to individual basis or by organized in-service training events. Some facilities welcome the opportunity to have an advocate come to a staff meeting to explain her role and responsibilities. Advocates should beware, however, that without proper planning, such session can turn adversarial and be counter-productive. The P&A program should ensure that the leadership of the facility will support the training effort and will help to maintain an atmosphere which encourages candid exchange but does not sink into personal attack. For our part, P&As should approach such efforts with humility and without projecting an attitude of superiority or needless aggressiveness. Many good advocacy programs have found that one way to improve relations with staff is to identify issues and cases in which the P&A and the staff have a common interest. For example, it is not unusual for a facility to be in conflict with a local school system over an educational placement for a child. Representation of the child by the advocacy program may further both the interests of the facility and the client. Although such cases are seldom the majority of the advocate's case load, they do help build relationships and may help to assure the facility that the P&A is not just reflexively against whatever the facility is for.

Some advocacy programs have established regular meetings with facility heads to raise issues and avoid, where possible, more formal action. Such periodic meetings only work, of course, when the facility head is willing to listen and to take action when it is warranted. Also, in some states, for instance Massachusetts, the state Department of Mental Health (DMH) sponsors and convenes quarterly meetings which are attended by the program directors of all the inpatient children and adolescent programs and all the external advocates with clients in those programs. Those meetings have been very helpful in identifying systemic problems and working together to solve them.

In the final analysis, however, the success of an institutional representation program will depend heavily on the ability of the advocate to develop working relationships with staff at all levels. These relationships must be built on a respectful, professional approach to advocacy and problem solving, even in the face of something less than that from the facility.

VI.

Substantive Legal Issues (See footnote 84)

A.

Conditions of confinement

Juveniles confined to institutions are often held in deplorable living conditions, where they are deprived of adequate housing, food, plumbing, clothing, exercise, and medical care. Such conditions often spark class action litigation on the theory that they violate the juvenile's constitutional right to reasonably safe and sanitary conditions of confinement. (See footnote 85)

Since juveniles in state custody are confined for rehabilitation and not for punishment, most courts assess conditions of confinement under the standards of the Due Process Clause of the Fourteenth Amendment, rather than the less exacting proscription against cruel and unusual punishment set forth in the Eighth Amendment. (See footnote 86) Based on *Youngberg v. Romeo*, (See footnote 87) and *Bell v. Wolfish*, (See footnote 88) juveniles have a right under the Fourteenth Amendment "to reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and minimally adequate training to protect those interests." (See footnote 89) In addition, any restrictions on liberty beyond the initial confinement must be "reasonably related to a legitimate governmental objective," such as rehabilitation, safety, or internal security, but may not amount to punishment. (See footnote 90)

Although courts construe the precise contours of the Due Process Clause somewhat more liberally when dealing with a juvenile facility as opposed to a jail, (See footnote 91) many of the principles that have evolved in correctional conditions litigation also apply in the juvenile context. Thus, a court may not find a constitutional violation based solely on the totality of the conditions at the facility. Instead, it must identify a discrete area of human need — such as fire safety, plumbing, or exercise — which is not being met and provide a remedy tailored to that deficiency. (See footnote 92) Nonetheless, the courts must consider each challenged condition in the context of the overall institutional environment, especially when the ill-effects of particular conditions are exacerbated by other related conditions. (See footnote 93) But the principal focus must be on a specific condition, as opposed to the overall condition of the facility.

Further, courts must accord institutional administrators

wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security. . . Such considerations are peculiarly within the province and professional expertise of corrections officials, and, in the absence of substantial evidence in the record to indicate that the officials have exaggerated their response to these considerations, courts should ordinarily defer to their expert judgment in such matters. (See footnote 94)

Thus, courts should not ordinarily order compliance with minimum standards established

by professional organizations because such standards may go beyond the demands of the Constitution. [\(See footnote 95\)](#)

Deference to institutional administrators is also mandated by the Prison Litigation Reform Act ("PLRA"), which was enacted in 1996 to limit the involvement of the courts in prison operations, but which expressly applies to juvenile facilities. [\(See footnote 96\)](#) The PLRA governs any action arising under Federal law with respect to the conditions of confinement or the effects of actions of government officials on persons confined," [\(See footnote 97\)](#) and therefore has a major effect on class action concerning juvenile institutions. [\(See footnote 98\)](#) Among the PLRA's more significant provisions is the requirement that a court may neither order nor approve any remedy for unconstitutional conditions unless it "finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation." [\(See footnote 99\)](#) As a practical matter, this provision merely codifies the standard previously used by many courts for granting prospective relief. [\(See footnote 100\)](#) What is different, however, is that the court must now make the same findings before it approves a consent decree containing prospective relief. [\(See footnote 101\)](#) Further, the PLRA also provides that any prospective relief must be terminated after two years unless the court makes written findings that there is a "current and ongoing violation of a Federal right," [\(See footnote 102\)](#) Finally, the PLRA places substantial limits on attorneys' fees if the litigation is unsuccessful.

B.

Population caps

Overcrowding is a widespread problem in juvenile institutions, especially with the increasingly punitive attitude of state legislatures and judges towards juvenile crime. Since overcrowding, i.e., an institutional census that exceeds rated capacity, is not *per se* unconstitutional, [\(See footnote 103\)](#) courts look at such factors as the size of the rooms, the amount of time each day detainees spend in their cells, the length of time they must spend at that institution, and the overall deterioration of the physical environment. [\(See footnote 104\)](#) Courts will also examine the effect of reduced access to treatment programs and the increased risk of assaultive behavior caused by overcrowding. For example, in *Doe v. Washington County*, [\(See footnote 105\)](#) the court upheld a judgment for monetary damages on behalf of a juvenile who was beaten, raped, and tortured by other juvenile pretrial detainees, reasoning that unconstitutionally overcrowded conditions contributed to the assault by making it impossible to house juveniles in a safe setting. [\(See footnote 106\)](#)

Because overcrowding has pervasive repercussions throughout an institution, reducing the population is often the most effective mechanism to improve the overall quality of life in a juvenile facility. Consequently, courts have frequently employed population caps as a simple and effective remedy for unconstitutional overcrowding. [\(See footnote 107\)](#)

The enactment of the PLRA, however, has severely curtailed the authority of the courts to order a population cap. Under the PLRA, a "prisoner release order" can only be entered if previous, less intrusive, relief has failed to remedy unconstitutional overcrowding, and then only by a three judge court. The PLRA defines a "prisoner release order" as "any order that has the purpose or effect of limiting the prison population, or that directs the release from or non-admission of prisoners to a prison." [\(See footnote 108\)](#) The courts are divided, however, as to

whether any orderlimiting population constitutes a "prisoner release order." (See footnote 109) Thus, although there is room to argue for creative remedies that do not implicate the PLRA, courts are now much more likely to defer to the judgment of state officials in devising a solution for unconstitutional overcrowding, and will order a population cap only as a last resort.

C.

Health Care _ Right to adequate care and the right to refuse treatment

Juvenile facilities are often plagued by woefully inadequate health care services, including poor medical, dental, and mental health care. (See footnote 110) The problem is particularly acute with respect to mental health services since as many as 50% of the individuals held in juvenile facilities have some sort of mental disability. (See footnote 111)

The constitutional principles underlying the right of a juvenile to health care are somewhat unclear. In *Estelle v. Gamble*, (See footnote 112) the Supreme Court held that the Eighth Amendment's prohibition against cruel and unusual punishment is violated by a correctional official's "deliberate indifference" to the "serious medical need" of a prison inmate. Under the Due Process Clause, state officials must provide safe conditions of confinement to institutionalized persons, including medical care that accords with professional judgment. (See footnote 113) Although in theory the *Youngberg* standard provides more protection than *Estelle*, in practice there is little difference between the two, and courts considering juvenile claims regarding the denial of medical care generally rely on prison cases that use the "deliberate indifference" standard. (See footnote 114)

There are two basic elements to a "deliberate indifference" claim: an objective component, the existence of a "serious medical need"; and a subjective, or state-of-mind, component, namely that the custodial official was knowingly indifferent to the need for treatment. (See footnote 115) Generally, a medical problem is "serious" if a physician or other health care provider "concludes with reasonable medical certainty (1) that the symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm by reason of delay or the denial of care would be substantial." (See footnote 116) However, the cases deciding whether a particular medical problem is sufficiently "serious" are often murky and inconsistent. (See footnote 117)

Discerning whether or not state officials have demonstrated the requisite "deliberate indifference" can be similarly confusing. If the denial of treatment was for non-medical reasons, it clearly violates the constitution. (See footnote 118) But if a doctor merely exercised poor judgment, or was negligent, or even grossly negligent, there is no constitutional cause of action; rather the juvenile plaintiff must demonstrate that the defendant denied appropriate medical treatment despite having actual knowledge of what was required. (See footnote 119) This does not mean that custodial officials may shield themselves from liability by deliberately remaining ignorant about the need for treatment. They will still be held accountable if they deliberately disregard a known risk, even if they are ignorant of the details of a particular individual's situation. (See footnote 120) But even if there is no Federal constitutional claim, there may still be a cause of action under state law. (See footnote 121)

While there may be controversy about whether a specific individual has

received constitutionally acceptable care, the criteria for an adequate system of health care are much more clear. They include adequate screening of incoming residents, appropriate diagnosis and treatment, and access to a sufficient number of trained health care professionals. (See footnote 122) Further, although courts are fond of saying that professional standards may well exceed the constitutional floor, a number of professional organizations have promulgated useful standards governing healthcare services in juvenile institutions. (See footnote 123) These standards are often valuable to evaluate the quality of health care in the institution, and are sometimes mandated by State law, if not by the Constitution.

