

UNMET MENTAL HEALTH NEEDS CAUSE FAILURE ACROSS YOUTH-SERVING INSTITUTIONS

By Patrick Gardner

The following article was adapted from an article originally published in the July-August 2001 issue of *Clearinghouse Review: Journal of Poverty Law and Policy*, a publication of the Chicago-based National Center on Poverty Law.

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

Children's mental illness is one of society's most difficult challenges, the nature of our response may be making the difficult impossible. Not only do we fail to aid every child in need; but also we tend to isolate the children we do aid from their families and communities. We build arbitrary constraints that determine which children we help, in what setting, and for how long; and the services we provide tend to be generic and sporadic.

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

I. Unmet Mental Health Needs

Mental health disorders among youth harm individual children and, when aggregated across communities, constitute a serious public health challenge. Among young adults, "mental illness is the most common cause of hospitalization . . . with the exception of childbirth, and is the second leading cause of disability . . ." ¹ Unmet psychiatric treatment needs cause widespread failure in family

relationships and child-serving institutions. Poor outcomes, however, are not preordained. A better understanding of mental health and a more informed view of how mental disorders affect families and institutions yield useful tools for effecting change and securing improved outcomes.

A. Dire Needs

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

Unlike somatic illness or injury, psychological disorders involve both the individual and society: "A mental disorder results from the interaction of a child and her environment. Thus mental illness often does not lie with the child alone. [Conceptually] the mental disorder is an 'emergent property' of a transaction with the environment."⁴

Children in out-of-home placements disproportionately suffer mental health disorders: ⁵ "Experts estimate that between 30 and 85 percent of youngsters in out-of-home care suffer significant emotional disturbance. Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders of those living with

¹ *Serena Clayton et al.*, Investing in Adolescent Health: A Social Imperative for California's Future 50 (2000), available at <http://youth.ucsf.edu/nahic>.

² *U.S. Dept of Health & Human Services*, Mental Health: A Report of the Surgeon General 123-24, 179 (1999).

³ *Id.*

⁴ *Id.* at 136.

⁵ *Id.* at 185.

their own families.”⁶ The circumstances among detained youth are no better: “It is estimated that 60 percent of the teenagers in juvenile detention have behavioral disorders and approximately 20 percent experience serious emotional disturbance In addition, some 50 to 75 percent have serious substance abuse problems.”⁷

B. Adverse Outcomes

According to Dr. Steven Hyman, director of the National Institute of Mental Health, “Children with unrecognized or untreated cognitive and emotional disorders cannot learn adequately at school . . . [and] are at heightened risk for school failure and drop out, drug use, risk behaviors for HIV [human immunodeficiency virus] transmission, and many other difficulties.”⁸ Mental health problems also may lead to increased family stress and disorganization, domestic violence, and child abuse or neglect. Evidence is strong that more than 90 percent of the approximately 5,000 children and adolescents who commit suicide each year have a mental disorder.⁹ Suicide is the third leading cause of death among teens.¹⁰

⁶ Ellen Battistelli, *Child Welfare League of America*, Fact sheet: The Health of Children in Out-of-Home Care, www.cwla.org/programs/health/healthcarecfact.htm (last visited May 17, 2001).

⁷ *The Substance Abuse and Mental Health Services Administration* defines “serious emotional disturbance” as “a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, and that resulted in functional impairment which substantially interferes with or limits [a] child’s role or functioning in family, school, or community activities” within the past year. *Dep’t Of Health & Human Servs.*, *supra* note 2, at 172. See 58 *Fed. Reg.* 29422–25 (1993); *Lewin Group, Nat’l Ass’n Of Psychiatric Health Sys., Enhancing Youth Services* 3 (2000), at www.naphs.org/youth_services/lewinpaper.html. See also Special Education Advocacy under the Individuals with Disabilities Education Act (Idea) for Children in the Juvenile Delinquency System 1–6 (*Joseph B. Tulman & Joyce A. Mcgee Eds.*, 1998) (“Within the juvenile justice system . . . children and adolescents with disabilities are grossly over-represented and are disproportionately detained and confined.”) [*hereinafter* *Special Education Advocacy*].

