

CHILDREN OF COLOR WITH MENTAL HEALTH PROBLEMS: STUCK IN ALL THE WRONG PLACES

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Thomas, a fifteen year old, suffers from severe bipolar disorder. After Thomas ran away from a mental health program, he was set to a juvenile justice facility. While there, Thomas experienced bouts of depression and agitation. For his safety and the safety of others, he was often "locked-down" in his cell, increasing his isolation. One afternoon, Thomas hung himself from a noose fashioned from ripped bed sheets. He was found in time to perform CPR and restart his heart, but his brain was damaged beyond repair and the rest of his life will be spent in a persistent vegetative state on life support¹

While nationally, one out of every five youth suffers from mental health problems, in juvenile justice facilities the numbers grow to one out of every two.² An average of 17,000 incidents of suicidal behavior occur each year in juvenile justice facilities in this country.³ In Maryland, in 1998, 53% of the youth in the 15 juvenile justice facilities had mental health problems.⁴

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1. COALITION FOR JUV. JUST., HANDLE WITH CARE: SERVING THE MENTAL HEALTH NEEDS OF YOUNG OFFENDERS, THE SIXTEENTH ANN. REP. TO THE PRESIDENT, THE CONGRESS, AND THE ADMINISTRATOR OF THE OFFICE OF JUV. JUST. AND DELINQUENCY PREVENTION, 2000 ANN. REP. 1-2 [hereinafter HWC].

2. Whereas 20% of children and adolescents in the general population experience mental health problems, national statistics relate that 50-75% of the youth in juvenile justice facilities suffer from mental health problems. HWC, *supra* note 1, at ii. See Bruce Kamradt, *Wraparound Milwaukee: Aiding Youth With Mental Health Needs*, 7 JOURNAL OF THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION 14 (2000) (hereinafter *Wraparound Milwaukee*).

3. This is four times greater than the instance of youth suicide in the general population. *Juvenile Offenders Suffer from Lack of Mental Health Services*, PSYCHIATRIC NEWS, Jan. 19, 2001, at 6.

4. Henry R. Cellini, *Mental Health Concerns of Adjudicated Adolescents*, JUVENILE JUSTICE UPDATE, (Oct./Nov. 2000) at 1, 2. Statistics for Maryland's "Adjudicated Adolescents" indicate 57% of the youth had a history of mental illness. Specific mental illnesses such as anxiety disorders (58% of youth), mood disorders (17% of youth), schizophrenia (32% of youth), disruptive behavior disorders (including ADHD and Conduct

This paper takes an in-depth look at how the mental health system is failing Maryland youth, specifically those of color.⁵ It first tracks how children who need mental health services are often denied appropriate services by the education and mental health system. Tossed to the juvenile justice system, which is ill equipped to handle the youth's needs, their problems are often exasperated. After addressing the overrepresentation of minority youth in this system, I next look at the various solutions to divert these youth from the juvenile justice system and to the appropriate program for them.

I. MARYLAND'S CHILDREN OF COLOR - STUCK IN ALL THE WRONG PLACES'

John, a 13-year-old African American boy, lives with his mother and three brothers in a poor section of Baltimore. John's mother works as a domestic worker in a hotel but cannot afford health insurance for John. John has had a hard time learning to read and it is very difficult for him to pay attention in school. John's brother was recently shot and John became depressed and withdrawn. Because John was doing very poorly in school and began running out of the school building, his mother asked the school to provide extra tutoring and counseling. However, the school said John did not qualify for special education services because he did not meet the definition of a seriously emotionally disturbed child. Instead, they treated him as a disciplinary problem and suspended him from school.⁶

Disorders) (40% of youth), and substance use problems (37% of youth) were found. *Id.* at 1-2. As many as two-thirds of youth in Maryland have co-occurring diagnoses. *Id.* at 2.

5. According to the Surgeon General's Report, African American children are more likely than white children to have unmet mental health needs. OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY—A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 59 (2001), *available at* <http://www.mentalhealth.org/crc/default.asp> [hereinafter MENTAL HEALTH].

6. John's story is based on a client who was served in the Children's Law Clinic, University of Maryland Law School.

A. Mental Health Problems Facing Children

There are a variety of mental health disorders that may affect children. As many as five of every 100 children have Attention-Deficit /Hyperactivity Disorder (ADHD).⁷ Children with ADHD may have difficulty paying attention to details and are easily distracted by other events that are occurring at the same time.⁸ They may find it difficult and unpleasant to finish their schoolwork and may put off anything that requires a sustained mental effort.⁹ Children with ADHD may be inattentive, hyperactive, aggressive and/or defiant.¹⁰

It is estimated that four to ten percent of youth have conduct disorders.¹¹ As many as six percent of children may be affected by depressive disorders.¹² Depression disorders substantially increase the risk of suicide.¹³ Incidents of suicide attempts peak during the midadolescent years and suicide is the third leading cause of death for teenagers.¹⁴ Eight to 10 of every 100 children are affected by anxiety disorders; the most common of which are phobias, panic disorders, obsessive compulsive disorder and post traumatic stress disorders.¹⁵

Symptoms of bipolar disorder, which affects as many as one in 100 people, often begin appearing in the teenage years.¹⁶ Bipolar disorder is among the most treatable of the psychiatric illnesses.¹⁷ With the correct medication the number and intensity of episodes can be greatly decreased.¹⁸ Although schizophrenia is rare in children under 12, it does occur in about three of every 1000 adolescents.¹⁹

Though children with these disorders often have serious problems, public schools do not always recognize these children as being in need of special education. For example, children with

7. HWC, *supra* note 1, at 3.

8. MENTAL HEALTH, *supra* note 5, at 142.

9. *Id.*

10. *Id.* at 137.

11. HWC, *supra* note 1, at 3.

12. *Id.*

13. MENTAL HEALTH, *supra* note 5, at 150.

14. *Id.*

15. HWC, *supra* note 1, at 3.

16. *Id.*

17. CME, Inc., Mental Health Facts, at <http://www.mhsource.com/resource/mh.html> (last visited May 4, 2002).

18. *Id.*

19. HWC, *supra* note 1, at 3.

conduct disorders are specifically excluded under the definition of seriously emotionally disturbed.²⁰

Many of these children, particularly those of color, are viewed as disciplinary problems and suspended from school.²¹ Nor is there a single place in Maryland where parents can go to access the range of services their children need. For example, children with mental health problems may need educational services as well as counseling,²² day programming,²³ community-based care,²⁴ case management services,²⁵

20. According to Maryland state regulations, a child is “emotionally disturbed” who exhibits one or more of the following characteristics over a long period of time and to a marked degree, that adversely affects a student’s educational performance: 1) an inability to learn that cannot be explained by intellectual, sensory, or health factors; 2) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; 3) inappropriate types of behavior or feelings under normal circumstances; 4) a general, pervasive mood of unhappiness or depression; or 5) a tendency to develop physical symptoms or fears associated with personal or school problems. MD. REGS. CODE tit. 13a § 05.01.03(20)(a). “Emotionally disturbed” includes children who are schizophrenic, but not those who are socially maladjusted unless they are also determined to be seriously emotionally disturbed. MD. REGS. CODE tit. 13a § 05.01.03(20)(b), (c).

21. MARYLAND STATE DEPARTMENT OF EDUCATION, SUSPENSIONS MARYLAND PUBLIC SCHOOLS 1998-1999, TABLE 3, *available at*, <http://www.mdse.state.md.us/AboutMSDE/Divisions/prim2000/suspen.pdf>. In the 2000–2001 school year, there were 70,258 suspensions in Maryland public schools; 39,934 or 56% of those were suspensions of African American students while 27,181 or 38% were suspensions of white students. MARYLAND STATE DEPARTMENT OF EDUCATION, SUSPENSIONS, EXPULSIONS, AND HEALTH RELATED EXCLUSIONS: MARYLAND PUBLIC SCHOOLS 2000-2001, TABLE 3, *available at*, <http://www.mdse.state.md.us/AboutMSDE/Divisions/prim2000/susp01.pdf>. Of the total Maryland student population, 316,231 students or 37% were African American while 455,164 students or 53% were white students. MARYLAND STATE DEPARTMENT OF EDUCATION, MARYLAND PUBLIC SCHOOL ENROLLMENT BY RACE/ETHNICITY AND GENDER AND NUMBER OF SCHOOLS, (September 30, 2000), *available at*, <http://www.mdse.state.md.us/AboutMSDE/Divisions/prim2000/enroll00.pdf>.

