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School-to-Prison Pipeline

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SCHOOL-TO-PRISON-PIPELINE: WHY EARLY INTERVENTION PROGRAMS AREN'T PROPERLY SERVING OUR MENTALLY ILL YOUTH AND THE CURRENT JUVENILE JUSTICE SYSTEM IS TOO PUNITIVE

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ABSTRACT

This article explores the intersect between mentally ill youth and the juvenile justice system. Mentally ill youth are disproportionately represented at every stage in the juvenile justice system due to their symptoms being mistaken for delinquent behavior. This stems from the legislators reforming the juvenile justice system from rehabilitative to punitive over the years in an attempt to hold delinquent youth accountable for their actions. Federal statutes have been enacted and federally funded programs have been implemented that seek to address the mental health crisis in today's youth and keep mentally ill youth out of the juvenile justice system. This article discusses the goals, regulations, and guidelines set forth by these statutes and programs along with the shortcomings that are faced when they are actually put into practice. This article then gives suggestions to improve these statutes and programs based on current research that has proven to be successful.

I. Introduction

Mental health has become an increasing topic of debate and study in recent years. There are a variety of mental disorders from which children suffer that fall under broad categories, such as emotional disturbances ("ED"), behavioral disorders, and mental illness.[1]

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More specifically, children experience anxiety, depression, bipolar disorder, eating disorders, obsessive-compulsive disorder ("OCD"), tic disorders, schizophrenia, and psychotic disorders.[2] Some red flags that signal a child has a mental illness are changes in school performance, random and frequent outbursts of anger, inability to cope with their feelings, drug abuse, sleeping habit changes, defying authority, hyperactivity, hearing voices, and hallucinating.[3]

According to the Centers for Disease Control and Prevention ("CDC"), among children aged three to seventeen, 7.4% or 4.5 million have a diagnosed behavioral problem, 7.1% or 4.4 million have diagnosed anxiety, and 3.2% or 1.9 million have diagnosed depression.[4] According to the Office of Juvenile Justice and Delinquency Prevention ("OJJDP"), an estimated 9-22% of the general youth population has at least one diagnosable mental health disorder.[5] However, these numbers may underrepresent the true number of children suffering from a mental illness because studies have also shown that an estimated one-third of these illnesses in children go undetected.[6]

Comparatively, about two-thirds of youth in the juvenile justice system have at least one diagnosable mental health problem.[7] In 2008, Fazel and Langstrom found that youth in the custody of the juvenile justice system were ten times more likely to suffer from psychosis than those youth in the general population.[8] In 2006, the National Center for Mental Health and Juvenile Justice ("NCMHJJ") in collaboration with the Council of Juvenile Correctional Administrators ("CJCA") carried out the most comprehensive juvenile justice mental

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[1] Cynthia A. Dieterich et al., A Legal Study of Children with Emotional Disturbance and Mental Health Needs and Implications for Practice, 45 J.L. & EDUC. 39, 39 (2016).

[2] Id. at 40.

[3] Id. at 40.

[4] Id. at 39.

[5] Office of Juvenile Justice and Delinquency Prevention, *Intersection between Mental Health and the Juvenile Justice System,* OJJDP.gov (2017), https://www.ojjdp.gov/mpg/litreviews/Intersection-Mental-Health-Juvenile-Justice.pdf.

[6] Dieterich et al., *supra* note 1, at 39, 40.

[7] Office of Juvenile Justice and Delinquency Prevention, *supra* note 5.

[8] *Id.*

health prevalence study of its time.[9] This study, funded by OJJDP, found that 65-70% of youth in the juvenile justice system had a diagnosable mental health disorder.[10] Of those youth with disorders, over 60% also had a substance use disorder, and almost 30% had a disorder that was severe enough to require immediate and significant treatment.[11]

There are many reasons for the drastic numbers of mentally ill youth that encounter the juvenile justice system. For starters, symptoms of mental illness in juveniles can often come across as delinquent behavior, such as poor school performance, substance use, and anti-social behavior and acquaintances, all of which can often stem from a lack of family support.[12] Secondly, mental health can deteriorate when youth are taken out of their homes and communities – away from their families and friends – and placed into detention centers or correctional facilities.[13] Most facilities are not equipped to handle the mental health needs of its juveniles; many are overcrowded, lack access to necessary treatment and services, and have staff that are not trained to provide adequate supervision and care to their mentally ill youth.[14]