⁸ *Mental Health of America’s Children Before the House Subcommittee on Labor-DHHS, Education and Related Agencies Committee on Appropriations, 105th Cong. (Oct. 29, 1997) (Statement of Steven E. Hyman, Director of the Nat’l Inst. of Mental Health).*

⁹ *Dep’t Of Health and Human Servs.*, *supra* note 2, at 150.

¹⁰ *Id.*

Mental health disorders often engender incorrigible or defiant behavior. Undiagnosed and untreated, these behaviors can lead to school suspensions and expulsions, delinquency adjudication, and detention with the attendant labeling, sanctions, segregation, and hopelessness. Public school statistics tell a chilling story: “National data indicate that 20 percent of students with serious emotional disorders are arrested at least once before leaving high school; 50 percent drop out of high school; and almost 75 percent of those that drop out are arrested within five years of leaving school.”¹¹

Through varying pathways, many disordered children end up in restrictive care--in residential treatment centers, including group homes and halfway houses, juvenile detention, and psychiatric hospitals. Studies suggest that each year child welfare, juvenile justice, and mental health authorities institutionalize more than 700,000 children with diagnosable mental health needs.¹² Although institutional care is necessary for the most severely disordered youth, for others it likely aggravates their condition. A stable link between a caring adult and an at-risk child is a critical element for successful development.¹³ Isolating disordered youth from their families, friends, school, and community threatens these links. Moreover, as youth become socialized to institutional life, they become less capable of making the transition back to the families and communities they need for support.¹⁴

C. Failure in Child-Serving Institutions

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

¹¹ *Clayton et al.*, *supra* note 1, at 51.

¹² *Dep’t of Health & Human Servs.*, *supra* note 2, at 180.

¹³ *Id.* at 125–26.

¹⁴ *Id.* at 170.

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

According to one expert in the case,

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

When the child's mental health problems manifest themselves in difficult or dangerous behaviors, the foster parents are unprepared and unable to deal with the child's behaviors. They lack adequate access to professional mental health and case management resources to help the child and assist them with the child's behaviors. When the behaviors become unmanageable, the foster parents demand that the child be removed from their home.

DSHS removes the child from the home but subsequently moves the child to a similar placement. Again, the child's behaviors exceed the foster parent's ability to manage and help the child and the home again asks [that] the child be removed. The cycle repeats itself. With each additional placement, the child is further damaged."¹⁵

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

For much of his childhood, [Thomas's] mental disorder went undiagnosed and untreated. When a crisis hit, the family was bounced back and forth between systems. A mental health worker would be involved with the family one week, then absent for years. A well-meaning social worker would rush in with some patchwork services to get the family stabilized, and then disappear.

Eventually, Thomas' trajectory mirrored that of so many youth around the country with unacknowledged and untreated mental health disorders. He reached adolescence and broke the law. Like most youth who wind up in juvenile hall, his crime was not a violent one.¹⁶

Efforts were made to place Thomas in a therapeutic program, but few spaces were available and he was obliged to wait weeks, and then months for a transfer. During this time, Thomas began acting out and was "locked down in his cell more and more often."¹⁷ One day his spirits seemed to rise, and suddenly he was "happy and joking around."¹⁸ And then, minutes later, he was discovered "hanging by his neck, his bed sheet ripped and fashioned into a noose."¹⁹

Although Thomas survived, he "remains on life support, his brain damaged beyond repair."²⁰ Tragically Thomas is not alone: "Youth suicide in juvenile detention and correctional facilities is more than four times greater than youth suicide in the general public."²¹

When child-serving systems fail, minority children and adolescents are disproportionately harmed. Studies show that minority children are less likely to receive preventive services and more likely to be in detention than white children.²² Research