D.

Education (by Peter Rice, Disability Rights Center, Augusta, Maine)

One of the most powerful tools P&As have when representing juveniles in custody is the IDEA. While IDEA was written with local public schools in mind, most of its provisions apply to schools in juvenile detention facilities. The full extent of its reach in juvenile facilities is still unknown at this point. That makes it an excellent vehicle for P&As to use in enforcing the rights of those incarcerated there. It is powerful, in part, because it brings outsiders, like hearing officers or complaint investigators, into the institution and holds the institution accountable in ways that correctional institutions are not used to being held accountable. It is also an opportunity to make law. (See footnote 124)

According to a variety of studies, between 40% and 60% of all youths incarcerated in juvenile detention facilities are eligible for special education, most with a psychiatric or a mental retardation label. (See footnote 125) However, since most juvenile facilities merely rely on the labels juveniles have when they are committed to the institution, instead of doing their own evaluations and screenings, it may well be that there are more juveniles eligible for P&A representation than has been reported.

While Congress has significantly curtailed the educational rights of juveniles 18–21 years old incarcerated in adult facilities, neither Congress nor the U.S. Department of Education has done anything to limit the rights of youths in juvenile detention facilities. (See footnote 126) However, there are some obvious limitations on the rights of juveniles in juvenile detention facilities, such as the right to be educated in the least restrictive environment.

All students with disabilities are entitled to a free appropriate public education, including students incarcerated in juvenile facilities. (See footnote 127) It does not matter how the school in a juvenile detention facility is organized, that is whether it is a department of corrections school, an independent school district or even a state educational agency school. The state education department is the state agency responsible for ensuring that students who are eligible or who may be eligible for special education services are identified, evaluated and receive an appropriate education. (See footnote 128)

Once a child has been identified as entitled to special education, IDEA imposes upon the State the obligation to provide a free appropriate public education (FAPE). FAPE is implemented through an Individualized Education Program (IEP). (See footnote 129) In order to develop an IEP, a multi-disciplinary team must meet to assess a student's needs and then craft an educational program based upon that student's particular needs. Only the multi-disciplinary team can make programming changes. This means that any change in

programming requires the multi-disciplinary team to reconvene. [\(See footnote 130\)](#) Schools in juvenile detention facilities routinely ignore this provision.

If the multi-disciplinary team determines that a child needs particular related services in order to benefit from his or her educational program, then the school is required to provide those services. [\(See footnote 131\)](#) Related services can be developmental, corrective or other services such as mental health services, speech and language assistance, physical or occupational therapy, including even recreational services. [\(See footnote 132\)](#) For children with some types of disabilities in need of such services, IDEA might be a way to identify them, assess their needs and, at least, begin to provide them with services, assuming they meet the criteria for special education.

IDEA also has a number of disciplinary provisions. [\(See footnote 133\)](#) A child can be removed from his or her educational programming for up to ten days without the requirement that he or she be provided with educational services. However, if a child is removed from his or her educational programming for more than 10 days and it constitutes a change in placement, a manifestation determination review (MDR) must be conducted. [\(See footnote 134\)](#) An MDR is a process whereby the multi-disciplinary team, plus any other relevant personnel, review the IEP and the behavior in question in order to determine whether the behavior was a result of the student's disability and if the IEP was adequate. A student cannot be denied educational services if the result of the MDR is that the behavior was a result of the disability.

IDEA may also apply to students not yet identified as special education eligible. There is a specific provision that addresses juveniles whom the school knew or should have known were special education eligible. [\(See footnote 135\)](#) If the school knew or should have known the juvenile was eligible, then the protections special education students have, extend to them.

In a juvenile detention facility, a child is often facing disciplinary sanctions for behavior that is a manifestation of his or her disability and where his or her IEP is not adequate, even assuming it is being properly implemented, which is very often not the case. This is another area where there are a number of outstanding issues facing representatives of juveniles because of the nature of the institution.

A new IEP does not have to be drafted when a youth is being held in a detention facility on a short-term basis, such as pre-trial detention. If a pre-trial detainee has an IEP, the facility must implement the IEP. If a youth is going to be held long term at a juvenile detention facility, then the facility must convene a multi-disciplinary team meeting within a reasonable time in order to evaluate the student and draft a new IEP. [\(See footnote 136\)](#)

IDEA also provides a way for institutions to start preparing juveniles to live independently. When a child reaches 14, transition planning must begin. [\(See footnote 137\)](#) When he or she turns 16, a transition plan must be drafted. The institution is the agency responsible for implementing the plan. [\(See footnote 138\)](#) If schools at juvenile detention facilities are doing these things at all, they are probably not doing them well.

This could also be part of a larger discharge plan that institutions develop when a juvenile leaves an institution. In some states, different state agencies come together in order to provide money and "wrap around" services for a child. There are, of course, downsides to this type of planning. For example, a youth discharged from the detention facility will normally be

put on probation and his or her probation officer will end up policing the discharge plan, including the transition plan. If the youth does not follow the transition plan, his or her probation may be revoked and the youth ends up back at the institution.

Both Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act apply to juvenile detention facilities. Section 504 has a FAPE requirement; however, the protections under 504 are not as clearly outlined as they are in IDEA. For example, IDEA has clearly outlined processes and procedures to be used when disciplining students with disabilities. Section 504 has a requirement that an evaluation take place before a placement and a prohibition against discriminating on the basis of disability. There is nothing in 504 requiring that school officials undertake something like an MDR in order to determine whether a particular behavior in question is related to a child's disability. Analytically, there is no reason why a school should not undertake to determine if certain behaviors of a child with an identified disability are a manifestation of the disability before disciplining the child. If they don't, they could be discriminating on the basis of disability.

One important distinction between Section 504 and IDEA is the ability to go directly to court under 504. IDEA has a very strong administrative exhaustion requirement, almost magnetic. This plus the highly individualized nature of educational planning makes class actions very difficult under IDEA, especially after the passage of the Prison Litigation Reform Act. (See footnote 139) Section 504 has no such exhaustion requirement.

E.

Right to treatment and training

Basic substantive due process analysis requires that if the government acts to deny a person of his liberty, it may only deprive the individual of freedom to the extent necessary to achieve a legitimate governmental purpose. (See footnote 140) Therefore, in certain circumstances, substantive due process claims may be made to challenge the conditions of a child's confinement, including the right to training and treatment. Because courts have very cautiously applied the Fourteenth Amendment to programs housing or holding people with disabilities, advocates wanting to pursue such claims need to proceed with care. (See footnote 141) To begin with, "custody" is a crucial concept in the substantive due process analysis. The Supreme Court has held that it is the "State's affirmative act of restraining the individual's freedom to act on his own behalf _ through incarceration, institutionalization, or other similar restraint of personal liberty _ which is the 'deprivation of liberty' triggering the protections of the Due Process Clause...." (See footnote 142) Among those receiving "the protections of the Due Process Clause" are involuntarily committed mental patients. (See footnote 143) At least one court has extended protection to "conditional voluntary" patients in mental hospitals and to persons placed by the state in community residences upon their discharge from a state hospital. (See footnote 144) However, courts have been reluctant to extend constitutional protections to individuals who are involuntarily committed to private, as opposed to publically operated, mental hospitals, finding that neither the hospital nor its doctors are state agents or actors for the purpose of the Fourteenth Amendment. (See footnote 145)

Therefore, the Fourteenth Amendment may provide protection and a "right to treatment" to children and adolescents in custody in public psychiatric hospitals. However, in the context of the juvenile justice system, the degree of protection provided to children under the

substantive due process clause has never been explicitly defined by the Supreme Court. (See footnote 146)

As noted earlier in this paper, since juveniles in state custody in juvenile facilities are confined for rehabilitation and not for punishment, most courts assess conditions of confinement under the standards of the Due Process Clause of the Fourteenth Amendment, rather than the less exacting proscription against cruel and unusual punishment set forth in the Eighth Amendment. (See footnote 147) Based on *Youngberg v. Romeo*, (See footnote 148) and *Bell v. Wolfish*, (See footnote 149) juveniles have a right under the Fourteenth Amendment to "minimally adequate training to protect [their] interests" in "reasonably safe conditions of confinement, and freedom from unreasonable bodily restraint." (See footnote 150)

Just what "minimally adequate training" the juvenile is entitled to is determined by application of the "professional judgment standard." (See footnote 151) The treatment recommendations of child treating professional (See footnote 152) are accorded presumptive validity and are unconstitutional only if they are "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." (See footnote 153) The Supreme Court noted that it is not feasible

to define or identify the type of training that may be required in every case. A court properly may start with the generalization that there is a right to minimally adequate training. The basic requirement of adequacy, in terms more familiar to courts, may be stated as that training which is reasonable in light of identifiable liberty interests and the circumstances of the case. (See footnote 154)

The most successful right to treatment claims, therefore, are likely to be those in which the juvenile's treating professionals are recommending a course of care which the facility will not provide. (See footnote 155) Even then, the *Youngberg* Court was sympathetic to budget constraints on state governments. Apparently, a trial court considering a right to treatment issue is to balance the state's and the plaintiff's interests, using professional judgment as a guide. (See footnote 156) However, most lower courts seem to reject budget limitation arguments in such cases. (See footnote 157)

Although there is little case law regarding due process right to treatment claims in juvenile institutions after *Youngberg*, it seems safe to say that the Fourteenth Amendment probably protects juveniles in custody in state operated mental hospitals and in juvenile detention facilities. The extent of the treatment to which the youth is entitled will, in most cases, be determined by the professional judgment of her treating professionals. (See footnote 158)

F.