22. Counseling covers a large variety of therapeutic approaches. Counseling is the most common form of treatment for children and adolescents, utilized annually by an estimated five to ten percent of children and their families in the United States. Counseling is offered to individuals, groups, or families, usually in a clinic or private office. The duration of treatment varies from six to twelve weekly sessions to a year or longer. Newer counseling programs are provided with greater frequency (i.e., daily) in the home, school or community. OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 1999 168 (1999), *available at* <http://www.surgeongeneral.gov/library/mentalhealth/home.html> [hereinafter RPT. OF SURGEON GEN.].

23. Day programming is an alternative to inpatient treatment. Research shows that youth generally benefit from a structured daily environment that allows youth to return home at night to be with their family and peers. RPT. OF SURGEON. GEN., *supra* note 22, at 169.

24. Community-based care covers a range of comprehensive community-based interventions, including case management, home-based services, therapeutic foster care, therapeutic group homes, and crisis services. *Id.* at 172.

25. Case management coordinates a range of services. The case manager can take on the role of broker, whereby they obtain services for children and their families from multiple providers. *Id.*

and in-hospital care.²⁶ Each of these services may be accessed through a different agency with its own eligibility system.²⁷ For example, the Department of Education is required by state law to provide or fund special education and related services for educationally handicapped children. The Social Services Administration sometimes assumes the care and custody of mentally disabled children whose parents are unwilling or unable to care for them. At times the Juvenile Services Administration accepts responsibility for children adjudicated delinquent or in need of supervision. Additionally, the Developmental Disabilities Administration and the Mental Hygiene Administration are responsible for some mentally disabled children.²⁸ Each of these agencies has its own eligibility requirements and procedures that a child must navigate before they can receive services. Because it is often so difficult to access the range of needed services in a timely manner, many children fall through the cracks.²⁹

The failures of the mental health system³⁰ are exacerbated for older children and adolescents of color because their mental health

26. In-hospital care is the most restrictive type of care. In-hospital care consumes about half of child mental health service but it is the clinical intervention with the weakest research support. Nevertheless, because some children with severe disorders do require a highly restrictive environment, hospitals are expected to remain an integral component of mental health care. *Id.* at 171.

27. For a thorough discussion of how Maryland provides services to children with mental health problems, see Susan P. Leviton & Nancy B. Shuger, *Maryland's Exchangeable Children*, 42 MD. L. REV. 823 (1983).

28. Leviton & Shuger, *supra* note 27, at 823-24.

29. *Id.* The situation is such that the "people with the most complex needs and the fewest financial resources often find [the mental health system] difficult to use. This problem is magnified for minority groups." MENTAL HEALTH, *supra* note 5, at 33.

30. See NATIONAL MENTAL HEALTH ASSOCIATION [hereinafter NMHA], COMMUNITY PERSPECTIVES ON THE MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT NEEDS OF YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM: COMMENTARY AND CALL TO ACTION 5 (1999) for a list of common themes regarding service and policy gaps.

Nationwide, primary care physicians report significant barriers to referral for children with mental health problems. These barriers included: lack of available specialists, insurance restrictions, and appointment delays. More than two-thirds of primary clinicians report appointment delays. The average waiting time for an appointment with a specialist takes three to four months. OFFICE OF THE SURGEON GENERAL, REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH 19 (2000), available at <http://www.surgeongeneral.gov/cmh/childreport.html> [hereinafter RPT. OF SURG. GEN. CONF.]. "Of those patients who were referred, 59% had zero visits to the specialist: only 13% averaged one or more visits a month in the follow-up period of six months. In short, an increasing number of problems (15-30%) are being identified by primary care providers, but connections to mental health specialists are difficult." *Id.* at 19.

As a group, Hispanic-Latino and African American children more often leave mental health services prematurely than do Caucasian children. Many factors contribute to premature termination, such as insensitivity of mental health providers to the culture of these children and their families. *Id.* at 19.

problems often go undiagnosed since the child's family may not have insurance or their insurance policy will not cover needed treatment.³¹ Nearly one-fourth of African Americans are uninsured. This is 1.5 times the rate for whites.³² In the United States, health insurance is typically provided as an employment benefit. Because African Americans are more often employed in marginal jobs, the rate of employer-based coverage among employed African Americans is substantially lower than the rate among employed whites (53% versus 73%).³³

Lack of insurance is not the only barrier between African Americans and appropriate mental health care. First, the stigma surrounding mental health issues is a significant deterrent to seeking care in the African American community.³⁴ In many minority communities, mental health clinics are equated with state hospitals where "crazy" people are sent.³⁵ Also, in many minority families, problems like mental health issues are handled within the family unit. So, seeking help from the mental health clinics or from social workers

31. Families report that private sector insurance has often been an ineffective means of accessing necessary services for their children. RPT. OF SURGEON GEN., *supra* note 22, at 182.

Also, most children, whether using private or public insurance are part of a managed care system. Managed care is a significant barrier to mental health treatment for everything but medications. Managed care has shortened hospital stays and increased the use of short-term therapy models. *Id.* at 182; Carey Goldberg, *Children Trapped by Mental Illness*, N.Y. TIMES, July 8, 2001, at A1 [hereinafter *Children Trapped*]. Particularly difficult is accessing in-patient care in a crisis. Many felt their children had been limited or denied access to services to the detriment of their child's health. Press Release, National Alliance for the Mentally Ill [hereinafter NAMI], Families Forced to Relinquish Custody, Lose Children to Juvenile Jails Due to Pervasive Lack of Basic Treatments, Services, Educational Programs (July 1, 1999), available at <http://www.nami.org/pressroom/990701.html>.

More minority children are poor. While 8 percent of whites are poor, 24 percent of African Americans are poor. Also, poor people have the poorest level of health and higher levels of psychological distress. MENTAL HEALTH, *supra* note 5, at 39.

Although most poor children qualify for health insurance, many parents are unaware or do not know how to apply for coverage. Also, recently many families have left welfare for low paying jobs. It was assumed that once former welfare recipients entered the workforce that their employers would provide private health insurance. However, according to the Children's Defense Fund, less than one-quarter of employed former welfare recipients receive any health insurance through their employer and even fewer (11%) reported receiving coverage for their family. *Families Struggling to Make it in the Workforce: A Post Welfare Report*, (Children's Defense Fund, Washington, D.C.), 2000, at 29, available at <http://www.childrensdefense.org/pdf/CMPreport.pdf>.

32. MENTAL HEALTH, *supra* note 5, at 63.

33. *Id.*

34. One study found that African Americans feared mental health treatment 2.5 times more than whites. MENTAL HEALTH, *supra* note 5, at 63.

35. HWC, *supra* note 1, at 28.

is discouraged and considered shameful.³⁶ Also, for many African Americans distrust of the mental health system is reinforced by perceived clinician bias and stereotyping. This further impedes minorities from seeking help.

Second, appropriate care depends on accurate diagnosis. Evidence indicates that African Americans, when seen in primary care or in emergency rooms, are diagnosed less accurately than whites.³⁷ African Americans are also less likely than whites to receive the best available treatments for depression and anxiety and treatments that adhere to practice guidelines.³⁸ For many, their care is provided in emergency rooms and psychiatric hospitals, which undermine the delivery of high quality care.³⁹ In addition, there are very few African American providers for patients who would prefer one.⁴⁰ African Americans also feel that many providers neither understand nor relate to their cultural needs, and consequently, the services they receive do not meet their needs.⁴¹ Studies show that tailoring services to the specific needs of African American groups will improve utilization and outcomes. This has not happened and thus many minority patients fail to continue in treatment.⁴²

Another reason why children with mental health problems often fall between the cracks of the various providing agencies is because each agency disclaims responsibility for providing care.⁴³ This is especially true for children with mental health problems who need residential care. Arguing that the residential placement is not needed for educational reasons but rather because of medical, home or environmental factors, departments of education often claim that some other agency should provide the placement.⁴⁴

36. *Id.*

37. MENTAL HEALTH, *supra* note 5, at 32, 66.

38. *Id.* at 32, 36.

39. *Id.* at 34.

40. *Id.* at 63, 68.

41. MENTAL HEALTH, *supra* note 5, at 36, 42, 68. Cultural competent services are responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs and values. *Id.* at 36.

42. RPT. OF SURGEON. GEN., *supra* note 22, at 19.

43. RPT. OF SURG. GEN. CONF., *supra* note 30, at 24.

44. When the child needs a residential placement in order to learn, the education agency is responsible for the full cost of the placement. 20 U.S.C § 1412(12)(B) (1998); MD. CODE ANN., EDUC. § 8-406 (b).