¹⁵ *Motion to Certify as Class Action Pursuant to CR 23: Declaration of Kathleen Westover, M.A., at 5, Braam V. State Of Washington, No. 98 2 01570 1 (Wash. Super. Ct. Wash. Whatcom County filed July 10, 2000).*

¹⁶ *Coalition for Juvenile Justice, supra note 17, at 12–17.*

¹⁷ *Id. at 17.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id. at 18.*

²² *Gary B. Melton et al., No Place to Go: The Civil Commitment of Minors 22–25 (1998), available at*

suggests that a two-tiered system shows “youth in private facilities and in the health stream...[coming] from more affluent families, on average, than youth confined in public facilities and within justice centers.”²³

Differences in personal histories or medical problems cannot account for the discrepancies. According to one research team, “[V]iolent, disturbed adolescent blacks were incarcerated; violent, disturbed whites were hospitalized. Even when black children were initially considered to be psychiatrically disturbed and were hospitalized, they often subsequently were transferred to corrections.”²⁴ T.M. Lurhman, in her anthropological study of the training of American psychiatrists, put it this way: “Psychiatric illness, like all medical problems but more so, is mired in the ugly realities of the American class structure.”²⁵

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

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

A. Balkanized Bureaucracy

According to the surgeon general:

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

services from the schools, about 11 percent from the health sector, about 6 percent from the child welfare sector, and about 4 percent from the juvenile justice sector. For nearly half the children with serious emotional disturbances who received services, the public school system was the sole provider.²⁶

Which government entity assumes responsibility for a disturbed child’s care is often happenstance.²⁷ Very often agencies ping-pong children back and forth.²⁸ Consider the case of Sheila M., a 16-year-old who has a dual diagnosis of mental retardation and manic depression. Sheila “has been transferred more than 65 times between children’s shelters, group homes, psychiatric hospitals and juvenile jails . . .”²⁹

The state psychiatric hospital rejected Sheila because “her I.Q. of around 60 is too low to enable her to participate in the therapy.”³⁰ The developmental disability regional center declined to treat Sheila “because she was too mentally ill and therefore too aggressive and dangerous.”³¹ Sheila may well end up incarcerated. Against her is a charge of vandalism, a felony for which she could be in detention for years. Allegedly she broke “a pipe in a bathroom at a children’s shelter after being locked in there for punishment.”³²

Transfers among agencies reflect not only the reluctance by any one department to accept full responsibility for effectively treating

www.netstoreusa.com/ljbooks/080/0803230958.shtml; see also *Dept of Health & Human Servs.*, supra note 2, at 181–82; *Coalition for Juvenile Justice*, supra note 17, at 26–31.

²³ *Melton et al.*, supra note 25, at 23.

²⁴ *Id.* at 23–24 (quoting *D.O. Lewis & S.S. Shanok*, *Racial Factors Influencing the Diagnosis, Disposition, and Treatment of Deviant Adolescents, in Vulnerability to Delinquency 295–311 (D.O. Lewis Ed., 1981)*).

²⁵ *T.M. Lurhmann*, *Of 2 Minds: The Growing Disorder In American Psychiatry 157 (2000)*.

²⁶ *Dep’t of Health & Human Servs.*, supra note 2, at 180.

²⁷ *Jane Knitzer, Children’s Def. Fund*, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Health Services 67 (1982)* (“*Chance often determines whether disturbed children and adolescents become the responsibility of state mental health agencies. They are just as likely, if not more so, to fall under the auspices of state child welfare, juvenile justice, or education agencies, or even public agencies serving mentally retarded persons or alcohol and drug abusers. In part, which system ends up with primary responsibility for a disturbed child rests upon whether the child has an intact, functioning family, or whether the child has been picked up for a status offense or a delinquent act. It may also depend upon the way various state agencies are organized.*”).

²⁸ *Melton et al.*, supra note 25, at 10.