Restraints

The use of restraint in mental health facilities and the particular dangers to children of misapplied restraint have been the subject of considerable debate since the publication of an investigative series in the Hartford Courant in October 1998. (See footnote 159) Indeed, some of the most common issues that advocates confront in the representation of

institutionalized children involve restraint and seclusion. [\(See footnote 160\)](#) The Supreme Court has held that involuntarily institutionalized people with disabilities have an interest in bodily safety and a minimum of restraint and a right to training to “ensure safety and freedom from undue restraint.” [\(See footnote 161\)](#) The use of restraint, the justifications for it and the training or treatment offered to minimize its use should all be considered in the framework of the *Youngberg* decision.

Several justifications for restraint have been suggested – as punishment, for the prevention of harm to the person, to others, or to property, and for the purpose of treatment. [\(See footnote 162\)](#) Nearly all commentators reject the use of restraint as punishment in mental health settings. [\(See footnote 163\)](#) There is, however, considerable literature to support the efficaciousness of restraint to prevent injury and to reduce agitation. Although the extent of legal regulation of restraint varies considerably, [\(See footnote 164\)](#) most state laws establish prerequisites for its use. For example, a statute or regulation may allow restraint only where there is an immediate risk of harm to the person or to others. The existence of such standards is useful to advocates for clients who protest a restraint. Complaints, for example, about the necessity of a restraint, abuse or injury during the process of restraint, [\(See footnote 165\)](#) and unnecessary length of restraint, may find support in the whatever rules apply to the facility. [\(See footnote 166\)](#)

Complaints by clients about the need for some restraints will find less clear support in the rules. From the advocates' point of view, perhaps the most troubling are those in which the justification for restraint is, in part at least, that it is clinically appropriate and useful. Dr. Thomas Gutheil has written that, for adults, seclusion offers containment (to provide reassurance to the patient by keeping her safe), isolation (to provide relief from difficult personal relationships) and a decrease in sensory input. [\(See footnote 167\)](#) He suggests that if not misused, restraint can be an effective part of active treatment. Dr. Nancy Cotten, writing as the director of a child inpatient psychiatric unit in a private hospital, has suggested that restraint of young people should also be considered not only in light of their psychiatric needs, but in consideration of their development as well. She argues that when used in a manner consistent with the child's developmental needs, restraint can demonstrate that adults care, can address issues of poor ego formation and can teach internal and social controls. [\(See footnote 168\)](#)

Comparing the use of seclusion with the kinds of discipline used by parents in homes, Dr. Cotten says that seclusion “is not in itself a punishment, [but] is a place where children complete punishments.” [\(See footnote 169\)](#) She argues that restraint used as “socializing punishment” (that is, part of the process of teaching “control through the experience of control”), as distinguished from “retaliatory punishment,” is worthwhile and should be allowed. [\(See footnote 170\)](#)

Such arguments will be familiar to advocates who work on juvenile mental health units where they may be posited to support what in an adult setting might appear to be excessive use of restraint. Also, the teaching and socialization utility of seclusion and its supposed behavior modification benefits, may be offered as a justification for interventions like “room plans” or “timeout” which have all or most of the earmarks of seclusion, but which some programs may try to argue fall outside whatever rules govern restraint.

Although some of the clinical literature hypothesizes that young people benefit from and are not harmed by properly used restraint, there is less literature describing how children

actually experience it. A 1998 study by Wanda Mohr of the University of Pennsylvania found that many children in hospitals were further traumatized when they were restrained or secluded _ or even when watching others undergo the procedure, and that most children experienced such treatment as punishment. (See footnote 171) This study appears to be consistent with descriptions by adult ex-patients and consumers. Dr. Fisher quotes from a letter to him from the always eloquent activist and advocate Rae Unzicker:

They take my clothes. They leave me naked, without armor. They lead me, bruising my arms, to the seclusion room, so I can think about the lie they have given me to live, and change my mind. . . . [A] part of me is still there, irretrievable. She is dead. Gone. She was a young woman of spirit and integrity and hope and vision. She is dead, killed by the dullie of hope. (See footnote 172)

When the appropriateness of a restraint is at issue, P&A Advocates in juvenile mental health facilities should discuss with their clients how they experience the restraint and let the staff know. (See footnote 173) It may be more difficult to justify restraint or seclusion as clinically helpful if the client is able to describe negative consequences. Advocates should be familiar with the growing literature about the impact of restraint on people, women mostly, who have been victims of sexual or physical abuse. Many facility staff are not familiar with these studies and may welcome the chance to learn about them. (See footnote 174) Whenever it appears that a facility may be misusing restraint with a client, the P&A should attempt to enforce the client's right to training to minimize the need for restraint.

Also, P&As should regularly obtain and review aggregate restraint data by facility, unit and shift. Such review may help to pinpoint areas of potential abuse sufficient to warrant monitoring or even investigation.

The nature of restraint in juvenile detention facilities may bear a resemblance to that in mental health facilities, but it often has the added justification of the institution's interest in security. The form of restraint may also differ somewhat. Juvenile detention centers may use more prison-like restraints such as restraint chairs, rubber rooms and shackling. Searches, including strip searches, are more likely to be used in such settings. Furthermore, detention settings may have disciplinary systems which include isolation or solitary confinement. In *Alexander S.*, the court held that "[a]n effective discipline system is necessary in a juvenile correction institution to aid staff in controlling violence and other inappropriate behavior, to maintain safety and security and to serve as a training tool for the overall purposes of correcting the juveniles' behavior." (See footnote 175)

Restraint, therefore, is probably regulated by a mix of mental disability rights law and prisoners' rights law. There have been a few cases which have addressed the use of restraint in juvenile detention facilities. In an unreported case, *Clarence M. v. Board of Commissioners of Yakima County*, (See footnote 176) a consent decree included a provision that isolation could only be used when a child posed an immediate physical threat to himself or to others. In another unreported case, the court order required approval by a psychiatrist before tie-downs, soft tie restraints and the use of the rubber room except in a clear emergency. (See footnote 177) In *Milonas*, the trial judge enjoined the use of isolation except when the youth was physically violent. (See footnote 178)

P&A advocates challenging restraint in juvenile detention facilities, therefore, should

look to both the standards in mental health facilities and the case law and standards regarding prisons.

VII.

Conclusion

Advocating for children and adolescents in institutional settings presents unique legal and personal challenges to P&A staff. If we approach our clients with respect and compassion, mindful of how it must feel to be young and institutionalized, we may be able to use the law and our skill to create opportunities to improve their lives. There are few more difficult undertakings for P&As, and few which promise such profound rewards.

Footnote: 1 Courts almost consistently hold that a minor's constitutional rights are not "co-extensive" with those of those of an adult. As Professor Jan Costello points out, this often means "not even close to" having the weight and scope of the adult's rights." Jan C. Costello, *Making Kids Take their Medicine: the Privacy and Due Process Rights of De Facto Competent Minors*, 31 *Loy. L.A. L. Rev.* 907 n. 5 (1998). See also, Michael J. Dale, *The Supreme Court and the Minimization of Children's Constitutional Rights: Implications for the Juvenile Justice System*, 13 *Hamline J. Pub. L. & Pol'y* 199 (1992); Michele D. Sullivan, Note, *From Warren to Rehnquist: The Growing Conservative Trend in the Supreme Court's Treatment of Children*, 65 *St. Johns L. Rev.* 1139 (1991).

Footnote: 2 Norman Rosenberg and Jane Yohalem, *Litigation on Behalf of Mentally Disabled Children: Targets of Opportunity*, 10 *Mental & Physical Disability L. Rep.* 70 (1986); *Report of the ABA Presidential Working Group on the Unmet Legal Needs of Children and their Families, America's Children at Risk, A National Agenda for Legal Action* (July 1993).