Federal and state courts have had difficulty in determining when a child needs a residential placement for educational reasons and when such a placement is necessary for non-educational reasons. In one of the first cases to deal with this issue, the United States District Court for the District of Columbia enjoined a school board from denying a sixteen-year-old child with multiple disabilities a free placement in a residential academic program because the

court found his social, emotional, medical, and educational problems to be so intertwined that it was not possible for the court to perform the "Solomon-like task" of separating them. *North v. District of Columbia Bd. of Educ.*, 471 F.Supp. 136 (D.D.C. 1979).

When presented with similar facts, several federal and state courts have adopted the *North* intertwined-needs test. See, e.g., *Erdman v. Connecticut*, No. H80-253 (D.Conn. Aug. 22, 1980), reprinted in 3 EDUCATION FOR THE HANDICAPPED LAW REPORTER [EHLR] (CCR) 552:218; *Manchester Bd. of Educ. v. Connecticut Bd. of Educ.*, No. 227093 (Sup. Ct., Jud. Dist. Hartford/New Britain Apr. 22, 1981), reprinted in 3 EHLR (CCR) 552:397. The Office of Civil Rights (OCR) has taken a similar approach in several cases. See, e.g., *OCR/Complaint LOFS* (Conn. Dept. of Educ. Oct. 17, 1979), reprinted in 3 EHLR (CCR) 257:57-58.

In *Kruelle v. New Castle County Day School Dist.*, 642 F.2d 687, 694 (3d Cir. 1981), the Third Circuit found that a child with cerebral palsy and profound mental retardation could learn only in a residential placement where his medical, social, and emotional problems were treated, and that the inability to separately handle the child's educational, medical, social, and emotional needs was "the very basis for holding that these services [were] an essential prerequisite for learning." *Id.*

In a related line of cases, several courts have framed the issue in terms of whether the child needs a residential placement to succeed in school; that is, whether the child is able to learn only in a residential setting where medical, emotional, and social problems are treated. See, e.g., *Capello v. District of Columbia Bd. of Educ.*, No. 79-1006 (D.D.C. Jan. 23, 1980), reprinted in 3 EHLR (CCR) 551:500 (child's academic progress in day programs and residential settings determines whether the child needed a residential setting); *Gladys J. v. Pearland Indep. School Dist.*, No. G-81-134 (S.D. Tex. Galveston Div. Aug. 17, 1981), reprinted in 3 EHLR (CCR) 552:480 (same); *Matthews v. Campbell*, No. 78-0879-R (E.D. Va. July 16, 1979), reprinted in 3 EHLR (CCR) 551:264 (same); *Mahoney v. Administrative School Dist. No. 1*, No. 13417 (Oregon Ct. App. Oct. 22, 1979), reprinted in 3 EHLR (CCR) 551:532; *Manchester Bd. of Educ. v. State Bd. of Educ.*, No. 227093 (Sup. Ct., Jud. Dist. of Hartford/New Britain Apr. 22, 1981), reprinted in 3 EHLR (CCR) 552:397; *Wallingford Bd. of Educ. v. State Bd. of Educ.*, No. 17-84-46 (Sup. Ct., Jud. Dist. of New Haven, Conn. Jan. 6, 1981), reprinted in 3 EHLR (CCR) 552:305 (asking if the child needs a residential placement to achieve his or her maximum potential for self-sufficiency). *Leviton & Shugar*, *supra* note 27, at 840 n.104.

Most courts have been unwilling to fund residential placement when the placement is in a psychiatric hospital, relying principally on language in the statute and regulations limiting related medical services to those needed for evaluation. E.g., *Los Gatos Joint Union High School Dist. v. Doe*, 1984-85 Educ. Handicapped L.Rep. (CRR) 556:281 (N.D. Cal. 1984); *Darlene L. v. Illinois State Bd. of Educ.*, 568 F. Supp. 1340 (N.D. Ill. 1983). Other courts have allowed such placements. E.g., *Bucks County Pub. Schools v. Commonwealth*, 108 Pa. Commw. 511, 529 A. 2d 1201 (1987) (proper to consider both medical and educational regression). See Mark C. Weber, *The Transformation of the Education of the Handicapped Act: A Study in the Interpretation of Radical Statutes*, 24 U.C. DAVIS L. REV. 349, n 193 (1990).

Courts have denied funding for residential placements if the residential placement is necessitated by medical, social or emotional problems which are segregable from the child's learning process. In *Burke County Board of Education v. Denton*, 895 F.2d 973, 980 (1990), the Court found that residential placement is only required if "the educational benefits which can be provided through residential care are essential for the [student] to make any educational progress at all." The Student in *Burke* ("Chris") was a 19-year-old with autism who exhibited aggressive and other disruptive behavior. Chris could not control his own behavior and at times had to be managed by others. The Court denied his parents' request for a home component to Chris's IEP because he made educational progress at school. The Court reasoned that "if the educational benefits which can be provided through residential care are essential for the child to make any educational progress at all, then residential care is required .

Mentally handicapped children who are not eligible for residential services provided by the Department of Education face other hurdles. For children needing in-patient hospital care, insurance will only pay for very brief hospitalization and will never pay for longer-term community-based residential care.⁴⁵ Because of the short

...” *Id.* at 980 (emphasis in original), but, quoting *Abrahamson v. Hershman*, 701 F.2d 223, 227 (1st Cir. 1983), the Act “does not authorize residential care merely to enhance an otherwise sufficient day program.”

The U.S. District Court recognized that a child’s dangerous behavior outside the structure of the school programming is not enough to compel residential placement, if the student is receiving educational benefit at school. *Ciresoli v. M.S.A.D. No. 22*, 901 F. Supp. 378, 386-87 (D. Me. 1995) (child sometimes assaulted peers, took kitchen knife to bed, and mother feared for her own safety and the safety of her daughter). The *Ciresoli* court said a different result might be required if the child was “uncontrollable both in and outside of school, rendering him uneducable without extensive psychological treatment.” *Id.* at 387.

45. Many children placed in acute hospitals have commercial insurance and are denied additional treatment even though they are not yet ready to return to their home.

The denial of this care may be linked to the average length of stay in the acute care hospitals . . . [which is] now approximately six days and has dropped consistently over the past several years from a high of approximately 30 days. Any days beyond those approved and paid by the individual’s insurance company are not considered as allowable for payment by the Maryland Health Services Cost Review Commission (HSCRC) for the purposes of bad debt calculations because Maryland’s all-payer system only compensates for uninsured individuals, not for insured individuals whose insurance company is denying care. The Maryland Insurance Administration has been helpful in directing insurers to pay for such denied psychiatric in-patient days. There are, however, levels of care not recognized by commercial payers, despite Maryland’s attempts to achieve parity in mental health coverage. Currently in Maryland, acute and long-term care are reimbursed by commercial insurance companies for adults. Residential treatment centers, intermediate and long-term settings for children and adolescents are almost never covered by the same commercial insurance companies.

Insurers currently cover only acute care or outpatient care.

MD. DEPT. OF HEALTH & MENTAL HYGIENE, ET AL., RPT. ON THE EFFICACY OF THE INTERAGENCY POLICY ADOPTED IN RESPONSE TO INSTANCES WHERE CHILDREN WITH MENTAL DISABILITIES WHO ARE NOT IN STATE CUSTODY REMAIN HOSPITALIZED BEYOND THEIR RECOMMENDED DISCHARGE DATE, at 10 (December 18, 2000) [hereinafter *CHILDREN STUCK IN HOSPITALS*]. Nor at the present time does Medicaid pay for residential community-based care. *Id.* at 16.

In fiscal year 1999, 2,397 children with Medical Assistance were discharged from acute psychiatric units in general hospitals and private psychiatric hospitals. Maryland Mental Health Block Grant Application FY 2001, at 66. Many of these children who were ready for discharge needed community-based residential care but at the present time there was no system to finance such care, unless the parents relinquish custody. *Id.* See also, *Children Trapped*, *supra* note 31. (among children cared for by the child welfare system in Massachusetts from October 2000-March 2001, stuck patients spent 15,796 days—or more than 43 years—of unnecessary time in hospitals, 33% longer than in the previous six months.).

hospital stay, adequate discharge planning is difficult to achieve, and parents feel pressured and ill equipped to handle their child at home.⁴⁶

Parents are not told that their child may be entitled to in-home behavioral aides to help the family keep the child at home.⁴⁷ Children eligible for Medicaid have the right to virtually any home or community-based mental health service that a practitioner determines is medically necessary.⁴⁸ Not aware that they can get help and fearing for their own safety, families often are told that the only way their child can receive needed services is by relinquishing custody.⁴⁹

46. CHILDREN STUCK IN HOSPITALS, *supra* note 45, at 10.

47. "The Medicaid Act requires states to provide comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to categorically eligible children under age twenty-one. As part of EPSDT, states must provide eligible children with health care, diagnostic services, treatment, and other measures 'to correct or ameliorate defects and physical and mental illnesses and conditions.'" Jane Perkins & Randolph T. Boyle, *Addressing Long Waits for Home and Community-based Care Through Medicaid and the ADA*, ST. LOUIS U. L.J. 117, 124 (2001) [hereinafter *Addressing Long Waits*]; see 42 U.S.C.S. § 1396d(r)(5) (Law. Co-op. 1993). The Omnibus Budget Reconciliation Act of 1989 amended the Medicaid Act to further expand the services provided to Medicaid eligible children. See 42 U.S.C.S. § 1396a(a)(10) (Law. Co-op. 1993); 42 U.S.C. §§ 1396a(a)(43), d(a)(4)(B), d(r) (Law. Co-op. 1993). For an in-depth discussion of EPSDT, see *Addressing Long Waits*.