Biannually, the OJJDP conducts the Juvenile Residential Facility Census ("JRFC"). This census collects information about the characteristics of facilities where juveniles are held after being adjudicated for violating the law, including the type of facility, the type of security, and the types of evaluations and services provided to the juveniles in their care.[15] In 2016, the latest census to be released to the public, 65% of these facilities reported using an in-house mental health

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[9] Jennie L. Shufelt and Joseph J. Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study,* NAT'L CTR. FOR MENTAL HEALTH AND JUVENILE JUSTICE, 2-3 (2006), https://www.unicef.org/tdad/usmentalhealthprevalence06(3).pdf.

[10] *Id.* at 2-3; Wade Askew, *Keeping Promises to Preserve Promise: The Necessity of Committing to a Rehabilitation Model in the Juvenile Justice System,* 20 GEO. J. ON POVERTY L. & POL'Y 373, 384 (2013).

[11] Shufelt & Cocozza, *supra* note 9, at 2-3.

[12] Askew, *supra* note 10, at 381.

[13] Office of Juvenile Justice and Delinquency Prevention, *supra* note 5.

[14] Office of Juvenile Justice and Delinquency Prevention, *supra* note 5.; Fred Meservey & Kathleen R. Skowyra, *Caring for Youth with Mental Health Needs in the Juvenile Justice System: Improving Knowledge and Skills*, NAT'L CTR. FOR MENTAL HEALTH AND JUVENILE JUSTICE, May 2015, at 1, 1.

[15] Sarah Hockenberry et al., *Juvenile Residential Facility Census, 2014: Selected Findings*, U.S. DEP'T OF JUSTICE, 1, 1 (2016), https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/250123.pdf.

professional to evaluate the mental health needs of all of their youth. Thirty-five percent reported using an in-house mental health professional to evaluate the mental health needs of only some of their youth.[16] While this is an improvement from 2014, where 58% of respondents reported that they evaluated all youth for mental health needs and 41% reported that they evaluated some but not all of their youth,[17] the number of facilities that evaluate all residential youth is still not enough. The juvenile justice system has shifted too far away from rehabilitation and therefore incarcerated youth are not getting the mental help they need.

In this paper, I will discuss the national mental health crisis amongst our nation's youth and how children with mental illness disproportionately come into contact with the juvenile justice system as compared to youth without mental illness because their symptoms are mistaken for delinquency. I will also delve into the history of the juvenile justice system to showcase how its reforms have turned the system from rehabilitative to punitive, thereby adding to the incarceration rate of mentally ill youth. Lastly, I will explore two federal statutes – the Juvenile Justice and Delinquency Prevention Act and the Individuals with Disabilities Education Act – and two federally funded programs – Residential Treatment Centers and Positive Youth Development programs – that all seek to address the mental health crisis in today's youth and keep mentally ill youth out of the juvenile justice system. I will discuss the goals, regulations, and guidelines set forth by these statutes and programs, how they are not adequately meeting the needs of mentally ill youth, and then make recommendations of ways to improve them that have proved successful in smaller settings.

II. Background

NATIONAL MENTAL HEALTH CRISIS: RELINQUISHING CUSTODY FOR ACCESS TO CARE

Mental health has always been a taboo subject. Only recently has there been a shift in the way the United States views those with mental illnesses. This has left parents of mentally ill children with nowhere to turn when trying to seek treatment options for their child. Many parents are unable to pay for treatment for their children, their

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[16] *Id.* at 16.
[17] *Id.* at 12.

insurance will not cover the necessary treatment, they cannot find or do not have access to the type of treatment their child needs due to unavailability in their geographical region, or they find themselves overwhelmed by the impact their child's mental illness has on the family.[18] Some parents become desperate and relinquish custody of their children to the state in order for the children to receive the treatment they need by filing a petition in dependency court, known as "custody relinquishment."[19]