Footnote: 3 One commentator has both criticized P&As for "fail[ing] to provide adequate P&A services to institutionalized children" and suggested revisions to the enabling law to make such representation easier. Lisa Marie Sunderman, *The Institutionalized Child's Right to Counsel: Satisfying Due Process Requirements Through the Protection and Advocacy for Mentally Ill Individuals Act*, 23 *Valparaiso U. L. Rev.* 629, 651 (1989) (footnote omitted).

Footnote: 4 See, generally, Stanley S. Herr, *Representation of Clients with Disabilities: Issues of Ethics and Control*, 17 *N.Y.U. Rev. L. & Soc. Change* 609 (1990). These issues will be discussed at some length in Section III.

Footnote: 5 The institutions to which we refer in this paper fit comfortably within the definition of a "facility" under the regulations governing the operation of the PAIMI program. That is, "any public or private residential setting that provides overnight care accompanied by treatment services." Facilities include "general and psychiatric hospitals, nursing homes, board and care homes, community housing, juvenile detention facilities, homeless shelters, and jails and prisons..." 42 C.F.R. § 51.2.

Footnote: 6 Between 1985 and 1994, the number of children judicially waived to adult

court increased 71%. Office of Juvenile Justice and Delinquency Prevention, U.S. Dep't of Justice, *Juvenile Offenders and Victims: 1997 Update on Violence*, 31 (1997). This number does not include waivers through prosecutorial discretion or automatic waiver, statistics for which have not been satisfactorily documented. N. Lee Cooper, Patricia Puritz & Wendy Shang, *Fulfilling the Promise of In re Gault: Advancing the Role of Lawyers For Children*, 33 Wake Forest L. Rev. 651, 675 (1998).

Footnote: 7 Charles A. Kiesler, *U.S. Mental Health Policy: Doomed to Fail*, 47 Am. Psych. 1077, 1081 (1992) (children are being treated in residential treatment centers, private psychiatric hospitals, and hospitals without special psychiatric units).

Footnote: 8 Beth E. Molnar, *Juveniles and Psychiatric Institutionalization: Toward Better Due Process and Treatment Review in the United States*, 2 Health & Hum. Rts. 99 (1995); Lois A. Weithorn, Note, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 Stan. L. Rev. 773, 786 (1988); Beverly Balos & Ira Schwartz, *Psychiatric and Chemical Dependency Treatment of Minors: The Myth of Voluntary Treatment and the Capacity to Consent*, 92 Dick. L. Rev. 631 (1988).

Footnote: 9 Gary B. Sutnick, Comment, "Reasonable Efforts" Revisited: Reforming Federal Financing of Children's Mental Health Services, 68 N.Y.U. L. Rev. 136, 147 (1993).

Footnote: 10 For example, the Pennsylvania P&A has filed suit against the Royer-Greaves School for the Blind, alleging that the school has denied it access to the facility, its residents and their records after the P&A received complaints concerning activities which the P&A perceived as systemic neglect. *Pennsylvania Protection and Advocacy, Inc. v. Royer-Greaves School for the Blind*, No. Civ.A. 98-3995, 199 WL 179797 (E.D. Pa., March 25, 1999) (granting partial summary judgment to P&A on issues of access to facility and to names of guardians, but requiring twenty-four hour notice of intention to visit a particular student.)

Footnote: 11 Secure community treatment facilities may either be locked or "staff secure," that is, having enough staff on hand to ensure that a client cannot leave without permission.

Footnote: 12 Status offenders are children who have been determined by a court to need the state's supervision due to, for example, waywardness, stubbornness, truancy or running away. Despite the provisions of the federal Juvenile Justice and Delinquency Prevention Act, 42 U.S.C. § 5633(A)(12)(A), status offenders still occasionally find themselves in secure detention. Karen A. Joe, *The Dynamics of Running Away, Deinstitutionalization Policies and the Police*, 46 *Juv. & Fam. Ct. J.* 43 (1995); Jan C. Costello & Nancy L. Worthington, *Incarcerating Status Offenders: Attempts to Circumvent the Juvenile Justice and Delinquency Prevention Act*, 16 *Harv. C.R.-C.L. L. Rev.* 41 (1981). See also, Holly Metz, *Branding Juveniles Against Their Will: How Wayward Adolescents are Punished for the Crime of Rebellion*, 20 *Student Law.* 21 (1992).

Footnote: 13 Lee Cooper, Patricia Puritz & Wendy Shang, *Fulfilling the Promise of In re Gault: Advancing the Role of Lawyers For Children*, 33 Wake Forest L. Rev. 651 (1998) (footnotes omitted).

Footnote: 14 42 C.F.R. § 51.2.

Footnote: 15 42 U.S.C. § 51.42(d).

Footnote: 16 42 C.F.R. § 51.2.

Footnote: 17 62 Fed. Reg. 53548 (Oct. 15, 1997).

Footnote: 18 *Michigan Protection & Advocacy Service, Inc. v. Miller*, 849 F.Supp. 1202 (W.D.Mich. 1994); *Maryland Disability Law Center, Inc. v. Mt. Washington Pediatric Hospital, Inc.*, 664 A.2d 16 (Md. App. 1995).

Footnote: 19 45 C.F.R. § 1386.19.

Footnote: 20 Access to facilities for the PAIMI program are governed by 42 U.S.C. §10805(a)(3) and 42 C.F.R. § 51.42. PADD access provisions are found at 42 U.S.C. § 6042(a)(2)(H) and 45 C.F.R. § 1386.22. It is clear that Congress intended that the respective access authorities under the PAIMI, PADD and PAIR programs be applied in a consistent manner. Indeed, the PAIR Program expressly incorporates (at Section 509(f)) the authority regarding access to facilities and records (as well as the other general authorities granted to P&As) set forth in the DD Act.

The legislative history of the PAIR Program provides that, in implementing the Program, RSA shall adopt the same policies as has been applied by ADD under the PADD Program; the purpose of this approach is to “ensure consistency and uniformity of interpretation.” S. Rep. 357, 102nd Cong., 2d Sess. 100 (1992). Congress expressed a similar intent with regard to the consistent application of the PAIMI and PADD Programs. *See, e.g.*, S. Rep. 454, 100th Cong., 2d Sess. 10 (1988); S. Rep. 109, 99th Cong., 1st Sess. 3 (1986); S. Rep. 113, 100th Cong., 1st Sess. 24 (1987).

Footnote: 21 Although P&As have been successful in most access lawsuits, and although the cases are extremely important, they do siphon resources from direct representation of clients. If litigation can be avoided by making concessions that do not threaten or unduly compromise the P&A's authority, compromise is probably appropriate. Unfortunately, a number of P&A programs have had to litigate to obtain access to facilities. Among the most important cases are *Michigan Protection & Advocacy Services, Inc.*, *supra* n.18; *Maryland Disability Law Center, Inc.*, *supra* n.18, *Robbins v. Budke*, 739 F.Supp. 1479 (D.N.M. 1990), and *Mississippi Protection and Advocacy System, Inc. v. Cotten*, No. J87-0503(L) (S.D. Miss. August 7, 1989) *aff'd*, 929 F.2d 1054 (5th Cir. 1991). For a complete description of these and other cases, see ATTAC's Access Manual.

Footnote: 22 For example, a city-operated hospital insisted that CPR advocates address all questions about and complaints on behalf of clients only to the manager of the psychiatric unit. CPR objected, but complied. Within several weeks the manager found the process so time-consuming that she began to instruct the advocate to talk directly to the clinicians and ward staff. The restrictive condition just evaporated.

Footnote: 23 849 F. Supp. at 1207. See also, *Georgia Advocacy Center, Inc. v. Camp*, 172 F.3d 1294(1999)(acknowledging P&A right to general access to juvenile group home serving both children with and without emotional problems, but denying access to a particular child.)

Footnote: 24 42 C.F.R. § 51.42(b).

Footnote: 25 42 C.F.R. § 51.42(d) (PAIMI) and 45 C.F.R. §1386.23(h)[PADD].

Footnote: 26 42 C.F.R. § 51.42(e).

Footnote: 27 42 C.F.R. § 51.42(b). A “full investigation” is defined at 42 C.F.R. § 51.2 [PAIMI] as “access” that is “necessary for a P&A system to make a determination about whether an allegation of abuse or neglect is taking place or has taken place.” The PADD definition is very similar. 45 C.F.R. § 1386.19.

Footnote: 28 42 C.F.R. § 51.42(c).

Footnote: 29 42 C.F.R. § 51.42 (e) and § 51.42(b)(3). There is no parallel provision in the PADD regulations.

Footnote: 30 42 C.F.R. § 1386.19 [PADD]; 45 C.F.R. § 51.2.

Footnote: 31 62 Fed. Reg. 53552.

Footnote: 32 *Parham v. J.R.*, 442 U.S. 584, 604 (1979).