Some of the services covered through EPSDT under federal Medical Assistance law include: Diagnostic evaluation and intervention; Individual therapy; Group therapy; Living skills training; Family counseling; Case management; wrap-around mental health services; Therapeutic behavioral intervention (including in-home behavior therapy provided by a one-on-one behavioral aide to carry out a treatment plan designed by a behavior specialist); Enhanced support (such as in-home one-on-one support and supervision); Professional consultation; Psychiatric rehabilitation; Substance abuse services; In-patient hospitalization and residential treatment; Partial hospitalization, such as psychiatric day treatment; Mobile treatment and crisis intervention services; Personal care services (such as assistance with hygiene, toilet and eating); Transportation assistance for the child and parents to any service; Any other mental health service recommended by a physician or other licensed "practitioner of the healing arts," within the scope of his or her practice under State law.

All services must be provided in the setting deemed most beneficial to the child, with preference for the child's "natural environment," such as home or school. MD. DISABILITY LAW CENTER [hereinafter MDLC], *ASSESSING MENTAL HEALTH SERVICES FOR CHILDREN IN MARYLAND THROUGH THE MEDICAL ASSISTANCE/MEDICAID EPSDT BENEFIT* (Mar. 2001).

48. *Id.*

49. Parents in Maryland have erroneously been told that the only way to get services for their child is to relinquish custody. Memorandum from Tom Grazio, Director of Family and Children Services for the Social Services Administration (Oct. 11, 2000) (on file with author).

In 1999, the National Alliance for the Mentally Ill released the results of a survey of parents with children with special health care needs which revealed that 23% of parents were told to relinquish custody in order to obtain mental health services for their child and 20% of parents actually relinquished custody. *Relinquishing Custody: The Tragic Result of Failure to Meet Children's Mental Health Needs*, (Bazelon Center for Mental Health Law, Washington, D.C.), Mar. 2000, at 7. Because of insurance issues, many children with psychiatric problems will only be able to stay in hospitals for very short stays. The families concerned about safety both for the child and other family members feel unable to take the child home. The short

Once discharged from psychiatric hospitals, many emotionally disturbed children are referred to residential treatment centers. Even though their psychiatrists submit the necessary paperwork, children wait for months to gain admission because of illegal and harmful delays.⁵⁰

Others remain at home with no services waiting for admission to the residential treatment center. This inability to access services when needed is caused by the different and often conflicting eligibility requirements that states and programs have established. For example, in Maryland, most private residential treatment programs will only admit children if they have been approved for residential care as well as approved by their local school for a non-public educational program.⁵¹ Many children, because they have not been approved by their local school system for a non-public educational program, are then precluded from entering the residential treatment program.⁵²

B. Tossed to the Juvenile Justice System

Because John's school did not consider him seriously emotionally disturbed, he never received the mental health services he needed. As a result, John became even more depressed. He stopped going to school and became violent when asked to do any task. John's mother, fearful for her and her other children's safety, turned to the police for help. The police told John's mother that if she wanted help, she had to bring charges against John and relinquish custody to the

hospital stay also does not provide enough time for hospital staff to engage in effective discharge planning. CHILDREN STUCK IN HOSPITALS, *supra* note 45, at 10.

50. For example, in Maryland according to recent data there are 51 children awaiting residential treatment placement in psychiatric hospital respite facilities. In addition to these children, at any one time, an additional 85 children await RTC placements—not counting children in DJJ detention or in several other special population. *Testimony of MDLC before Senate Subcomm. on Educ., Bus. and Admin., and Health and Hum. Resources on the Budget of the Governor's Off. for Children, Youth and Fam.*, at 2 (Feb. 15, 2001) [hereinafter *MDLC Testimony on OCY Budget*].

51. *Id.* at 2.

52. *Id.* Other states have resolved this problem by adopting a policy that prohibits the use of state dollars for the placement of children in private residential treatment centers that "bundle" clinical and residential services. MSDE could also refuse to license any non-public school affiliated with an RTC that bundles educational and clinical services. Letter from Cathy Surace, Managing Attorney, Mental Health Unit, MDLC 6 (June 14, 2000). *See also*, *MDLC testimony on OCY Budget*, *supra* note 50, at 3.

Department of Juvenile Justice. Having no other options, John's mother pressed charges against her son.

With few or no mental health services readily available,⁵³ an older child's agitated or aggressive behaviors may lead parents to call the police, not only for help but because it may be the only way to obtain any attention for the child's mental health needs.⁵⁴ As one juvenile court judge commented, "It's tragic. If you are a young person and mentally ill, you have to get arrested to receive treatment."⁵⁵ Putting aside for the moment this judge's generally unfounded optimism that the juvenile justice system will provide mental health treatment, many researchers and observers of the juvenile justice system have noted that jails and detention centers are becoming the mental hospitals for the mentally ill adolescent who has committed a delinquent or criminal offense.⁵⁶ This holds true not only for the undiagnosed child whose criminal behaviors are symptoms of an illness, but also for children who have received proper and thorough mental health assessments yet cannot obtain treatment soon enough to prevent involvement with the law.⁵⁷ This is especially true for African American children. African American children with mental health problems are identified and referred at the same rates as other children.

53. NATIONAL MENTAL HEALTH ASSOCIATION, COMMUNITY PERSPECTIVES ON THE MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT NEEDS OF YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM 5 (2000).

54. HWC, *supra* note 1, at 14. Because of the dearth of early assessment and early intervention programs, many "youth with emotional disorders . . . go undetected and untreated to the point that they suffer from behavioral symptoms and come to the attention of juvenile authorities and family courts." Deborah Shelton, *Emotional Disorders In Young Offenders*, 33 JOURNAL OF NURSING SCHOLARSHIP 259, 261 (2001).

55. HWC, *supra* note 1, at 14 (quoting Judge Hal Gaither of the Dallas County Juvenile Court).

56. *Id.*

57. Nationwide, primary care physicians report significant barriers to referral for children with mental health problems. These barriers include: lack of available specialists, insurance restrictions, and appointment delays. More than two-thirds of primary clinicians report appointment delays. The average waiting time for an appointment with a specialist takes three to four months. RPT OF SURG. GEN. CONF., *supra* note 30, at 19. "Of those patients who were referred, 59% had zero visits to the specialist: only 13% averaged one or more visits a month in the follow-up period of six months. In short, an increasing number of problems (15-30%) are being identified by primary care providers, but connections to mental health specialists are difficult." *Id.* at 21.

In October 2000, Baltimore Mental Health Systems conducted a survey of the experiences of parents in accessing services with particular regard for the average length of time it took to schedule an initial appointment. Of a total of 26 calls, only 7 calls (23%) resulted in the scheduling of an appointment. The average delay ranged from one day to four weeks. CROWEL, PSY. D., ACCESSIBILITY SURVEY (2001).

However, African American children are much less likely to actually receive specialty mental health services or psychotropic medications.⁵⁸

With proper mental health treatment unavailable, parents will often continue to struggle with their child until a crisis arises, and then the child *must* be placed in out-of-home care—often an inappropriate juvenile correctional facility. In Maryland, once arrested the youth wind up in inappropriate detention facilities for very long periods of time, instead of in appropriate treatment programs.⁵⁹

Although Maryland has examples of effective comprehensive services that would enable children to remain at home, children and their families often cannot access these services.⁶⁰ This denial of services results in a child's reaching the point of requiring residential care. If these services could be provided earlier, parents would not need to relinquish custody, and the outcomes for children and their families would be better.⁶¹

58. RPT. OF SURG. GEN. CONF., *supra* note 30, at 19. Many factors contribute to premature termination, such as insensitivity of mental health providers to the culture of children and families. Additionally, Hispanic-Latino and African American children more often leave mental health services prematurely than do Caucasian children. African American children were also found to be less likely than whites to receive an antidepressant when they were first diagnosed with depression. Specialized programs and supports linked with the culture of the community being serviced have been found to be successful in promoting favorable patterns of service utilization for all ages. RPT. OF SURGEON GENERAL, *supra* note 22, at 181.