²⁹ *Fox Butterfield*, *Concern Rising over Use of Juvenile Prisons to “Warehouse” the Mentally Ill*, *N.Y. Times*, Dec. 5, 2000, at A14.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

mental health problems, but also the difficulty of coordinating care among multiple bureaus. Without effective coordination, agencies may transfer children to conserve resources or get rid of high-needs or difficult children.

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

The full range of funding options for agencies working across the [Child Protective Services] and [Alcohol and Other Drug] systems is truly bewildering: a Los Angeles program serving pregnant and parenting mothers with [Alcohol and Other Drug] problems, for example, has woven together 40 different funding sources. In working on these issues, we have found no one who understands all the available categorical funding sources in the three systems, and no state or county has yet developed a comprehensive inventory of the three systems' funding sources and updated it on an annual basis.³³

The proliferation of programs and funding sources for mental health needs engenders deep frustration on the part of advocates for, and parents of, children in need. It also makes holding government accountable for duties owed to at-risk kids much more difficult because obtaining services from one agency often requires enforcing a duty that another owes.

B. Insufficient Access to Services or Individualized Care

Mental health care typically begins with a referral and then a mental health screen. The

referral may come from any number of sources, including a teacher, social worker, probation officer, crisis counselor, guardian *ad litem*, or a parent. If the initial screen indicates, a diagnosis is undertaken which then forms the basis for a treatment plan. Services follow, with periodic adjustments to the treatment plan as the child progresses toward a hoped-for outcome of improved health and functioning. Typical mental health services include inpatient treatment, residential treatment, therapeutic foster care or group home placement, outpatient treatment, partial hospitalization or day treatment, community-based care, counseling, medical management, case management, and crisis services.³⁴

Although many children receive mental health care each year in the United States, the response to troubled youth oftentimes is no response at all. The U.S. Office of Technology Assessment reported in 1986 that "approximately 70 percent of children and adolescents in need of treatment do not receive mental health treatment."³⁵ The recent surgeon general's report similarly concluded that "a high proportion of young people with a diagnosable mental disorder do not receive any mental health services at all."³⁶

The gap between need and services arises, in part, because states fail to provide adequate resources to support necessary services. As a result, reimbursement rates are too low, arbitrary "utilization" restrictions are put on services, and too few providers are available to meet youth's needs.³⁷

Children are also underserved in the manner in which they receive services. Public entitlement to services often depends upon whether a child has a formal diagnosis.³⁸

³⁴ *Dep't of Health & Human Servs.*, supra note 2, at 168–79.

³⁵ *Dep't of Health & Human Servs.*, supra note 2, at 180.

³⁶ *Id.*

³⁷ *Dep't of Health & Human Servs.*, supra note 2, at 138. *Insufficient funding is not unique to children's mental health services as all child-serving institutions are obliged to get by with too little money. But mental health is particularly vulnerable because at-risk children, especially impoverished adolescents, are politically unpopular and virtually powerless.*

³⁸ *Medicaid is the largest funder of children's mental health in the United States. See Dep't of Health & Human Servs.*, supra note 2, at 183; see also *Melton et al.*, supra note 25, at 16. *Under Medicaid, access to care is limited to medically necessary services, often necessitating a formal diagnosis and disorder. See Chris Koyanagi et al., Bazelon Ctr. for Mental Health Law, Defining*

³³ Nancy K. Young & Sidney L. Gardner, *Children at the Crossroads*, 56 *Public Welfare* 3, 6 (1998).

Moreover, offered services depend upon the agency providing them, and all agencies tend to provide categorical services without sufficient regard to individual or family needs. For example, a mental health department may provide residential care but no urgent response capability; day treatment services but no respite care; or outpatient counseling but only for six or eight sessions.

Common barriers to getting physical health care also impede access to mental health care. Such barriers include lack of health insurance, complex eligibility rules, and burdensome application procedures for public health insurance; limited outreach and knowledge about the availability of subsidized care; cultural and language barriers; and lack of trust in government programs and providers.