Footnote: 33 See, *Jan C. Costello, Making Kids Take Their Medicine: The Privacy and Due Process Rights of De Facto Competent Minors*, 31 *Loyola of L.A. L. Rev.* 907 (1998)(addressing why a teenage girl may be considered mature enough to decide to have an abortion, but not to make decisions about antipsychotic medications); *Joan–Margaret Kun, Rejecting the Adage “Children Should be Seen and Not Heard” – The Mature Minor Doctrine*, 16 *Pace L. Rev.* 423 (1996). See also, *Carol Sanger & Eleanor Willemsen, Minor Changes: Emancipating Children in Modern Times*, 25 *U. Mich. J.L. Ref.* 239 (1992)(noting that a California study determined that parents may emancipate children for parental advantage rather than for minors' needs).

Footnote: 34 45 C.F.R. § 1386.22(a)(2)(ii)[PADD] and 42 C.F.R. § 51.41(a)(2)(ii)[PAIMI].

Footnote: 35 42 C.F.R. § 51.2. See also, 45 C.F.R. § 1386.19 [PADD](similar language).

Footnote: 36 62 Fed. Reg. 53552.

Footnote: 37 42 C.F.R. § 51.42(e).

Footnote: 38 See, generally, *Lisa Marie Sunderman, The Institutionalized Child's Right*

to Counsel: Satisfying Due Process Requirements Through the Protection and Advocacy for Mentally Ill Individuals Act, 23 Val. U. L. Rev. 629 (1989); Hafen, *Children's Rights and Legal Representation – The Proper Roles of Children, Parents, and Attorneys*, 7 Notre Dame J.L., ethics & Pub. Pol'y 423 (1993).

Footnote: 39 See Section II.

Footnote: 40 42 C.F.R. § 51.32.

Footnote: 41 42 U.S.C. 10806 §§(a)(4), 10806 and 6042 §§ (a)(2)(I).

Footnote: 42 42 C.F.R. § 51.41(c)(4) and 45 C.F.R. § 1386.22 (e)(1). P&As should keep in mind that a report is not “peer review” just because the facility says it is. Rather, the report must meet whatever prerequisites state law sets for peer review. See, e.g., *Disability Rights Center, Inc. v. Brodeur*, No. 96–E–251, Superior Ct., New Hampshire, Jan. 26, 1997 rev'd No. 97–282 (NH Supreme Court, June 29, 1999). Access Manual, p.31–32.

Footnote: 43 45 C.F.R. § 1386.22(a)(2)(ii)[PADD] and 42 C.F.R. § 51.41(a)(2)(ii)[PAIMI]. The language regarding state agency guardians is in both regulations. Since most minors will have either a parent or a guardian, this provision will probably be most helpful to the P&A when the guardian is the state. “Probable cause” is defined at 42 C.F.R. § 51.2 [PAIMI] and 45 C.F.R. § 13.86.19 [PADD]. The definitions are identical.

Footnote: 44 42 C.F.R. § 51.41(b)(3)[PAIMI] and 45 C.F.R. § 1386.22(a)(3)[PADD].

Footnote: 45 *West Virginia Advocates, Inc., v. Appalachian Community Mental Health Center, Inc.*, 191 W.Va. 671, 676, 447 S.E.2d 606, 611 (1994).

Footnote: 46 42 U.S.C. § 10806(a).

Footnote: 47 The Florida statute has been successfully challenged. *Doe v. Stincer*, 990 F.Supp 1427 (1997). The Appeals Court did not disturb the underlying ruling in the case but, rather, remanded for a determination whether the Florida P&A has made a sufficient evidentiary showing to warrant its status as an organizational plaintiff. 175 F.3d 879 (11th Cir. 1999).

Footnote: 48 42 C.F.R. § 51.46. There is no similar language in the PADD regulations.

Footnote: 49 The same questions, of course, attend the representation of those adults with disabilities who are incapable to make decisions for themselves.

Footnote: 50 Some of these questions were addressed at a 1995 Conference on Ethical Issues in the Legal Representation of Children at Fordham University School of Law. The Conference recommendations are published in the *Fordham Law Review*. See, *Special Issue, Ethical Issues in the Legal Representation of Children*, 64 *Fordham L. Rev.* (March 1996). Articles from that very helpful volume will be cited throughout this section of the paper.

Footnote: 51 Justice Louis Brandeis is reported to have argued that lawyers should engage in lawreform and to exhort their clients to act in the public good. David Luben, *The Noblesse Oblige Tradition in the Practice of Law*, 41 Vand. L. Rev. 717, 721 (1988). See, Thomas L. Shaffer, *The Profession as a Moral Teacher*, 18 St. Mary's L. J. 195 (1986); Katherine Hunt Federle, *The Ethics of Empowerment: Rethinking the Role of the Lawyers in Interviewing and Counseling the Child Client*, 64 Fordham L. Rev. 1655 (1996) (hereinafter Federle, *Ethics of Empowerment*). See, also, Marvin R. Ventrell, *Rights and Duties: An Overview of the Attorney–Child Client Relationship*, 26 Loy. U. Chi. L. J. 259 (1995) (supporting zealous child advocacy).

Two early attempts to define the representational ethics of representing people with disabilities were Samuel J. Brakel, *The Role of the Lawyer in the Mental Health Field*, 1977 Am. Bar. Found. Res. J. 467 and Neil H. Mickenberg, *The Silent Clients: Legal and Ethical Considerations in Representing Severely and Profoundly Retarded Individuals*, 31 Stan. L. Rev. 625 (1979). Mickenberg wrote from his experiences at the Minnesota Developmental Disabilities Advocacy Project and later at the Vermont Developmental Disabilities Advocacy Project.

In 1976 the American Bar Association established a handful of mental disability representation projects. The projects were evaluated, and some criticized, in Samuel J. Brakel, *Legal Aid in Mental Hospitals*, 1979 Am. Bar Found. Res. J. 23. Among other things, Brakel was critical of programs which adopted an adversarial advocacy style, arguing for their clients' expressed wishes. A dialogue on the validity of the criticisms can be found at Samuel J. Brakel, Steven J. Schwartz & Robert D. Fleischner, *Legal Advocacy for Persons Confined in Mental Hospitals*, 5 Ment. Dis. L. Rep. 274 (1981). For a further exploration of this issue, see Steven J. Schwartz, Robert D. Fleischner, Marilyn Schmidt, et al., *Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy*, 14 Rutgers L.J. 541 (1983).

Footnote: 52 Federle, *Ethics of Empowerment*, *supra* n. 51 at 1658–59.

Footnote: 53 *Id.*

Footnote: 54 Professor Federle argues that “a right is power” and that “a right has merit because [it] hold[s] out the promise of challenging hierarchy and mitigating marginalization.” *Id.* at 1693. These are ideas that should resonate profoundly with people with disabilities and their advocates. However, another commentator argues that children's rights are a significant cause of the breakdown of families, since they encourage parents' reluctance to punish their children for violating communal norms. Barbara Bennett Woodhouse, *Children's Rights: The Destruction and Promise of Family*, 1993 B.Y.U.L. Rev. 497. This argument may gain currency in the search for something to blame for the recent spate of tragic school shootings.

Footnote: 55 This approach, of course, is one that divides the mental health bar from many mental health treatment providers and from a number of other advocates, particularly organized family members. That division has often made it difficult for legal advocates to work together with other advocates even on issues on which they share a common interest. Forced treatment is also a primary issue which divides organized ex–patient and consumer groups

from family based and professional organizations.

Footnote: 56 Federle, *Ethics of Empowerment*, supra n. 51 at 1664.

Footnote: 57 *Id.* (footnotes omitted).

Footnote: 58 A significant body of literature, and even the case law, cites the inadequacy of counsel in civil commitment cases. For a comprehensive discussion, see Michael L. Perlin, *Mental Disability Law: Civil and Criminal*, Vol 1, 2ed. 191– 292 (Lexis Law Pub. 1998)(Perlin). For an analysis of similar issues in forced treatment cases, see Michael L. Perlin & Deborah Dorfman, *Is It More than “Dodging Lions and Wastin’ Time” ? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 *Psychology, Pub. Pol’y & L.* 114 (1996).

Footnote: 59 The familiar common law “Rule of Sevens” may provide a touchstone to determining competency but is hardly a steady rock on which to stand. The rule holds that children under seven lack capacity. A rebuttable presumption of lack of capacity exists for children between seven and fourteen and a rebuttable presumption of capacity for those fourteen to twenty-one. *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987).

Footnote: 60 Federle, *Ethics of Empowerment* supra n. 51 at 1661. People with disabilities will recognize the theory that one must be competent to have or to exercise a right.

Footnote: 61 *Bellotti v. Baird*, 443 U.S. 622 (1979).

Footnote: 62 Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 *Wash. & Lee L. Rev.* 695 (1993)(arguing that treatment in the mental health context involves privacy interests and potential harm similar to those involved in abortion); Gina Yarborough, *The Rights of Minors to Make Decisions: A Response to the Critics*, *Advisor* (Fall/Winter 1997) 24 (Available from Mental Health Legal Advisors Committee, 294 Washington St., Boston, MA 02108.)