59. For example, juvenile delinquents with mental health problems needing residential care are often placed in detention as opposed to committed to the custody of the Department of Health and Mental Hygiene for placement in one of their health facilities. "Considering the mental health needs of these youths, detention is undeniably not the desired placement for them." THE MARYLAND DEPARTMENT OF JUVENILE JUSTICE, ADJUDICATED YOUTH PENDING PLACEMENT REPORT (2001) [hereinafter PLACEMENT REPORT].

60. According to Oscar Morgan, Director of MHA, 50% of MHA's budget of \$400 million is spent on 3,300 individuals. The majority of these individuals are children who receive episodic and repeated hospitalizations. It would be cheaper for the state and better for the child if we could provide case management and the range of needed services. Interview with Oscar Morgan, Director of MHA, in Baltimore, Md. (June 7, 2001).

61. Maryland's effective services seem to only be accessible as an alternative to out-of-state residential placement. For example, under the East Baltimore Mental Health Partnership (EBMHP) Diversion from Out-of-State and Return from Out-of-State Placement Services, in order to be eligible for the "Diversion from out-of-state placement" program, the child must (1) be determined to be eligible by the LCC for a residential treatment center (RTC); (2) have been rejected from available in-state RTC's and at-risk for out-of-state placement; (3) be able to be helped if augmented services were provided to the child's community-based services or current placement; (4) be clinically documented to be expected to benefit from a community-based wrap around system which will prevent an out-of-state placement. In order to be eligible for the "Return from out-of-state placement" program, the child must be in an out-of-state residential placement, and (1) able to return only with the help of EBMHP; (2) continue to need intensive community-based services in order to maintain the progress made out-of-state; (3) require interagency collaboration in order to return; (4) require and deserves specialized services to facilitate a return to a less restrictive environment. EAST BALT.

C. Minority Over-Representation in Juvenile Justice Facilities

John's mother brought charges against her son in order to get help. However, the help she received was John being placed in an inappropriate juvenile detention facility. There he never received the mental health services he needed and his condition only got worse.

A disproportionate number of youth in the juvenile justice system with mental health problems are minority youth, poor children, or children with co-morbid disorders.⁶² Young African American males are frequently misdiagnosed as overly aggressive or dangerous rather than as emotionally disturbed or in need of mental health services, and consequently end up in trouble with the law.⁶³

MENTAL HEALTH PARTNERSHIP, DIVERSION FROM OUT-OF-STATE AND RETURN FROM OUT-OF-STATE PLACEMENT SERVICES 2-3 (2000).

62. RPT OF SURG. GEN. CONF., *supra* note 30, at 24. The youth in juvenile justice facilities are plagued by specific disorders such as clinical depression, Attention Deficit Hyperactivity Disorder (ADHD), schizophrenia, Anxiety Disorders, Disruptive Behavior Disorders, and Affective Disorders. National stats: 55% have depression, 45% have ADHD, schizophrenia 1-6%. Maryland stats: Anxiety Disorders (14.5%, 57.6%), disruptive Behavior Disorders (4.8%, 39.8%), Schizophrenia/Psychoses (5.1%, 32%), Affective Disorders (0.7%, 16.7%). Shelton *supra* note 54, at 263. Many of the youth are substance abusers. "In effect, what many of the adolescents are doing is self-medicating for untreated mental health problems." HWC, *supra* note 1, at 11. In Maryland (3%, 37.2%), had substance abuse disorders. Shelton *supra* note 54, at 263. In addition, "[i]t is not uncommon for 80 % or more of the juvenile justice population to be diagnosed with conduct disorder." Joseph J. Cocozza & Kathleen Skowrya, *Youth With Mental Health Disorders: Issues and Emerging Responses*, 7 JOURNAL OF THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION 3, 6.

63. National Mental Health Association, *Factsheet: Mental Health and Youth of Color in the Juvenile Justice System*, at <http://www.nmha.org/children/justjuv/colorjj.cfm> (last visited May 5, 2002). Minority youths are most often the victims of the systemic shuffling of older youth into the juvenile justice system rather than providing the appropriate mental health, emotional and family supports in the community. Nationally, African American youth between the ages of 10 and 17 (15% of U.S. population) represent: 26 % of juvenile offenders; 32% of delinquency referrals to juvenile court; 41% of juveniles detained in delinquency cases; 46 % of juveniles committed to secure institutions; and 52 % of juveniles transferred to adult criminal court. Hispanic youth between the ages of 10 and 17 (32 % of U.S. population) represent: 68% of the detention population; and 68% of those committed to a secure institution.

Specific Milwaukee statistics regarding minority representation: 65% are African American; 28% are Caucasian; 7% are Hispanic; and 53% are at or below poverty level. *Wraparound Milwaukee*, *supra* note 2, at 15.

Specific Maryland statistics regarding minority representation in the juvenile justice facilities: 57 % are African Americans compared to 26 % Caucasian and 17 % were Hispanic, American Indian, Asian, and/or bi-racial. Shelton *supra* note 54, at 265.

Some research suggests that poor children and children of color are tracked into the juvenile justice system while their white, middle-class counterparts are diverted to health and mental health systems resulting in a two-tiered child mental health service delivery system. There is no need for this kind of service delivery given the vast economic wealth of this country. The issue is to have the political will to serve all children with equity in attitudes, practices, and resources.⁶⁴

There is an over-representation of minority youth at every decision point in Maryland's juvenile justice system.⁶⁵ Although African American youth represent 32% of youth statewide, they represent 48% of youth at intake, 64% at detention and 72% at secure commitments.⁶⁶ This phenomenon has been explained several different ways. Poor minority youths, growing up in "inequitably harsh social and economic conditions," are at great risk for developing mental illness and are far less likely to receive proper diagnosis and timely treatment.⁶⁷ They may experience a multitude of known risk factors for the development of mental illness, such as poverty⁶⁸ and poor education, exposure to personal violence, pre-natal drug and alcohol exposure, exposure to environmental hazards such as lead poisoning, racism and community violence.⁶⁹

Many, if not most, of these youths have emotional and mental health needs that are simply not addressed:

Youth of color, particularly males, are misdiagnosed or not diagnosed at all . . . [they exhibit an] "aggressive tenor," which means that they psychologically overcompensate for feelings of vulnerability, hopelessness, depression and anxiety. Often, assessment tools and untrained personnel

64. RPT OF SURG. GEN. CONF., *supra* note 30, at 19.

65. MARYLAND JUVENILE JUSTICE COALITION, PRINCIPLES OF A MODEL JUVENILE JUSTICE SYSTEM 4 (2001).

66. *Id.*

67. HWC, *supra* note 1, at 26.

68. People living in poverty have the poorest overall health and are more likely to have high levels of psychological distress. Poor neighborhoods are marked by high turnover of residents and low levels of supervision of teenagers and young adults creates an environment conducive to violence. Young racial and ethnic men from such environments are often perceived as being especially prone to violent behavior and indeed they are disproportionately arrested for violent crimes. MENTAL HEALTH, *supra* note 5, at 39.

People who are poor are more likely to be exposed to stressful social environments and to be cushioned less by social or material resources. In this way poverty is a risk factor for poor mental health. *Id.* at 40.

69. HWC, *supra* note 1, at 26.

perceive these young people as “threatening,” not mentally ill.⁷⁰

Despite a clear understanding of the overwhelming pressures these youths face and the consequences for their mental and emotional health, government mental health systems are either not in place or ineffective in addressing those consequences and preventing further behavioral problems. The juvenile justice system becomes the *de facto*, and discriminatory, answer for coping with minority older children and adolescents with mental health needs.⁷¹

II. FAILURE TO TREAT MENTAL HEALTH PROBLEMS IN THE JUVENILE JUSTICE SYSTEM

Seventeen-year-old Dean Honomichi was diagnosed with attention deficit disorder, bipolar disorder, manic depression, and Tourette’s syndrome at the time he was placed in a juvenile justice facility. Although Dean was scheduled to receive visits from counselors and psychologists while in prison, these visits never occurred. Dean became increasingly frustrated, ripping his mattress, dismantling his sink, flooding his cell, and kicking and spitting at guards. The response of the guards was to enforce sterner punishments with more vigor. Eventually Dean came to regard self-inflicted injury as the only escape from his personal torment. He stuck a pencil in his arm. He survived the incident but has an inch-long scar on his

70. *Id.* at 27.