C. Overreliance on Institutional Care

Most of the children who do receive mental health care get low-level services such as counseling or medication management. As many as an estimated 5 percent to 10 percent of children and families in the United States annually seek outpatient psychotherapy.³⁹ Most expenditures on the costs of care, however, are on residential treatment and inpatient hospitalization, which account for about three-fourths of all mental health expenditures on children each year.⁴⁰

Excessive use of institutional care not only soaks up resources that might otherwise be available for less restrictive interventions, but also can be harmful to the intended beneficiaries.⁴¹ Unnecessary institutionalization, whether in a mental health hospital, a residential care facility, or a juvenile correctional facility, isolates youth from their families, friends, schools, and communities. According to Justice Ruth Bader Ginsberg, writing for the majority in *Olmstead v. L.C.*, “[U]njustified institutional isolation . . . is a form of discrimination . . . [that] severely diminishes the everyday life activities of individuals, including family

relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”⁴²

Youth who spend even short periods in restricted facilities often become socialized to the institution. This is especially problematic for disordered youth in detention. Correctional camps and juvenile halls are criminogenic institutions that “create criminals or exacerbate criminal behavior.”

While some children need and benefit from restrictive care, still others are in institutional care because, ironically, their parents cannot afford treatment for them. Relinquishing custody of a child can gain access to needed care because children in state custody are usually eligible for Medicaid benefits.⁴³ According to a National Alliance for the Mentally Ill survey in 1999,

36 percent of survey respondents said their children were in the juvenile justice system because mental health services outside of the system were unavailable to them; 23 percent of parents were told that they would have to relinquish custody of their children to get needed services; and 20 percent said that they actually relinquished custody to get services.⁴⁴

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

III. Improving Accountability and Outcomes

The public mental health system for children and adolescents in the United States consists of numerous independent agencies pursuing disparate missions in a largely unplanned and uncoordinated effort to “serve

Medically Necessary Services to Protect Children (1998), www.bazelon.org/paper5.pdf.

³⁹ Id. At 168.

⁴⁰ Id. At 169.

⁴¹ *Melton et al.*, supra note 25, at 52–77; *Dep’t of Health & Human Servs.*, supra note 2, at 170; *Weithorn*, supra note 53, at 783–98.

⁴² *Olmstead v. L.C.*, 527 U.S. 581, 600–601 (1999) (Clearinghouse No. 52,203).

⁴³ *Mary Giliberti & Rhoda Schulzinger*, *Bazelon Ctr. For Mental Health Law*, *Relinquishing Custody: The Tragic Result of Failure to Meet Children’s Mental Health Needs 9–13* (2000).

⁴⁴ *Coalition For Juvenile Justice*, supra note 17, at 39–40.

children.” Adolescents who are seeking alternatives in an unresponsive bureaucracy or are “lost in the cracks” between bureaus need public interest attorneys to serve as crossing guards.

Used to dealing with administrative agencies, public interest attorneys can navigate children and their families through the intersections among agencies. But, in order to be effective crossing guards, advocates need to adopt a more global view by stepping outside of the bureaucratic structure of individual agencies. There are many examples of how public defenders, legal services and Protection and Advocacy attorneys, children’s advocates, and members of the private bar have pooled their expertise and formed partnerships to cut across bureaucratic boundaries and improve outcomes for at-risk children and adolescents.

A. TeamChild

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

Jack, at age 16, already had been in juvenile detention. He came out and got in trouble again: attempted robbery in the first degree. Project TeamChild in Seattle interceded, obtained a psychiatric evaluation and discovered Jack had undiagnosed and untreated mental health issues. The TeamChild attorney presented the judge with a cost-effective alternative to incarceration[,] and Jack’s behavior and progress finally improved with the concentrated medical treatment.⁴⁵

Seattle’s project gets referrals primarily from defenders whom TeamChild trains to spot

⁴⁵ Susan Kellum, *Teamchild: Curbing Delinquency at its Roots*, 20 A.B.A. Child L. Prac. 28 (2001), www.abanet.org/child/15-12toc.html.