In 2001, the United States General Accounting Office ("GAO") conducted a study that estimated 12,700 children were relinquished by their parents in order to access mental health services.[20] Twenty-three percent of families in this study who had children with a severe mental illness were told by state agencies they had to relinquish custody, and 20% of this 23% did relinquish custody in order to receive care for their child.[21] In 2003, a six-month study was done by a national congressional committee that estimated nearly 15,000 juveniles remained in facilities because they could not access the mental health care that they needed in their home communities.[22]

Unfortunately, detention centers have become the main facility for holding mentally ill youth due to the lack of services in the community.[23] Typically, children who are in the juvenile justice system can enroll in a court-ordered treatment program. As children in the juvenile justice system can get priority access to the limited mental health resources available, parents have another incentive to relinquish custody to obtain treatment for their child.[24]

The parents' choice to relinquish custody creates further barriers for the child's treatment process, including disruption of family relations and removing parents from decision-making.[25] Parents are only allowed to visit periodically with their children and may rarely be

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[18] Adrian N. Bullock, *The Sacrifice Wrought by a Costly and Fragmented Mental Health Care System: Parents Forced to Relinquish Custody to Obtain Care for Their Children*, 24 DEV. MENTAL HEALTH L. 17, 24 (2005); Yael Zakai Cannon, *There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children,* 61 DEPAUL L. REV. 1049, 1062 (2012).

[19] Simone S. Hicks, *Behind Prison Walls: The Failing Treatment Choice for Mentally Ill Minority Youth,* 39 HOFSTRA L. REV. 979, 986 (2011).

[20] Bullock, *supra* note 18, at 17.

[21] Bullock, *supra* note 18, at 17.

[22] Hicks, *supra* note 19, at 984.

[23] Hicks, *supra* note 19, at 984.

[24] Bullock, *supra* note 18, at 20.

[25] Hicks, *supra* note 19, at 986.

consulted about their child's treatment.[26] This can further drive a wedge between the parent and child's relationship, making reentry into the community harder on the child.[27] Parents have also complained about being seen as a "nuisance" by the custodial agency to which the child is assigned or in which the child is being treated, even though the parents voluntarily relinquished custody.[28] However, even parents who can afford to treat their children at home are still faced with barriers due to the national shortage of resources and limited access to mental health services in the community.[29]

HISTORY OF THE JUVENILE JUSTICE SYSTEM

The juvenile justice system has undergone three major reforms since its creation. At common law, it was presumed that children under the age of seven could not possess criminal intent and therefore were not subject to criminal prosecution.[30] However, children over the age of seven were presumed to possess criminal intent and were charged with crimes like adult offenders.[31] However, reformers decided that it was society's duty to protect its children, not just punish them, and this line of thinking led to the creation of juvenile courts in the United States in 1899.[32] In the beginning, juvenile offenders were viewed differently from their adult counterparts. It was believed that the State, through its parens patriae power, should intervene when the natural parents were unwilling or unable to provide the necessary care and guidance for their children. The State would then help that child create a stable and nourishing future for themselves.[33]

During the early 1960s, another reform began. Researchers began realizing that the rehabilitative services put into place were ineffective due to the system's failure to provide necessary resources.[34] In *Kent v. United States,* Justice Fortas of the United States Supreme Court stated that in juvenile court, "the child receives the worst of

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[26] Bullock, *supra* note 18, at 25.

[27] Bullock, *supra* note 18, at 25.

[28] Bullock, *supra* note 18, at 25.

[29] Bullock, *supra* note 18, at 19.

[30] Vanessa L. Kolbe, *A Proposed Bar to Transferring Juveniles with Mental Disorders to Criminal Court: Let the Punishment Fit the Culpability,* 14 VA. J. SOC. POL'Y & L. 418, 421 (2007).

[31] *Id.* at 421.

[32] *Id.* at 421.

[33] *Id.* at 421-422.