71. Detention is a key entry point from which youth enter the juvenile justice system. By 1997, in 30 out of 50 states, minority youth represented the majority of youth in detention. Reasons why youth of color are disproportionately detained are: (1) minority youth have less access to good education and are more likely to come from poor families suffering from high rates of unemployment; (2) policing practices, like targeting minority neighborhoods, have the unintended consequence of disproportionately arresting more minority youth than whites, who commit the same crimes; (3) white youth have access to better legal representation and program and services in the community; and (4) people involved in the decision to detain may bring stereotypes to their decision. THE JUSTICE POLICY INSTITUTE, THE JUSTICE POLICY INSTITUTE REDUCING DISPROPORTIONATE MINORITY CONFINEMENT: THE MULTNOMAH COUNTY, OREGON SUCCESS STORY AND ITS IMPLICATIONS (2001) *available at* http://www.cjcj.org/portlannd/portland_web.html.

forearm as a testament to the mistreatment of his illness.⁷²

Once children with mental health problems become involved with the juvenile justice system they often receive inadequate services that only aggravate their situation.⁷³ Mentally ill children who need residential treatment wind up in juvenile detention centers for extremely long periods of time while they await appropriate care.⁷⁴ Detention centers are supposed to provide secure temporary care for juveniles determined to be a threat to the community or who are at risk of absconding before their court hearing.⁷⁵ They were not designed as treatment facilities or to provide the type of ongoing intensive mental health services a youth might need even in the interim between court and placement in a residential treatment center. Many mentally ill children in the juvenile justice system remain in detention without mental health services for very long periods of time waiting for an appropriate placement.⁷⁶

If children with mental health problems are unable to access residential treatment centers they are often placed in juvenile justice facilities which are correctional, not treatment facilities.⁷⁷ These correctional facilities have particularly disastrous effects on seriously troubled children.⁷⁸ A recent suicide at the Waxter Center, an all-girls juvenile justice facility in Maryland, is an example of these problems. In March 2002, a 15-year-old resident at the Waxter Center, threatened

72. *60 Minutes II: Three-Year Nightmare* (CBS television broadcast Jan. 2, 2001) available at <http://www.cbsnews.com/stories/2001/01/02/60II/main260849.shtml>.

73. In March of 1998, Dr. Deborah Shelton examined 312 youth committed and detained by DJJ and found that 53% were in need of mental health services. Substance abuse screening indicated that 50 to 60% of juveniles committed to DJJ residential programs had a substance abuse problem, while 40% of the youth detained and 30% of youth on probation had substance abuse problems. MD. DEPT. OF HEALTH AND MENTAL HYGIENE & MD. DEPT. OF JUVENILE JUSTICE, MENTAL HEALTH & SUBSTANCE ABUSE PROGRAMMING ENHANCEMENTS IN THE JUVENILE JUSTICE SYSTEM: A THREE YEAR PLANNING & BUDGET STRATEGY 5 (2001).

74. PLACEMENT REPORT, *supra* note 59. The report confirms that youths experiencing the longest lengths of stay in detention are those presenting serious and complex problems who need placement in specialized treatment programs: sex offenders, seriously emotionally disturbed and behaviorally disordered youths, and developmentally disabled youths. Eighty-six percent of all youths in detention are released or placed within 50 days; 86% of all youths in detention awaiting placement in a residential treatment center or a sex offender program waited 150 days on average.

75. MD. CODE ANN. CT. & JUD. PROC. §3-815 (2001).

76. PLACEMENT REPORT, *supra* note 59.

77. HWC, *supra* note 1, at 15-16.

78. *60 Minutes II: Three-Year Nightmare* (CBS television broadcast Jan. 2, 2001) available at <http://www.cbsnews.com/stories/2001/01/02/60II/main260849.shtml>. (quoting Larry Brendtro, a psychologist who studies juvenile justice systems worldwide).

to commit suicide.⁷⁹ She had mental health problems and was being prescribed an antidepressant.⁸⁰ According to an independent oversight office report, she reported her suicide threat to a guard. The guard did not report her threat and failed to take any precautionary measures to prevent her suicide.⁸¹ Standard suicide prevention policy required that she be placed under direct watch.⁸² Instead, she was sent to her room. Within hours, she was found hanging by shoelaces tied from the bunk bed in her room.⁸³ Although the agency had been told to implement suicide prevention training for all staff, this had never occurred.⁸⁴

Furthermore, staff in correctional facilities may misinterpret symptoms of illness and forcibly restrain, overmedicate, or beat troubled youths.⁸⁵ Horror stories abound, including reports of children shot with stun guns in efforts to control behavior, and even punished for involuntary noises that were symptoms of Tourette's Syndrome.⁸⁶

The "get tough on juvenile crime" movement that swept the nation during the 1990's has catalyzed the shift in juvenile justice from rehabilitation and treatment toward retribution and punishment, rendering the possibility of mental health assistance within the system even more unlikely.⁸⁷ Clearly juvenile correctional facilities are not designed or intended to be mental health centers, nor are the staff in these facilities trained to provide the care a youth with mental illness will need.⁸⁸ Prison guards are hardly synonymous with qualified psychologists and psychiatrists and counselors. The facilities are already overcrowded, and initial screening and assessments, when and if they occur, are performed quickly and "en mass."⁸⁹

Another troubling characteristic of these facilities is their failure to adequately program for the youth both during their treatment

79. Todd Richissin, *State Agency Faulted in Death*, BALT. SUN, Apr. 13, 2002, at 1A.

80. Raymond McCaffrey, *Probe Urged at Youth Justice Agency*, WASH. POST, Apr. 14, 2002, at C03.

81. See Richissin, *supra* note 79.

82. See McCaffrey, *supra* note 80.

83. See Richissin, *supra* note 79.

84. *Id.*

85. *Juvenile Offenders Suffer From Lack of Mental Health Services*, PSYCHIATRIC NEWS, Jan. 19, 2001, at 6.

86. HWC, *supra* note 1, at 21.

87. Joseph J. Cocozza & Kathleen Skowrya, *Youth With Mental Health Disorders: Issues and Emerging Responses*, 7 JOURNAL OF THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION. 3, 5 (quoting D.M. Altschuler 1999 *Trends and Issues in the Adultification of Juvenile Justice*, in RESEARCH TO RESULTS: EFFECTIVE COMMUNITY CORRECTIONS (P. Harris ed., Lanham, Md 2000)).

88. HWC, *supra* note 1, at 15.

89. *Id.*

at the facility as well as after their release.⁹⁰ The model of “care” used by the facilities is not based on a cohesive treatment philosophy⁹¹ nor does it involve the family or community to which the youth belongs.⁹² Moreover, the juvenile correctional facilities fail to adequately address the youth’s aftercare needs.⁹³ There are limited services for the youth when re-entering society.⁹⁴ This is because Maryland lacks a comprehensive aftercare policy and programs that ensure effective supervision of youth while providing services that address children and their family needs, build strengths and promote integration with the community.⁹⁵

III. STRATEGIES FOR CHANGE

A. Diverting Youth from the Juvenile Justice System by Providing Appropriate Mental Health and Substance Abuse Services in the Community

In order to ensure that youth in danger of getting involved with the juvenile justice system receive the services they need rather than the correctional treatment typically rendered, several changes need to be made. Private insurance policies need to adequately cover children’s medically necessary mental health care. At the present time, they do not.⁹⁶ Because insurance will not provide the range of services children need, such as in-home supports, respite care, and long-term community residential care, many of these children get into trouble with the law and wind up in the juvenile justice system.⁹⁷ If private insurance companies won’t cover needed care, legislation should be approved making long-term residential treatment a mandatory benefit. Otherwise, the state should acknowledge that children needing that level of care should have it as part of the state’s Medicaid program, and without forcing parents to relinquish custody.

90. *Id.* at 15-16.

91. *Id.* at 16.

92. MARYLAND COALITION OF FAMILIES FOR CHILDREN’S MENTAL HEALTH, LISTENING AND LEARNING FROM FAMILIES IN JUVENILE JUSTICE 24 (2000). [hereinafter LISTENING AND LEARNING].

93. JUVENILE OFFENDER AFTER CARE ASSESSMENT TEAM, REPORT TO GOVERNOR PARRIS GLENDENING & LT. GOV. K. TOWNSEND 11-3 (2000).

94. *Id.* at 13-5.

95. *Id.* at 4-8.

96. RPT. OF SURGEON GEN., *supra* note 22, at 182.

97. *See supra* note 30.