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

One critical component to success, according to TeamChild’s Elizabeth Calvin, is teen-centered outreach and follow-up. Communicating with adolescents turns on trust that comes from understanding their developmental needs and meeting them on their terms. That might mean intake at Burger King; but so be it. Having gained the trust of their clients, TeamChild lawyers have the opportunity to help kids in crisis cross over the criminal/civil boundary to obtain health and social services to which they have.

TeamChild is gaining adherents in other states. Gator TeamChild, at the University of Florida Law School, incorporates law students and graduate students from the Florida State University School of Social Work into the model. In Connecticut the Center for Children’s Advocacy collaborates with the University of Connecticut School of Law as well as with the School of Medicine and the School of Social Work.

According to Martha Stone, executive director of the Center for Children’s Advocacy Inc., a TeamChild-modeled program in Hartford Connecticut, “We don’t care what system he’s in. We don’t care how old he is. We don’t care if he’s got truancy problems, abuse and neglect issues, or mental health problems. We offer one-stop shopping with the philosophy ‘whatever it takes.’”⁴⁶

B. Los Angeles’s Informal Coalition

California law empowers the juvenile court adjudging an abused or neglected child as dependent to “make any and all reasonable orders for the care, supervision, custody,

⁴⁶ Id.

conduct, maintenance, and support of the child, including medical support⁴⁷ The statute also provides: “To facilitate coordination and cooperation among government agencies or private service providers, or both, the court may, after giving notice and an opportunity to be heard, join in the juvenile court proceedings any agency or private service provider that the court determines has failed to meet a legal obligation to provide services to the child.”⁴⁸ Taken together, these provisions create an extraordinary opportunity to bridge bureaucratic boundaries and secure mandated services for at-risk youth.

Public interest law advocates and Dependency Court Legal Services in Los Angeles have teamed up to do just that.⁴⁹ Focusing on mandatory duties owed disabled children, including, for example, the Individuals with Disabilities Education Act, advocates have been petitioning Los Angeles’s juvenile courts to join local education and mental health authorities in dependency cases.⁵⁰ The Act entitles children with serious emotional disturbance to an individual evaluation, the development of an individualized education program, and special education and related services that enable the child to benefit from special education.⁵¹ The Act’s mandate provides the necessary “legal obligation to provide services” that allows the court to join the agencies as parties. Once an agency is before the court, lawyers can secure an order mandating appropriate services. In many cases the threat of joinder can get recalcitrant departments to act.⁵² In cases where multiple agencies are responsible for overlapping duties, the court can oblige them to sort out their respective responsibilities and hold them accountable for delivering treatment.

This partnership was born out of a concern that the nation’s largest juvenile court system was failing to provide individualized mental health services. The problem, according

to James Preis, executive director of Mental Health and Advocacy Services Inc., was an unaccountable balkanized bureaucracy:

One of the major bureaucratic barriers to individualized services for children is the lack of interagency collaboration. Cooperation between different agencies is one of the fundamental principles in systems-of-care. Everybody agrees. However, in practice interagency cooperation has come to mean that every agency serving children will develop its own interagency cooperative. As a result, child welfare departments have a program called Family Preservation. The Department of Mental Health has something similar called Systems of Care. The Department of Probation in Los Angeles has its own interagency program called Mary C., which is a demonstration project to help children who are at risk of ending up in the juvenile justice system. In addition, schools have their Healthy Start programs.⁵³

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

Clearly litigation is undesirable if children can receive the wraparound services they need without requiring a lawsuit. However, because the bureaucratic barriers that separate services for children are so ingrained in the system, real change will likely require a court order to force individual bureaucracies to cooperate.⁵⁴

The Los Angeles collaborative works informally together and with defenders in much the same way as do TeamChild advocates. At times attorneys cocounsel individual cases. They also share expertise and advice and coordinate training sessions that cut across the traditional boundaries between juvenile court and health and welfare matters. The team has prepared, as a

⁴⁷ *Cal. Welf. & Inst. Code* § 362(A) (2000).