[34] *Id.* at 422-423.

both worlds: that he gets neither the protection accorded to adults nor the solicitous care and regenerative treatment postulated for children."[35] To try to combat this, the Juvenile Justice and Delinquency Protection Act was created by the federal government in 1974.[36] This Act established the Office of Juvenile Justice and Delinquency Prevention, whose main function was, and still is, to research and evaluate the need for mental health services for youth involved with the juvenile justice system.[37] ODDJP is also responsible for promoting community-based projects that allow juvenile offenders to remain in their communities rather than be sent to a facility, since juvenile justice law at that time provided that juveniles should be incarcerated as little as possible.[38] These community-based projects could receive federal funding when they provided treatment to at-risk youth or juvenile offenders and their families, including those youth with mental health illnesses and emotional disturbances. Services should include youth counseling, training, and mentoring.[39] Rehabilitation remained the main focus during this reform, and ways to improve rehabilitation became the agenda.

Beginning in 1967 with the landmark case *In Re Gault* and continuing to today, a third shift in the juvenile justice system arose. A series of cases, including *Gault,* decided by the Supreme Court gave juvenile offenders similar procedural safeguards to those that adult offenders have.[40] By 1967, the focus of juvenile court had shifted from rehabilitating the juvenile to the need to protect society from the criminal offense the juvenile committed. Therefore, juvenile court became more punitive in nature.[41] This in turn led the public to believe there is an "epidemic of youth violence," and that juvenile offenders are just as culpable as their adult counterparts.[42] Perhaps the most notable change in the latest juvenile justice reform is that a juvenile offender can be easily transferred to adult criminal court.[43]

Typically, in juvenile court, a delinquency finding is followed by

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[35] *Kent v. United States*, 383 U.S. 541 (1966).

[36] Rachel Lugay, *Positive Youth Development Networks: The Community-Based Solution to Juvenile Delinquency and Other Problem Behaviors,* 23 RICH. PUB. INT. L. REV. 355, 360-61 (2020).

[37] Lugay, *supra* note 36, at 360-61; Cannon, *supra* note 18, at 1086.

[38] Cannon, *supra* note 18, at 1088-89.

[39] 34 U.S.C. § 11133 (2018); Cannon, *supra* note 18, at 1086.

[40] Kolbe, *supra* note 30, at 422-23.

[41] Kolbe, *supra* note 30, at 424.

[42] Kolbe, *supra* note 30, at 424.

[43] Kolbe, *supra* note 30, at 427.

a dispositional hearing where a rehabilitative plan rather than a punitive incarceration sentence is created by the judge.[44] Rehabilitation plans can include counseling, community service, youth court, out-of-home placement, diversion programs, juvenile facilities, or electronic monitoring.[45] However, it has now become easier to transfer youths to criminal court using one of three transfer methods: 1) "automatic transfer"; 2) "prosecutorial transfer"; and 3) "judicial waiver."[46] For automatic transfer, there are a list of offenses that require transfer if the juvenile meets certain statutory requirements, including a requisite minimum age and the alleged commission of certain crimes. For prosecutorial transfer, the prosecutor chooses between filing the case in juvenile or criminal court if the juvenile meets the statutory age and offense requirements. For judicial waiver, a judge, on the prosecutor's motion, decides whether to transfer a juvenile who meets certain statutory offense requirements.[47] Judicial waiver requires a hearing where the judge must find probable cause, competency of the juvenile to stand trial, and that the juvenile is not a "proper person" to stay in juvenile court.[48] There are seven factors that help determine whether a juvenile is a "proper person," including "1) the juvenile's age, 2) the seriousness and number of offenses, 3) whether the juvenile can be kept in juvenile system long enough for treatment to be effective, 4) the services available for treatment in the juvenile versus the adult system, 5) the juvenile's criminal record and history, 6) the existence and extent of mental illness or mental retardation, and 7) the juvenile's mental and emotional maturity."[49] Mental disorders are relevant to these transfer processes because a juvenile with a mental disorder is arguably less culpable, but under current transfer criteria, a juvenile's mental health may not be considered.[50]

These three changes to the juvenile justice system have severely impacted those youth with mental illness. At first, the juvenile justice system was set up to help mentally ill youth by rehabilitating them instead of punishing them. Children were seen as less culpable than their adult counterparts and therefore were punished less harshly.[51]

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[44] Lugay, *supra* note 36, at 360.
[45] *Id.*
[46] Kolbe, *supra* note 30, at 428.
[47] *Id.* at 428-29.
[48] *Id.* at 429.
[49] *Id.*; s*ee also* 18 U.S.C. § 5032 (2018).
[50] Kolbe, *supra* note 30, at 434, 436.
[51] *Id.* at 421-22.