Once a crisis has occurred, the adults with whom children with mental health problems have contact need to be better trained in how to divert the child from the juvenile justice system. For example, police officers need to be able to recognize mental health problems, and need to know how to respond appropriately.⁹⁸ Similarly, juvenile judges and masters should be trained regarding treatment options to ensure that youth receive the mental health and substance abuse services they need.⁹⁹

There needs to be a continuum of services for these youth.¹⁰⁰ Instead of providing episodic, stop-gap services, we need to develop effective early intervention and prevention programs and the range of services that will meet the needs of aggressive adolescent children with mental health problems.¹⁰¹

For example, we know that for many youth the traditional 50-minute therapy session is ineffective.¹⁰² We need to advocate for more research on what are the most effective treatments for children. We also need to utilize community-based alternatives to institutional care for offenders with mental health problems. Programs such as multi-systemic therapy that provide intensive short-term home, family and community-based treatment have proven effective. This program works with the young person, his peers, school, family and neighborhood to identify problem behaviors and build skills to resolve these behaviors.¹⁰³

We need to ensure that mental health services are culturally competent. This means that throughout the entire mental health

98. LISTENING AND LEARNING, *supra* note 92, at 24.

99. *Id.*

100. Cellini, *supra* note 4, at 15.

101. *Id.*

According to Oscar Morgan, director of MHA, 50% of MHA's budget of \$400 million is spent on 3,300 individuals. The majority of these individuals are children who receive episodic and repeated hospitalizations. It would be cheaper for the state and better for the child if we could provide case management and the range of needed services. Interview with Oscar Morgan, *supra* note 60.

102. Mark D. Weist & Kristin Christodulu, *Expanded School Mental Health Programs: Advancing, Reforming, Closing the Gap Between Research and Practice*, 70 JOURNAL OF SCHOOL HEALTH 195 (2000).

103. Evaluations of children receiving multi-systemic therapy programs reveal that MST is more effective than usual community services in decreasing adolescent behavioral problems and in improving family relations. Children involved in the program had fewer arrests than youth in usual services. Families reported increased family cohesion and decreased aggression. A four year follow up of re-arrest data indicated that MST was more effective than individual therapy in preventing future criminal behavior, including violent offenses. Studies found improved behavior, fewer arrests and lower costs. RPT. OF SURGEON GEN., *supra* note 22, at 176.

service system there is an acknowledgement at all the levels of the importance of culture. Services should be tailored to the individual's culture and should improve utilization and outcomes in treatment.¹⁰⁴

Examples of effective programs include the following:

1) Wraparound Services. Traditionally, children and families seeking mental health services must navigate numerous government agencies that each provide a discrete set of services with varying eligibility requirements. Children and families trying to access these services are often faced with delay or denial of needed care. States and communities who implement a "wrap around" approach provide more flexible services tailored to the specific needs of youth in the juvenile justice, mental health or child welfare systems.¹⁰⁵ The Wraparound philosophy accentuates the child and families' strengths. It stresses cultural identity and relies on natural community supports. The young person's family, instead of being blamed or criticized, is involved in the youth's treatment. Rather than placement in an institution away from their home and community, children when possible, are kept in their homes or communities with appropriate services.¹⁰⁶

Through cross-system collaboration and a blended funding approach, systems using the Wraparound philosophy are able to spend money more flexibly.¹⁰⁷ Blended funds are pooled funds from various agencies such as the child welfare and juvenile justice systems, as well as from various insurance sources such as Medicaid.¹⁰⁸ Wraparound initiatives are then able to distribute funds according to which services the child *needs* rather than to a particular agency for a particular service, i.e., residential care, which may not be the most effective treatment for that child.

In order to offer an increased array of services, Wraparound initiatives function with huge "provider networks."¹⁰⁹ This allows for more services to be provided to better meet the needs of each individual youth.¹¹⁰

104. MENTAL HEALTH, *supra* note 5, at 36.

105. *Wraparound Milwaukee*, *supra* note 2, at 15.

106. *Id.*

107. The program in Milwaukee, "Wraparound Milwaukee" blends funds. *Id.* at 18.

108. *Wraparound Milwaukee* also pools funds from a capitation payment for each Medicaid child in the system as well as from a Supplemental Security Income payment. In 1999, *Wraparound Milwaukee* had \$26 million in pooled funds. *Id.* at 18.

109. *Id.*

110. In Milwaukee, the number of services, since implementing Wraparound, has increased from 20 to 60. In addition, more than 170 agencies are currently involved in the provision of these services. *Id.*

States who implemented Wraparound initiatives have experienced great success for a population that has traditionally been very hard to serve effectively.¹¹¹ For example, in Milwaukee, the program now serves 650 youth, of whom 400 are part of the juvenile justice system.¹¹² Most of the children served are minorities from poor single parent families.¹¹³ Not only has the initiative yielded lower scores on the Child and Adolescent Functional Assessment Scale (meaning the youth is better able to function in society),¹¹⁴ but it has also yielded lower rates of recidivism for youth in the juvenile justice system.¹¹⁵

Baltimore, Maryland has implemented a version of Wraparound philosophy for youth that are either being diverted or returned from out-of-state residential placement. The Baltimore initiative, like Wraparound Milwaukee, focuses on the involvement of the family and the community. Treatment is tailored to the specific needs of each youth and is available on a 24-hour basis. The program exists as a partnership between the East Baltimore Mental Health Partnership (EBMHP), the Baltimore City Department of Social Services, Baltimore City Public Schools, and the Baltimore City Health Department. Services are delivered by both EBMHP and contracted vendors, something akin to the 'provider network' of the Wraparound initiative.¹¹⁶ The success of the Baltimore initiative is tempered only by limitations of scope, as most children can only access it if they are being diverted or returning from out-of-state residential placements.

2) Respite care. Respite care is temporary assistance for a child with mental health problems. In addition, respite care offers

111. For example, in Milwaukee the use of residential placements for treatment has decreased by 60% (from an average of 364 youth to 140 youth), inpatient psychiatric hospitalization has decreased by 80%, the average daily cost of care per child has decreased from more than \$5000 per month to less than \$3,300 per month, and the initiative now has enough money to serve almost twice as many youth (previously serving 360 youth and now serving 650 youth). *Id.* at 19-20.

112. *Id.* at 14.

113. *Id.* at 15.

114. In Milwaukee the scores decreased from an average of 74 before the program (considered to be in the high range of impairment) to an average of 48 one year later (considered to be a moderate level of impairment). *Id.* at 20 (citing K. Hodges, *Child and Adolescent Functional Assessment Scale* (1994)).

115. *Wraparound Milwaukee*, *supra* note 2, at 20.

116. See EAST BALTIMORE MENTAL HEALTH PARTNERSHIP, DIVERSION FROM OUT-OF-STATE AND RETURN FROM OUT-OF-STATE PLACEMENT SERVICES.

support to the child's primary caregiver as well.¹¹⁷ There are various ways that respites can be administered, including: a) a visit from a respite care worker to child's home; b) community-based activities with the child; c) an overnight stay with the provider; or d) a visit to a group home, day care center or residential center.¹¹⁸ The intended benefits of respite care include less stress and better mental health, better relations between family members, better behavior by the child, and less need for expensive and disruptive out-of-home child placements.¹¹⁹

In a study of Vermont's respite care program, a remarkable 67% of families believed that their child would have been placed out of the home had respite care not been available.¹²⁰ In the Vermont study, the rate of out-of-home placement for children and families who were able to access respite care decreased by more than 50%, while families who did not receive respite care increased their use of out-of-home placements.¹²¹

In Maryland, families report difficulties accessing respite care.¹²² According to a recent survey of Maryland's public mental health system, most respondents neither knew of the existence of respite care nor of its availability within the treatment continuum of mental health problems.¹²³ It is unclear whether the infrequent use of respite care is attributed to lack of availability of such service or poor publication of available services.¹²⁴

3) Quality School-Based Mental Health Services. Many juveniles who need mental health services will not go to community mental health centers because of stigma or transportation problems.¹²⁵ With more parents working, there is a need to provide the service to the child where they spend much of their time, such as in their schools. Providing services in the schools also enables the teacher and family to

117. Eric J. Bruns, *The Impact of Respite Care for Children with Emotional and Behavioral Problems and their Families: Results from the Vermont Family Services Study* (University of Vermont), Apr. 1997, at 3.

118. *Id.*

119. *Id.*

120. *Id.* at 4.

121. *Id.* at 8.

122. MD. MENTAL HYGIENE ADMIN., REPORT ON MD. PUB. MENTAL HEALTH SYS.: CONSUMER SATISFACTION AND OUTCOMES, 1999-YEAR 2 ASSESSMENT AND COMPARISON TO YEAR 1, CONDENSED REPORT 24 (2000).