⁴⁸ *Id.*

⁴⁹ *Partners include Public Counsel Inc., Mental Health and Advocacy Services Inc., and Protection and Advocacy Inc.*

⁵⁰ *Individuals With Disabilities Education Act*, 20 U.S.C. §§ 1412 *et seq.* (2000) (*West, Westlaw through P.L. 106-274*).

⁵¹ 20 U.S.C. § 1401(8); *Bd. of Educ. v. Rowley*, 458 U.S. 176 (1982). See also *Special Education Advocacy*, *supra note 9*, ch. 6.

⁵² *Cal. Welf. & Inst. Code* § 362(A) (2000).

⁵³ *James Preis*, *Advocacy for the Mental Health Needs of Children in California*, 31 *Loy. L.A. L. Rev.* 937, 943-44 (1998).

⁵⁴ *Id.* at 944.

part of the project, model pleadings to join other agencies in dependency proceedings.⁵⁵

C. The Threat of a Huge Damages Award

A new innovation in partnering has child advocates teaming up with personal injury attorneys. One case in Florida involves two children who, in 1986, were abandoned in a Miami park at ages 2 and 4. According to *New York Times* reporter Nina Bernstein, “[O]ver the next 14 years the sisters were shuttled through more than 30 foster homes and institutions, beaten, raped, and repeatedly separated from each other while a stream of case-workers overlooked such obvious evidence of abuse as the diagnosis of syphilis in the older girl when she was 9.”⁵⁶ A year ago a Florida jury awarded the girls \$4.4 million in damages. Sizable verdicts like that “have encouraged advocates for foster children and personal injury lawyers to join forces . . . in two-track litigation. Their lawsuits ask the courts to change the system, while separately seeking damages on behalf of children already harmed.”⁵⁷

Attorneys with the National Center for Youth Law and Brett & Daugert L.L.P. in Washington state have joined a demand for damages with class action claims for injunctive relief.⁵⁸ The complaint, filed on behalf of children who are in state custody and have emotional, behavioral, mental or physical handicaps or disabilities, includes state claims of negligence and discrimination and federal claims under the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Child Welfare and Adoption Assistance Act, and the Fourteenth Amendment.⁵⁹ The gravamen of the plaintiffs’ suit is that the state breached its duty to provide stable and permanent placements for

abused and neglected children. Plaintiffs allege that “[s]ome children have been moved as many as thirty to fifty times.”⁶⁰ The instability caused by repeated moves aggravates behavioral problems that can cause placement failures. Plaintiffs are seeking better training of foster parents and improved coordination of behavioral health and disability services to reduce transfers and avoid further harm to children already suffering from the trauma of abuse and abandonment.

Adding personal injury lawyers to the mix heightens the impact of a suit and increases the state’s accountability. The threat of a huge damages award may diminish an agency’s use of delaying tactics. Also, personal injury lawyers with jury trial experience can be a valuable supplement to the poverty lawyer’s administrative expertise. According to Jean Soliz, the former head of Washington’s Department of Social and Health Services, “[T]he torts give you the leverage to make [the state] take you seriously . . . ; the torts don’t fix anything.”⁶¹ Of course, winning a major damages award helps children who have been twice abused once by their natural parents and again by an indifferent or ineffective state bureaucracy.

D. Other Approaches, Old and New

Some old-fashioned partnerships also continue to pay dividends. In 1975 three San Francisco attorneys concluded that at-risk youth needed legal representation that was more comprehensive in scope than delinquency and status offenses.⁶² Legal Services for Children of San Francisco was born out of the idea that juveniles needed advocates who could cut across legal categories and represent youth in civil proceedings that affected their school, health, home life and even their freedom. Now in its twenty-sixth year, the organization teams up lawyers and social workers on solution-based advocacy that builds on children’s strengths and

⁵⁵ *Model pleadings are on file with and available from the National Center for Youth Law.*

⁵⁶ *Nina Bernstein, Foster-Child Advocates Gain Allies in Injury Lawyers*, N.Y. Times, Oct. 27, 2000, at A18 (quoting Jean Soliz, former head of Washington State’s Department of Social and Health Services).