However, when the system reformed to be more punitive, children started being held more accountable for their actions, much like adults.[52] Additionally, mental illness is much less likely to be taken into account, and therefore signs and symptoms of mental illness are often mistaken for delinquency behaviors.[53] This has led to mentally ill youth being overly represented at all stages in the juvenile justice system. The juvenile justice system needs to be reformed back to its rehabilitative roots.

III. Current Attempts At Early Intervention/Rehabilitation Of Mentally Ill Youth, The Shortcomings, and Arguments for Change

There are multiple ways in which the United States has engaged in early intervention and rehabilitation for its mentally ill youth; however, none of these systems have been effective. The current programs that exist are underfunded, inadequate, and being carried out in a disjointed and ineffective way. "America's new 'get tough' approach is in direct contradiction to recent research on how to rehabilitate young people."[54] Children with social, emotional, and behavioral problems face challenges at school, including truancy, suspension, and expulsion; they are at an increased risk of being involved with the juvenile justice system; they are at an increased risk for developing a substance abuse problem; they become hospitalized and institutionalized more frequently; and they are often taken from their communities and placed into residential treatment facilities.[55] Many of these children lack access to mental health services and find themselves shuffled between multiple agencies, leaving them without a true plan for success.[56] This results in their mental illness not being detected until too late, or not being detected at all, which can lead to tragedies such as the Sandy Hook school shooting.[57] As Cynthia Dieterich put it, "[d]iagnosis is particularly critical because it is a

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[52] *Id.* at 424.

[53] *Id.* at 424.

[54] Askew, *supra* note 10, at 381.

[55] Dieterich et al., *supra* note 1, at 42-43.

[56] *Id.* at 42.

[57] *Id.* at 41-42; The Sandy Hook Elementary school shooting occurred on December 14, 2012, when Adam Lanza murdered his mother in their home and then went to Sandy Hook Elementary School where he fatally shot twenty children and six adults, injured two more people, and then took his own life.

widely held and fundamental principle that *early* identification and detection is key to meeting the needs of individuals with disabilities; mental illness is no exception."[58] There are currently too many barriers to allow for early identification. There are four main barriers, excluding a lack of access to resources, which are: 1) a lack of public education about mental health; 2) a lack of awareness of a mental health crisis amongst the children of this nation; 3) a refusal of parents to acknowledge their children's mental health problems; and 4) a negative stigma that is attached to mental health in the United States.[59]

There are a multitude of statutes, regulations, and federally funded programs that have been implemented by the federal government and communities across the nation that are designed to address the mental health crisis – including early diagnosis and rehabilitation – but none are living up to their full potential. Some of the statutes and regulations include the Juvenile Justice and Delinquency Prevention Act and the Individuals with Disabilities Education Act, while some of the federally funded programs include residential treatment centers and positive youth development programs. Despite these attempts at intervention, the national mental health crisis amongst our youth persists. These early intervention programs have the potential to dramatically decrease the number of juveniles institutionalized for social, emotional, and behavioral challenges, and to facilitate the youth's successful transitions into adulthood. In order for the juvenile justice system to achieve its goals of treating mentally ill youth in their communities rather than in the justice system, and of decriminalizing status offenders, some changes and reforms are needed within these programs.

JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT

The first statute that currently exists to address the mental health crisis among youth is The Juvenile Justice and Delinquency Prevention Act ("JJDPA"). The JJDPA was created by the federal government in 1974. Its main objective was to deinstitutionalize status youth offenders in the juvenile justice system and to rehabilitate mentally ill youth in their communities rather than in the juvenile justice system setting.[60] The JJDPA mandates that state juvenile justice

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[58] Dieterich et al., *supra* note 1, at 41.

[59] *Id.* at 42.