123. *Id.*

124. *Id.*

125. Mark D. Weist & Kristin Christodulu, *Expanded School Mental Health Programs: Advancing, Reforming, Closing the Gap Between Research and Practice*, 70 JOURNAL OF SCHOOL HEALTH 195 (2000).

be involved in the treatment plan.¹²⁶ Since children spend more time with their teachers as opposed to mental health staff, training teachers to better understand the child's problems and to implement services is more effective.¹²⁷

4) Case Management Services. Case management services provide a range of services coordinated by individuals or teams for children and their families.¹²⁸ Some of the services a case manager can provide include arranging assessments; planning treatment, brokering and monitoring services; and advocating on behalf of the child and the family.¹²⁹ In better systems, the case manager, the child, and the child's family plan the services needed and have flexible access to funds to purchase the services.¹³⁰

5) Crisis Services: For children in crisis with mental health problems, emergency room and short-term hospital stays are not the solution. Rather, crisis mobile treatment teams that can come to the child's home and connect the child and family to the necessary service—including short-term therapeutic foster or group care, outpatient therapeutic services and appropriate educational and family supports¹³¹—are more effective and in the long run more cost effective for the state. Maryland currently lacks a comprehensive system that operates 24 hours a day, 7 days per week in every jurisdiction in the state. This is a huge gap in the community mental health system. The need experienced by families whose children are in crisis is tremendous. Program models involving both mental health and law enforcement communities can make a big difference for families whose children are involved with both systems.

B. Providing Appropriate Mental Health and Substance Abuse Services Within the Juvenile Justice System.

For children involved with the Juvenile Justice System, aggressive early intervention programs in the form of screening and assessment procedures need to appropriately identify the youth's mental health problems, and implement a plan of treatment.¹³² For

126. *Cf. id.*

127. *Id.*

128. RPT. OF SURGEON GEN., *supra* note 22, at 172-75.

129. *Id.*

130. *See Wraparound Milwaukee*, *supra* note 2.

131. RPT. OF SURGEON GEN., *supra* note 22, at 178.

132. The dilemma is that while as many as 75 percent of juvenile offenders have one or more diagnosable psychiatric disorders, most juvenile detention facilities are not equipped to

example, in Maryland, in March of 1998, Deborah Shelton examined 312 youth committed and detained by the Department of Juvenile Justice and found that 53% were in need of mental health services. Substance abuse screening indicated that 50-60% of juveniles committed to DJJ residential programs had a substance abuse problem, while 40% of the youth detained and 30% of youth on probation had substance abuse problems. Although we now have acknowledged that these problems exist, funds to serve these children still haven't been appropriated.¹³³

A "mental health oversight committee" or monitoring body, ensuring that the mental health and substance abuse needs of youth involved in the juvenile justice system are addressed is necessary.¹³⁴ This oversight committee should take special interest in the target population of youth with mental illness in danger of becoming involved with the juvenile justice system.¹³⁵

For youth placed in juvenile correctional facilities, they must receive mental health services provided by qualified and trained staff.¹³⁶ There also must be comprehensive suicide prevention plan that addresses staff training, screening and assessment, communication, intervention, reporting and follow-up/mortality review.¹³⁷ We must also acknowledge that for many children, particularly minority and female youth, traditional treatment models may not be beneficial.¹³⁸

Finally, we need to develop the range of services within the juvenile justice system so that it will be unnecessary to send children to the adult system.¹³⁹

treat them. *Juvenile Offenders Suffer from Lack of Mental Health Services*, *supra* note 3. See also, Cellini, *supra* note 4, at 14.

133. MD. DEPT. OF HEALTH AND MENTAL HYGIENE & MD. DEPT. OF JUVENILE JUSTICE, MENTAL HEALTH & SUBSTANCE ABUSE PROGRAMMING ENHANCEMENTS IN THE JUVENILE JUSTICE SYSTEM: A THREE YEAR PLANNING & BUDGET STRATEGY 5 (2001).

134. Cellini, *supra* note 4, at 15. These committees should include representatives from the agencies dealing with law enforcement, juvenile justice, education, substance abuse, mental health, social services and the judicial system. LISTENING AND LEARNING, *supra* note 92, at 24.

135. Cellini, *supra* note 4, at 15.

136. See *supra* note 68.

137. Lindsay M. Hayes, *Suicide Prevention in Juvenile Facilities*, 7 JUVENILE JUSTICE 27 (2000).

138. HWC, *supra* note 1, at 26.

139. LISTENING AND LEARNING, *supra* note 92, at 24.

C. Eliminating Overrepresentation of Minority Youth

Nationwide there is a tremendous need to eliminate the overrepresentation of minority youth in juvenile justice facilities and ensure that they receive appropriate mental health and substance abuse services. From 1985 to 1995, the number of youth held in secure detention nationwide increased by 72 percent.¹⁴⁰ During this period, the proportion of the detention population comprised of white youth dropped, and minority youth came to represent a majority of the young people detained.¹⁴¹ Therefore, it is not enough to just implement policies that will decrease the detention population. Rather, there must be a concerted effort to ensure that minorities are not overrepresented in the juvenile justice detention population. In order to accomplish this it is necessary to (1) make a committed effort with specific goals to reduce disproportionate minority confinement; (2) use data to determine the extent of the problems and strategies to solve them, instead of relying on anecdotal information; (3) develop community-based alternatives that are located in and operated by communities of color; (4) make decisions about who should be detained and who should not, and develop a risk-assessment that can objectively guide admission decisions, with particular emphasis on criteria that will not disproportionately affect minorities; (5) ensure that staff who work in juvenile justice programs are diverse and representative of the communities they serve, and also ensure that staff are receiving ongoing training in cultural competence to understand the dynamics of disproportional minority confinement; (6) increase resources to agencies that represent youth with particular emphasis on helping them develop treatment plans that are alternatives to confinement; (7) increase the range of sanctions in the community for violations of probation so that there will be a range of alternatives for youth.¹⁴²

140. THE JUSTICE POLICY INSTITUTE, THE JUSTICE POLICY INSTITUTE REDUCING DISPROPORTIONATE MINORITY CONFINEMENT: THE MULTNOMAH COUNTY, OREGON SUCCESS STORY AND ITS IMPLICATIONS, *available at* http://www.cjci.org/portland/portland_web.html.

141. *Id.*

142. JUDITH A. COX, SANTA CRUZ COUNTY PROBATION DEPARTMENT, ADDRESSING DISPROPORTIONATE MINORITY REPRESENTATION WITHIN THE JUVENILE JUSTICE SYSTEM (2000) (cited by HOYT, ET AL., THE ANNIE E. CASEY FOUNDATION, EIGHT PATHWAYS TO JUVENILE DETENTION REFORM: REDUCING RACIAL DISPARITIES IN JUVENILE DETENTION 47 (2002)). *See also* JUSTICE POLICY INSTITUTE, THE JUSTICE POLICY INSTITUTE REDUCING DISPROPORTIONATE MINORITY CONFINEMENT: THE MULTNOMAH COUNTY, OREGON SUCCESS STORY AND ITS IMPLICATIONS, *available at* http://www.cjci.org/portland/portland_web.html.

D. The Importance of Working With Family in Treating the Child

In order to serve children with mental health needs, the family must be a true partner in their child's treatment.¹⁴³ This means that parents must be involved in discussing and planning for their child's needs. Information from parents about the child's history, strengths and needs must be considered.¹⁴⁴ Also laws and practices that prohibit sharing of medical and other evaluations with parents must be changed.¹⁴⁵

If we want parents to be involved with their child's care, we must be respectful to families and parental authority as opposed to blaming them for their child's problems.

Explaining to parents and children the various court proceedings and the range of services available will enable them to better participate in the court proceedings. Also, if children are placed in residential care, eliminating barriers to visits (i.e., long distances, lack of transportation, limited visiting hours) helps to strengthen the parent-child relationship.¹⁴⁶

Providing family presentation services, wrap around services and community-based care best accomplishes the integration of the family into the services for the child.

V. CONCLUSION

If we expect children to respect our laws, we must show them that the laws are fair and just. Our present system fails to appropriately provide mental health and substance abuse services to children of color. Instead, the present system relies on juvenile justice system to correct problems that can only be solved with proper mental health treatment. If we expect our children to reform and rehabilitate themselves within our juvenile justice system, we need to provide them the proper mental health tools to accomplish that goal. For as James Baldwin states, "These are all our children. We will all profit by, or pay for whatever they become."

143. LISTENING AND LEARNING, *supra* note 92, at 24.

144. *Id.*

145. MD. CODE ANN., Cts. & Jud. Pro. § 3-816 (2001).

146. LISTENING AND LEARNING, *supra* note 92, at 24.