⁵⁷ *Id.*

⁵⁸ *Motion to Certify as Class Action*, Braam, No. 98 2 01570 1.

⁵⁹ *Americans with Disabilities Act*, 42 U.S.C. §§ 12101 et seq. (2000) (West, Westlaw through P.L. 106-274); *Section 504 of the Rehabilitation Act*, 29 U.S.C. §§ 794 et seq. (2000) (West, Westlaw through P.L. 106-274); *Welfare and Adoption Assistance Act*, 42 U.S.C. §§ 671 et seq. (2000) (West, Westlaw through P.L. 106-274); *U.S. Const. Amend. XIV*, § 1.

⁶⁰ *Second Amended Complaint at 7*, Braam v. State of Washington, No. 98 2 01570 1 (Wash. Sup. Ct. Whatcom County filed Apr. 3, 2000).

⁶¹ *Bernstein*, supra note 73, at A18.

⁶² *Legal Services for Children of San Francisco’s founders included Peter Bull of the Youth Law Center, John Bush of Huckleberry House, and Carole Brill, an attorney in private practice.*

resilience. The collaboration seeks comprehensive solutions in supportive resources in the community and in everyday legal assistance on matters involving out-of-home placement, school discipline, mental health, and HIV advocacy, among others.

Future partnerships may involve prosecuting attorneys, disability lawyers, and public benefit specialists. In California, for example, two counties are exploring mental health courts for youthful offenders.⁶³ They are modeling their efforts after drug courts that divert offenders from detention by using intensive monitoring, treatment, and supportive services.⁶⁴ This approach challenges the traditional adversarial relationship between prosecutors and defenders. Another intersection that needs crossing guards involves disabled TANF recipients.⁶⁵ Studies confirm that, after years of declining participation, program recipients often have disabilities that affect their capacity to secure and retain work:⁶⁶ “The Americans with Disabilities Act . . . has been mentioned as a likely source of protection for TANF clients.”⁶⁷ Using the Act for TANF recipients will likely require the cooperative efforts of disability advocates and legal services lawyers.⁶⁸

The mental health needs of children and adolescents in America are much greater than most of us understand. Unmet needs cause pain and suffering for tens of thousands of kids, as well as failure in child-serving institutions. A fractured system of care, limited access to individualized treatment, an isolating overreliance on restrictive care, and insufficient

resources are causing the vast gap between provided treatment and children’s needs. Advocates can improve the situation by holding agencies more accountable through partnerships that provide at-risk youth with a right-of-way at agency intersections. Greater agency accountability would mean better program coordination, more individualized services, less restrictive care, and better outcomes for kids who deserve it.

⁶³ *Craig Anderson*, Novel Program Treats Mentally Ill Offenders, *Daily J.*, Feb. 26, 2001, at 1.

⁶⁴ *Jahna Berry*, Clean Teens: Teens Fight Their Addictions from Pot to Alcoholism, *Recorder (S.F.)*, Mar. 30, 2001, at 1.

⁶⁵ *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished Aid to Families with Dependent Children and created the Temporary Assistance for Needy Families (TANF) program.* Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified as amended in scattered sections of 7, 29, 42 U.S.C.).

⁶⁶ *Cary Lacheen*, Using Title II of the Americans with Disabilities Act on Behalf of Clients in TANF Programs, 8 *Geo. J. on Poverty L. & Pol’y.* 1, 8 (2001).

⁶⁷ *Id.* at 9.

⁶⁸ See *Id.* at 10 (*Cary Lacheen’s manual on using the Americans with Disabilities Act for TANF clients anticipates that partnership*).