[60] Hicks, *supra* note 19, at 998.

systems that receive federal funding meet statutory requirements in order for the funding to be received.[61] States must implement a plan to provide qualified professionals from the mental health field to perform assessments and create individualized treatment plans for incarcerated youth that must be "broad and comprehensive, and include medical, educational, special education, social, psychological, and vocational services, corrective and preventive guidance and training, and other rehabilitative services as needed."[62] The state rehabilitative programs must focus on positive youth development and must incorporate counseling and mentoring.[63] The Act also requires the early identification of mental health needs in children struggling in school in order to prevent truancy, suspension, and expulsion; and to eliminate the school-to-prison pipeline. The Act mandates that community-based treatment be used to prevent the entry of children into the juvenile justice system from the beginning.[64] These treatment programs must also foster positive youth development, focus on identifying learning disabilities and language barriers, and address abuse and neglect in the home.[65] States must specifically provide mentoring programs, training programs, and counseling services to high-risk youth, particularly those who live in low-income or high-crime neighborhoods.[66]

While the JJDPA was originally solely rehabilitative in nature, a shift in the juvenile justice system caused it to take a more punitive stance. To secure federal funding, Congress required states hold their juveniles accountable for the crimes they committed.[67] Of these amendments, the most punitive in nature was the one in which states were allowed to try juveniles as adults.[68] In an effort to retain funding, states were forced to "crack down" on crime and start imprisoning more youth for non-violent offenses.[69] This especially impacted minority youth and youth of color, who are overrepresented at every stage in the juvenile justice system.[70]

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[61] Cannon, *supra* note 18, at 1085-86.

[62] Cannon, *supra* note 18, at 1088; 34 U.S.C. § 11133 (2018).

[63] Lugay, *supra* note 36, at 361.

[64] 34 U.S.C. § 11101 (2018); Cannon, *supra* note 18, at 1086.

[65] Lugay, *supra* note 36, at 361.

[66] Cannon, *supra* note 18, at 1086.

[67] 34 U.S.C. § 11101 (2018).

[68] Lugay, *supra* note 36, at 362.

[69] *Id.* at 362-63.

[70] Holly Cook, *Juvenile Justice & Delinquency Prevention Act,* AMERICAN BAR ASSOCIATION,

The JJDPA also does not mandate appropriate mental health treatment – instead, it merely states that in order to receive funding, states must "prepare a plan for providing needed mental health services to juveniles in the juvenile justice system."[71] However, it does not set a standard for the plan itself, nor does it set a standard for how to carry out that plan.[72] So, while this statute is good in theory, it is actually not ensuring that states carry out the mental health treatment plans they submit, nor ensuring that the plans are adequate or appropriate for its intended recipients.

The JJDPA went decades without being revamped. The latest reauthorization to the JJDPA was in 2018, but before that it had not been reauthorized since 2002.[73] In 2002, the JJDPA was reformed to have a punitive outlook that focused on holding juveniles accountable for their actions rather than rehabilitating them and addressing the mental, social, and emotional challenges driving the behavior.[74] This statute was untouched until 2015. Then new legislation was proposed to take this statute back to its rehabilitative roots.[75] However, due to a holdout in the Senate,[76] the new legislation did not go into effect until 2018.[77]

The revised JJDPA has four core requirements: 1) deinstitutionalizing status offenders; 2) removing juveniles from adult jails and prisons; 3) ensuring accused and adjudicated juveniles are not confined in an institution where they may come into contact with adult offenders; and 4) eliminating racial and ethnic disparities.[78] However, according to a study done by the Prison Policy Initiative in 2019, 15% of youth are still locked up for technical violations and 4% of youth

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https://www.americanbar.org/advocacy/governmental_legislative_work/priorities_policy/criminal_justice_system_improvements/juvenile_justice_delinquency_prevention_act/#:~:text=The%20federal%20Juvenile%20Justice%20and,youth%20and%20those%20of%20their (Last visited: June 19, 2020).

[71] Hicks, *supra* note 19, at 999-1000.

[72] *Id.* at 1000.

[73] Cook, *supra* note 70; Coalition for Juvenile Justice, *Juvenile Justice and Delinquency Prevention Act*, http://www.juvjustice.org/federal-policy/juvenile-justice-and-delinquency-prevention-act (Last visited: June 19, 2020).

[74] Lugay, *supra* note 36, at 362.

[75] Cook, *supra* note 70.