Footnote: 63 Professor Janet Weinstein argues strongly that attorneys “do not have the training to identify” the developmental needs of children and that the utilization of a model which treats “competent” children as adults for purposes of representation is “a reflection of the gap between our professional arrogance and an understanding of the needs of children.” Indeed, she believes that the “adult morphizing” of children “may, itself, be a form of child abuse caused by unrealistic expectations about children.” Janet Weinstein, *And Never the Twain Shall Meet: The Best Interests of Children and the Adversary System*, 52 *U. Miami L. Rev.* 79, 135–36 (1997).

Footnote: 64 See section II above regarding when a P&A may take “formal action” on behalf of a minor or person under guardianship.

Footnote: 65 One of the most helpful articles is Gerald P. Koocher, *Different Lenses: Psycho–Legal Perspectives on Children's Rights*, 16 *Nova L. Rev.* 711 (1992)(including information on how mental health professionals assess children's competency, focusing on comprehension, assertiveness and autonomy, rational reasoning, anticipation of outcome

events, and judgments in the face of uncertainties). See also, Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 Wash. & Lee L. Rev. 695 (1993) and Elizabeth S. Scott, et al., *Evaluating Adolescent Decision Making in Legal Contexts*, 19 Law & Hum. Behav. 221 (1995).

Footnote: 66 *Kurtenback v. TeKippe*, 260 N.W.2d 53 (Iowa 1977). For an excellent article on this subject generally, see Gina Yarborough & Jennifer Honig, *The Right of Minors to Retain Counsel*, Advisor (No. 40), 3 (Spring 1994); Mental Health Legal Advisors Committee, *Handbook of the Legal Rights of Minors* (1999) (Both the Advisor and the Handbook are available from Mental Health Legal Advisors Committee, 294 Washington St., Boston, MA 02108.)

Footnote: 67 *Wagstaff v. Superior Court Family Court Div.*, 535 P.2d 1220 (Alaska 1975) (minor may retain legal counsel of her own choice); *Yellen v. Bloom*, 61 N.E.2d 269 (Ill. 1945) (minor may make valid contract to retain counsel in personal injury case).

Footnote: 68 See, e.g., *Boston Bar Association Ethics Opinion*, 92-1 (attorney in civil rights action represents child, even though fee agreement is with parents); *Massachusetts Bar Association Ethics Opinion* 93-6, 78 Mass. L. Rev. 153 (1994) (counsel's role is to advocate for lawful objectives of child client). However, both these opinions were drafted prior to Massachusetts' adoption of ABA Model Rule 1.14. The comments to the rule provide in part that ordinarily the attorney should look to the legal representative of the person under a disability for decisions on behalf of the client.

Footnote: 69 See, e.g., Mass. G.L. c. 231 § 85O.

Footnote: 70 *McIssac v. Adams*, 190 Mass. 117, 119, 76 N.E. 654, 654 (1906).

Footnote: 71 ABA/BNA *Lawyer's Manual on Professional Conduct*, Model Rules of Professional Conduct Rule 1.16(b) (1998) (Model Rules).

Footnote: 72 See the discussion in Section IIC, above.

Footnote: 73 This section applies only to nonadversarial processes. 42 C.F.R. § 51.32.

Footnote: 74 Model Rules Rule 1.14.

Footnote: 75 Model Rules, Comment to Rule 1:14.

Footnote: 76 *Id.*

Footnote: 77 *Id.*

Footnote: 78 E.g., James R. Devine, *The Ethics of Representing the Disabled Client: Does Model Rule 1.14 Adequately Resolve the Best Interest/Advocacy Dilemma?*, 49 Mo.L.Rev. 493 (1984) (criticizing the rule); Paul Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 Utah L. Rev. 515 (same); David Luben, *Paternalism and the Legal Profession*, 1981 Wis.L.Rev. 454 (supporting exercise

of professional judgment for clients with disabilities).

Footnote: 79 Federle, 64 *Fordham L. Rev.* at 1689. See, generally, David A. Binder & Susan C. Price, *Legal Interviewing and Counseling: A Client Centered Approach* (1977).

Footnote: 80 Emily Buss, "You're my What?" *The Problems of Children's Misconceptions of their Lawyers Roles*, 64 *Fordham L. Rev.* 1723–724 (1996). See also, Nancy W. Perry & Larry L. Tepley, *Interviewing, Counseling and In-Court Examination of Children: Practical Approaches for Attorneys*, 18 *Creighton L. Rev.* 1369 (1985).

Footnote: 81 Jan C. Costello, *Representing the Medicated Client*, 7 *Mental Disability L. Reporter* 1 (1983). See also, David Ferleger, *Interviewing the Mentally Disabled Client*, in 3 *Legal Rights of Mentally Disabled Persons 1901* (Paul R. Friedman, ed.) *Practicing Law Institute* (1979).

Footnote: 82 Federle, 64 *Fordham L. Rev.* at 1692.

Footnote: 83 Anthony Platt & Ruth Friedman, *The Limits of Advocacy: Occupational Hazards in Juvenile Court*, 116 *U. Pa. L. Rev.* 1156, 1176.

Footnote: 84 The Center for Public Representation has prepared a comprehensive handbook and caselist for ATTAC of NAPAS entitled *Mental Health Services in Prisons and Jails: A Resource Manual for Protection and Advocacy Professionals*. The manual, which should be help to juvenile law advocates, is available from ATTAC.

Footnote: 85 See e.g., *Gary H. v. Hegstrom*, 831 *F.2d* 1430 (9th Cir. 1987) (pervasive unconstitutional conditions, including dirty and unsanitary cells, inadequate heating and ventilation; unsanitary and inadequate food, insufficient opportunities for exercise, and inadequate medical care); *Alexander S. v. Boyd*, 876 *F.Supp.* 773 (D.S.C. 1995) (overcrowding, lack of privacy, fire safety; use of tear gas; inadequate medical and mental health care). For subsequent opinions see 116 *F.3d* 1473 (unpublished opinion), 1997 WL 355626 (4th Cir.) (affirming access order) and 113 *F.3d* 1373 (4th Cir. 1997) (regarding fees); *Inmates of Boys Training School v. Affleck*, 346 *F. Supp.* 1354, 1374 (D. R.I. 1972) (cold, dark cells with only toilet and mattress, insufficient lighting, clothing, personal hygiene items, exercise, and inadequate medical and mental health services); *Morgan v. Sproat*, 432 *F.Supp.* 1130 (D. Miss. 1977) (overcrowding, inadequate exercise, fire hazards, inadequate, medical, dental, and psychological services).

Footnote: 86 *Doe v. Washington County*, 150 *F.3d* 920 (8th Cir. 1998); *Gary H.*, 831 *F.2d* at 1431; *H.C. ex rel. Hewett v. Jarard*, 786 *F.2d* 1080, 1084–85 (11th Cir. 1986); *Milonas v. Williams*, 691 *F.2d* 931, 942 (10th Cir. 1982), cert. denied, 460 *U.S.* 1069 (1983); *Santana v. Collazo*, 714 *F.2d* 1172, 1179 (1st Cir. 1983); *Alexander S.*, 876 *F.Supp.* at 796. But see, *Nelson v. Heyne*, 491 *F.2d* 352, 355 (7th Cir. 1974) (applying Eighth Amendment analysis to juvenile facility).

Footnote: 87 457 *U.S.* 307 (1982).

Footnote: 88 441 *U.S.* 520, 539 (1979).

Footnote: 89 *Milonas*, 691 F.2d at 942; *Santana*, 714 F.2d at 1180; *Gary H.*, 831 F.2d at 1432; *Alexander S.*, 876 F.Supp. at 797–98.

Footnote: 90 *Bell v. Wolfish*, 441 U.S. at 539; *Santana*, 714 F.2d at 1180.

Footnote: 91 *A.J. by L.B. v. Kierst*, 56 F.3d 849 (8th Cir. 1995).

Footnote: 92 *See Wilson v. Seiter*, 501 U.S. 294, 304–305 (1991); *Gary H.*, 831 F.2d at 1432.

Footnote: 93 *Wilson v. Seiter*, 501 U.S. at 304–305.

Footnote: 94 *Bell v. Wolfish*, 441 U.S. at 547–548.

Footnote: 95 *Gary H.*, 831 F.2d at 1432–1433; *See also, Alexander S. Boyd*, 876 F.Supp. at 779.

Footnote: 96 *See 18 U.S.C. 3626(g)(5) (defining a "prison" as any facility "that incarcerates ordetains juveniles or adults accused of, convicted of, sentenced for, or adjudicated delinquent for,violations of criminal law")*.

Footnote: 97 18 U.S.C. §3626(g)(2).

Footnote: 98 *See Alexander S. v. Boyd*, 113 F.3d 1373 (4th Cir. 1997).

Footnote: 99 18 U.S.C. § 3626(a)(1)(A).

Footnote: 100 *See Gary H.*, 831 F.2d at 1432.

Footnote: 101 18 U.S.C. §§ 3626(a)(1) and 2626(c)(1).

Footnote: 102 18 U.S.C. § 3626(b)(1)(A)(i); 18 U.S.C. § 3626(b)(3).

Footnote: 103 *A.J. v. Kierst*, 56 F.3d at 854–855.