[76] New legislation was proposed into the Senate in 2015 as S.1169 to strengthen the core protections of the JJDPA and accountability in administration of grants authorized by it, but it did not pass until three years later in 2018 with bipartisan support.

[77] Coalition for Juvenile Justice, *Juvenile Justice and Delinquency Prevention Act*, http://www.juvjustice.org/federal-policy/juvenile-justice-and-delinquency-prevention-act (Last visited: June 19, 2020).

[78] *Id.*

are still locked up for status offenses.[79] Nearly one in ten youth are sent to adult prisons or jails, which have been shown to be the worst place for youth. Due to the JJDPA's "sound and safety" requirement of keeping adult offenders away from juvenile offenders, many juveniles are sent to solitary confinement, where they are five times more likely to commit suicide than if they were in a juvenile facility.[80] Racial disparities are still prevalent, as only 14% of all youth in America are Black, yet 42% of boys and 35% of girls in juvenile facilities are Black.[81] Also, in 2017, Black youth made up 35% of all delinquency cases, but 54% of all juvenile cases transferred to adult court were Black youth. It has been statistically shown that racial disproportionality has actually increased since 2005.[82] Congress tried getting to the root of the problem by taking the JJDPA back to its original rehabilitative purposes; however, it appears that the states are still punishing juveniles more than rehabilitating them, as 48,000 youth are still imprisoned on any given day.[83]

i. *SEVEN REFORM STRATEGIES TO ACHIEVE THE JJDPA'S FOUR CORE REQUIREMENTS*

According to the Prison Policy Initiative, it has been shown that, since 2000, the number of confined youths has dropped by 60% and continues to decrease by 5% each year, going from over 108,000 in 2000 to approximately 48,000 in 2019.[84] However, recent studies have also shown that the four core requirements are not adequately being met nationwide, as status offenders and those with technical violations are still being incarcerated, juveniles are still being put and held in adult jails and prisons, and racial disparities are actually on the rise.[85] Forty-eight thousand incarcerated youth on any given day is still too high of a number for a system that is supposed to be rehabilitative.

Research by the Prison Policy Initiative has collected seven

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[79] Wendy Sawyer, *Youth Confinement: The Whole Pie 2019,* PRISON POLICY INITIATIVE (December 19, 2019), https://www.prisonpolicy.org/reports/youth2019.html.

[80] *Id.*

[81] *Id.*

[82] *Id.*

[83] *Id.*

[84] *Id.*

[85] *Id.*

reform strategies that have proved successful in achieving the goals set forth by the JJDPA. These seven reform strategies should be adopted by the JJDPA and implemented uniformly across the nation. These reform strategies are: 1) closing and repurposing prisons and detention centers; 2) developing community and in-home programs to serve juveniles charged with violent offenses; 3) adapting the current laws so that certain offenses will not have jail time attached to them; 4) issuing civil citations in lieu of arrests; 5) putting caps on sentencing; 6) shifting funding from incarceration to community-based alternatives; and 7) recognizing and addressing the impact of trauma on juveniles involved in the juvenile justice system.[86] These seven strategies have proven successful in decarcerating juveniles in the juvenile justice system.

First, states should close and repurpose prisons and detention centers to allow for resources to be redirected to community-based treatment, including professionals, funding, and space.[87] Currently, the juvenile justice system is too focused on punitive punishment and jail time, which takes away from community resources. This causes many juveniles who commit status offenses or who have mental illnesses to be jailed rather than rehabilitated.[88] Missouri was the first to try this approach over thirty years ago. Its model, referred to as the "Missouri Model," closed all correctional style centers and opened smaller treatment centers that were focused on rehabilitative programming.[89] This model has had great success in the state of Missouri and has shown that more humane styles of correctional systems can increase rehabilitative outcomes and reduce the harms of incarceration such as depression, anxiety, and recidivism.[90]

Second, states must decrease the incarceration of juvenile violent offenders in adult prisons.[91] Currently, most community-based treatment centers have exclusionary criteria that reject youth whose needs fall outside the scope of available services. These types of treatment centers focus on the services they provide rather than the youth's needs. They send rejected youth to detention centers, state incarceration, or out-of-state placement rather than developing

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[86] *Id.*
[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*

services to address this population.[92] The Youth Advocacy Program ("YAP") suggests this exclusionary criterion be eliminated. Rather, community-based centers need to refocus their intervention strategies from available services to the youth's needs.[93] This will, in turn, reduce the amount of youth being incarcerated for mental health needs.