Footnote: 104 *Id*; *Alexander S.*, 876 F. Supp. at 795; *Morgan v. Sprout*, 432 F.Supp. at 1148.

Footnote: 105 150 F.2d at 923.

Footnote: 106 *See also, Sprout*, 432 F. Supp. at 1149 (overcrowding produced a hostile, chaoticenvironment which was counter–therapeutic and resulted in fights).

Footnote: 107 *See, e.g. Doe v. Foti*, No. 93–1237 (consent decree entered October 14,1997)(population capped at 150); *E.R. v. McDonnell*, No. 94–N–2816 (D.Colo. May 26,1995)(population capped at 78); *G.C. v. Coler*, No. 87–6220–CIV–GONZALEZ (S.D. Fla.

Dec.15, 1988)(consent decree included provision for population cap). But see, *Alexander S. v. Boyd*, 876 F. Supp. at 784 (declining to order population cap on grounds that release would not be in the best interest of the juveniles, and the state should first have the opportunity to choose its own remedy for unconstitutional overcrowding); *Sprout*, 432 F.Supp at 1150 (threatening to take whatever steps may be necessary if state fails to build new facilities).

Footnote: 108 18 U.S.C. §3626(g)(4).

Footnote: 109 Compare *Ruiz v. Estelle*, 161 F.3d 814, 821–827 (5th Cir. 1998)(consent decree limiting population is a prisoner release order even though the defendants could comply by building new prisons), with *Inmates of Suffolk County Jail v. Sheriff of Suffolk County*, 952 F.Supp 869, 883 (D.Mass. 1997), *aff'd as modified and remanded on other grounds*, 129 F.3d 649 (1st Cir. 1997) (a population cap is not a "prisoner release order" in the absence of an order to release); *Doe v. Younger*, Civ. Action No. 91–187, Op. and Order at 10–12 (E.D. Ky, Sept. 4, 1996)(ban on housing juveniles in jail for more than 15 days not a prisoner release order).

Footnote: 110 See e.g., *Gary H. v. Hegstrom*, 831 F.2d at 1436 (pervasive problems with medical care, including inadequate, screening, medication, staffing, training, and suicide prevention); *Alexander S. v. Boyd*, 876 F.Supp. at 788–789 (insufficient number of trained medical staff placed health of entire population at risk); *Morgan v. Sproat*, 432 F.Supp. 1130, 1157 (D. Miss. 1977)(ordering minimum medical, dental, and mental health standards and increased staffing to provide emergency and regular care); *Affleck*, 346 F. Supp. at 1374 (training school had no psychiatrist or psychological counseling program).

Footnote: 111 See Pamela Casey and Ingo Keilitz, *Estimating the Prevalence of Learning Disabled and Mentally Retarded Juvenile Offenders: A Meta–Analysis*, in *Understanding Troubled and Troubling Youth* (Peter Leone, ed., 1990) (estimating that 12.6% of juvenile offenders are mentally retarded and 35.6% have learning disabilities). See also, *Santana*, 714 F.2d at 1182 (juveniles with mental retardation represented a major proportion of the population); *Sprout*, 432 F. Supp. at 1145, n.45 (estimating that almost 90% of students were in need of special education).

Footnote: 112 429 U.S. 97 (1996).

Footnote: 113 *Youngberg v. Romeo*, 457 U.S. 307 (1982).

Footnote: 114 See *Dolihite v. Maughon*, 74 F.3d 1027 (11th Cir. 1996); *H.C. ex rel. Hewett v. Jarard*, 786 F.2d at 1084–85.

Footnote: 115 *Farmer v. Brennan*, 511 U.S. 825 (1994).

Footnote: 116 *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977).

Footnote: 117 Compare *Steele v. Shah*, 87 F.3d 1266, 1267 (11th Cir. 1996) (prisoner who "suffered from insomnia, anxiety, and various bodily pains" and "feelings of helplessness" stated a claim under the Eighth Amendment) with *Doty v. County of Lassen*, 37 F.3d 540 (9th Cir. 1994) (female prisoner who experienced nausea, shakes, headache, sleeplessness, and

depressed appetites suffered merely from "mild, stress-related ailments" and "routine discomfort" did not have a "serious" medical need).

Footnote: 118 See *H.C. by Hewett v. Jarrard*, 786 F.2d 1080 (11th Cir. 1986) (denial of necessary medical care to juvenile confined to an isolation cell unconstitutional because motivated by the superintendent's desire to punish).

Footnote: 119 *Viero v. Bufano*, 925 F.Supp. 1374 (N.D.Ill. 1996) (failure to provide medication and counseling to juvenile diagnosed with major depression and suicidality).

Footnote: 120 *Farmer v. Brennan*, 511 U.S. 828–829.

Footnote: 121 See *Myers v. County of Lake*, 30 F.3d 847 (7th Cir. 1994) (parent of juvenile who committed suicide in detention facility won favorable verdict based on state law negligence claim after court had granted summary judgment to defendants on the Federal claim).

Footnote: 122 See *Gary H. v. Hegstrom*, 831 F.2d at 1436; *Alexander S. v. Boyd*, 876 F.Supp. at 788–789; *Morgan v. Sproat*, 432 F.Supp. at 1157. See also *John A. and Mary B. v. Michael N. Castle*, (D. Dela. 1994) (consent decree laying out detailed requirements for staffing levels, suicide prevention, mental health care, and medical in juvenile facility).

Footnote: 123 See *National Commission on Correctional Health Care, Standards for Health Services in Juvenile Detention and Confinement Facilities* (1995).

Footnote: 124 This section of the memo cannot possibly discuss all of the ramifications of the IDEA for children in the juvenile justice and mental health systems. Advocates seeking greater detail are encouraged to consult *Joseph B. Tulman & Joyce E. McGee (eds.), Special Education Under the Individuals with Disabilities Education Act (IDEA) For Children in the Juvenile Delinquency System* (1998). This comprehensive and very helpful manual is available from Professor Tulman at the University of the District of Columbia School of Law.

Footnote: 125 *Patricia Puritz & Mary Ann Scali, Beyond the Walls: Improving Conditions of Confinement for Youth in Custody, Office of Juvenile Justice and Delinquency Prevention Report*, at 16–17.

Footnote: 126 34 C.F.R. §300.311. Courts have held that children's rights under IDEA continue despite incarceration. E.g., *Alexander S. v. Boyd*, 876 F.Supp. 773 (S.D.C. 1995) (pre-trial detention and post-adjudication institutionalization); *Green v. Johnson*, 513 F.Supp. 965 (D.Mass. 1981) (adult jail).

Footnote: 127 34 C.F.R. §300.300.

Footnote: 128 *Id.*

Footnote: 129 34 C.F.R. §300.340.

Footnote: 130 §300.346.

Footnote: 131 §300.24.

Footnote: 132 *Id.*

Footnote: 133 §300.519.

Footnote: 134 §300.523.

Footnote: 135 §300.527.

Footnote: 136 *Statement of Interest, Alexander S. v. Boyd, 576 F. Supp. 773 (D.S.C. 1995).*

Footnote: 137 §300.347(b).

Footnote: 138 §300.348.

Footnote: 139 42 U.S.C. §1997(e)(9).

Footnote: 140 *Bell v. Wolfish, 441 U.S. 520 (1979)(adult inmates). In Jackson v. Indiana, 406 U.S.715 (1972), the Supreme Court held that, in the noncriminal setting, there must be a relationship between the purpose for which an individual's liberty is taken and the treatment provided to that person. "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." Id. at 738. Following this standard, some courts have held that since the purpose of confining juveniles in detention centers is rehabilitation, some treatment programs must be offered. See, Morgan v. Sproat, 432 F.Supp. 1130 (S.D.Miss.1977); Pena v. New York State Div. for Youth, 419 F.Supp. 203(S.D.N.Y.1976); Martarella v. Kelley, 349 F.Supp. 575 (S.D.N.Y.1972).*

Footnote: 141 *The Seventh Circuit has applied the cruel and unusual punishment test of the Eighth Amendment. Nelson ex rel. Nelson v. Heyne, 491 F.2d 352 (7th Cir.), cert. denied, 417 U.S.976 (1974); cf. Morales v. Turman, 562 F.2d 993, 998–99 (5th Cir.1977) (expressing doubt about juveniles' right to treatment under the Due Process Clause, but recognizing that the Eighth Amendment may afford relief to the plaintiffs). Other circuits have applied the Due Process Clause of the Fourteenth Amendment. Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir.1987); H.C. ex rel. Hewett v. Jarrard, 786 F.2d 1080 (11th Cir.1986); Santana v. Collazo, 714 F.2d 1172 (1st Cir.1983), cert. denied, 466 U.S. 974 (1984); Milonas v. Williams, 691 F.2d 931 (10th Cir.1982), cert. denied, 460 U.S. 1069 (1983). The United States Supreme Court has not decided the issue. However, in Ingraham v. Wright, 430 U.S. 651, 669 n. 37 (1977) while expressly reserving the question whether the Eighth Amendment applies to juvenile institutions, stated that it applies "only after the state has complied with the constitutional guarantees traditionally associated with criminal prosecutions." Id. at 671–72 n.40. Given the Court's refusal to extend all such guarantees to the juvenile delinquency process,*

McKiver v. Pennsylvania, 403 U.S. 528 (1971), it is unlikely that the Cruel and Unusual Punishment clause has any applicability to juvenile detention facilities.

Footnote: 142 *DeShaney v. Winnebago County Dep't of Social Services*, 489 U.S. 189, 200 (1989).

Footnote: 143 *Id.* at 201 citing *Youngberg v. Romeo*, 457 U.S. 307 (1982).

Footnote: 144 *McNamara v. Dukakis*, 1990 WL 235439, *4 (D. Mass. 1990).

Footnote: 145 See, e.g., *Rockwell v. Cape Cod Hospital*, 26 F.3d 254 (1st Cir. 1994). The Center for Public Representation has prepared and periodically updated a list for ATTAC of NAPAS of mental disability damage cases. The list, which is available from ATTAC, includes a comprehensive survey of state action cases.

Footnote: 146 *Michael J. Dale*, 32 U.S.F. L. Rev. at 700.

Footnote: 147 See cases listed in n. 141, *supra*.

Footnote: 148 457 U.S. 307 (1982).

Footnote: 149 441 U.S. 520, 539 (1979)(an adult pre-trial detainee may not be punished while indetention and may only be deprived of liberty to the extent necessary to operate the jail and to produce the person for trial). The standards in *Bell* are less onerous than those articulated in *Wilson v. Seiter*, 501 U.S. 294 (1991), in which the Supreme Court held that for convicted prisoners, public officials will be exposed to §1983 liability only if they are deliberately indifferent to the prisoner's welfare. The *Youngberg* standards may be the most protective and arguably apply to juveniles in detention settings. See *Michael J. Dale*, 32 U.S.F. L. Rev. at 700–02.

Footnote: 150 *Milonas*, 691 F.2d at 942. See cases listed at n. 141, *supra*.

Footnote: 151 Such “affirmative claims for adequate government services” are “an appropriate use of professional judgment” in the Professor Susan Stefan's opinion. Her important and very useful article on the standard finds fault when it is used in cases in which the individual seeks to resist government restrictions on his liberty. Susan Stefan, *Leaving Civil Rights to the “Experts”: From Deference to Abdication Under the Professional Judgment Standard*, 102 Yale L. J. 639 (1992).

Footnote: 152 The Court defined a treating professional as “a person competent, whether by education, training or experience, to make the particular decision at issue.” *Youngberg*, 457 U.S. at 323 n.30.

Footnote: 153 *Id.* at 323.

Footnote: 154 *Youngberg*, 457 U.S. at 319 n. 25.

Footnote: 155 Years of prison litigation have helped to define what is constitutionally mandated treatment for prisoners with mental illness. For a complete listing of those cases, see

Footnote: 156 Youngberg, 457 U.S. at 321.

Footnote: 157 See, e.g., *Clark v. Cohen*, 613 F. Supp. 684, 704 (E.D. Pa. 1985), *aff'd*, 794 F.2d 79(3d Cir. 1986). See, *Susan Stefan*, 102 Yale L. J. at 696–99 for a full complete examination of the budget constraint defense.

Footnote: 158 The Americans with Disabilities Act (ADA) applies mental hospitals and to, it is safe to assume, juvenile detention facilities. *Pennsylvania Dep't. of Corrections v. Yeskey*, 524 U.S.206 (1998)(Title II of ADA applies to prisons). The court in *Alexander S.* found that the ADA did not provide any rights to the plaintiffs that were not already provided by IDEA, §504 and other statutes. 876 F.Supp. at 803. The Supreme Court's decision in *Olmstead v. L.C.*, 119 S.Ct.2176 (1999), will provide advocates with a strong argument for discharge if there is professional judgment to support it. The full implications of *Olmstead* for juveniles in institutions are beyond the scope of this paper.

Footnote: 159 Eric M. Weiss, *Deadly Restraint*, *Hartford Courant*, October 11–15, 1998, available at <http://www.courant.com/news/special/restraint>.

Footnote: 160 Unless otherwise specified, we will use the word “restraint” to include seclusion, physical restraint, mechanical restraint and chemical restraint. Used alone, the word “seclusion” will mean placing someone in isolation in a room or area with egress therefrom prevented.

Footnote: 161 Youngberg, 457 U.S. at 317.

Footnote: 162 Several years ago, the Center for Public Representation prepared a comprehensive list of the clinical literature regarding the use of restraint with people with mental illness and mental retardation. The lists, which have not been updated, are available from ATTAC of NAPAS. For an analysis of nearly a hundred research studies, see William A. Fisher, *Restraint and Seclusion: A Review of the Literature*, 151 *Am. J. Psychiatry* 1584 (1994).

Footnote: 163 But see the distinction described on the following page that one commentator makes between retaliatory punishment and punishment that is designed to teach.

Footnote: 164 Some states allow restraint to prevent damage to property. State restraint statutes were classified in Note, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 *Yale L.J.* 1836, 1841 n.25 (1986). As a result of the *Hartford Courant* series, at the time of the drafting of this paper, several bills are pending in Congress which would regulate the use of restraint in facilities participating in the Medicaid or Medicare programs. HCFA published interim final rules regarding restraint in hospitals in the *Federal Register* on July 2, 1999. 64 *Fed. Reg.* 36069–89. 42 C.F.R. Part 482. Facilities which are inspected and certified by JCAHO should meet that organization's standards. HCFA has also issued restraint rules applicable to nursing homes (42 C.F.R. § 483.13) and Intermediate Care Facilities for people with mental retardation (42 C.F.R. §§ 483.420, .440 and .450).

Footnote: 165 The Center for Public Representation has litigated several personal injury and wrongful death cases arising from the misapplication of or injuries suffered during restraint. For an analysis of the impact of those and other damages cases on the quality of care, see Steven J. Schwartz, *Damage Actions as a Strategy for Enhancing the Quality of Care of Persons with Disabilities*, XVII N.Y.U. Rev. L. & Soc. Change 651 (1989–1990).

Footnote: 166 Perhaps the most comprehensive challenge to a facility's restraint practices was *Ihler v. Chisholm*, No. ADV–88–383 (Montana Dist. Ct. 1991) (ordering standards for restraint), described at 855 P.2d 1009 (Mont. 1993) (regarding award of attorneys' fees).

Footnote: 167 Thomas S. Gutheil, *Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient*, 135 Am. J. Psychiatry 325 (1978).

Footnote: 168 Nancy S. Cotten, *the Developmental–Clinical Rationale for the Use of Seclusion in the Psychiatric Treatment of Children*, 59 Am. J. Orthopsychiatry 442 (1989).

Footnote: 169 *Id.* at 448.

Footnote: 170 *Id.*

Footnote: 171 Wanda K. Mohr, Margaret M. Mahon, & Megan J. Noone, *A Restraint on Restraints: The Need to Reconsider the Use of Restrictive Interventions*, XII Archives of Psychiatric Nursing 95 (1998).

Footnote: 172 William A. Fisher, 151 Am. J. Psychiatry at 1585.

Footnote: 173 This strategy, while appropriate, is not always successful. In one recent case our young client asked not be restrained in a particular manner since, she said, it recreated her painful experiences of sexual abuse. She requested that if restraint must be used, another distinct method be employed instead. The facility denied this request, stating that her chosen of method was an inappropriate attempt to recreate yet another experience. She denies it and the dispute continues.

Footnote: 174 At least one case has raised these issues. *Caroline C. v. Johnson*, No. 4:CV95–22 (D.Neb.) (Consent Decree October 1998). See, also, Massachusetts Department of Mental Health, *Clinical Guidelines: DMH Clients with a History of Trauma* (1996); Katie Brennan, *Adult Survivors of Childhood Sexual Abuse in the Mental Health System: Involuntary Intervention, Retraumatization, and Staff Training*, Department of Community Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida (1998).

Footnote: 175 Alexander S., 876 F.Supp. at 785. With one exception, the court declined the plaintiffs' request to regulate the discipline system. The exception was in the “fairly regular” use of CS gas, a potent type of tear gas which causes instant pain, coughing fits and breathing problems. The court found the use of CS gas to be “counterproductive” and to violate due process. The defendants were ordered to use the gas only to prevent serious bodily harm and when no less intrusive method of restraint is possible. (Anyone who has ever experienced CS gas will be appalled that this noxious agent was used “fairly regular[ly]” in a juvenile

facility.)

Footnote: 176 No. C-78-166 (E.D. Wash. Oct. 7, 1982). The case is described in Michael Dale, 32 U.S.F. L. Rev. at 689-90.

Footnote: 177 Hollingsworth v. Orange County, No. 90-345 (Orange County, Cal. Super.Ct.) (Statement of decision and Judgment filed July 27, 1990). The case is described in Michael Dale, 32 U.S.F. L. Rev. at 690-91.

Footnote: 178 691 F.2d at 941-42.

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