At-home or community-based treatment is more effective for juveniles charged with all kinds of offenses.[94] Developing programs to serve youth charged with violent crimes has been pushed for by juvenile justice experts.[95] Experts recommend that community-based treatment centers adopt "no reject policies" that will allow youth with high risk needs to be accepted instead of sending them to a correctional facility.[96]

The third recommendation to reduce the rate of juvenile incarceration is to eliminate jail time attached to certain offenses, such as status offenses. This is one of the core requirements of the JJDPA, yet many status offenders are still being incarcerated. The problem with incarcerating status offenders is that status offenses are only illegal because of the youth's age. They are not violent offenses, and more often than not the offense is committed due to an underlying problem that requires rehabilitation, such as mental illness or substance abuse.[97] Utah and Massachusetts have already removed status offenses from their juvenile court's jurisdiction.[98] All other states should follow in order to get the number of status offenders incarcerated down to zero.

Fourth, a civil citation alternative should be put in place for nonviolent offenders to avoid their prosecution and court intervention. Instead, youth accused of misdemeanors are offered community-based sanctions, therapy, counseling, apology letters, community service, etc. in place of incarceration.[99] Delaware and Florida have already put these Civil Citation programs into effect. From November 2018 to October 2019, 62% of eligible Florida youth avoided formal

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[92] SHAENA M. FAZAL, SAFELY HOME: REDUCING YOUTH INCARCERATION AND ACHIEVING POSITIVE YOUTH OUTCOMES FOR HIGH AND COMPLEX NEED YOUTH THROUGH EFFECTIVE COMMUNITY-BASED PROGRAMS, 20 (June 2014).

[93] *Id.*

[94] Sawyer, *supra* note 79.

[95] *Id.*

[96] Fazal, *supra* note 92, at 2.

[97] Sawyer, *supra* note 79.

[98] *Id.*

[99] *Id.*

prosecution due to Florida's Judicial Circuit Civil Citation and Similar Prearrest Diversion program.[100]

The fifth recommendation of the Prison Policy Initiative is to cap sentences for juveniles. Having no caps in place gives judges too much freedom to further the punitive agenda of the juvenile justice system. Placing caps on sentencing puts a check on the system and forces it to stop relying on incarceration. All states should, at a minimum, place limits on non-felonious out-of-home placements that do not exceed one year. This is because out-of-home placements exceeding one year are more costly than beneficial to the youth and their communities. Long out-of-home placements make it harder for the youth to reenter their homes and communities by decreasing the youth's social and societal skills.[101] This often leads to repeat offending and recidivism.[102] Kentucky, Utah, and Tennessee have already capped the amount of time juveniles can be sent to out-of-home placements, be on probation, or be under court supervision. Georgia has reduced the maximum sentence for certain felonies from five years to eighteen months.[103] If felonies can be capped at eighteen months, then non-felonious out-of-home placements should be capped at one year.

Sixth, funding should be shifted to create and expand community-based alternatives to incarceration. According to the Youth Advocacy Program, in 2008, states spent $5.7 billion to incarcerate youth.[104] YAP suggests reallocating these funds to community-based programs, thereby institutionalizing less youth and creating more community-based alternatives without having to spend any additional money.[105] In 2018, Tennessee committed $4.5 million per year to provide juvenile courts with more treatment options and to expand community services.[106] Georgia created a grant program in 2013 for counties that reduced the number of committed youth and shifted $30 million to community-based alternatives by closing several detention centers.[107] These programs have been successful in reducing the number of incarcerated youths.[108]

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[100] *Id.*
[101] Cannon, *supra* note 18, at 1051.
[102] *Id.*
[103] Sawyer, *supra* note 79.
[104] Fazal, *supra* note 92, at 5.
[105] *Id.* at 7.
[106] Sawyer, *supra* note 79.
[107] *Id.*
[108] *Id.*

Lastly, juvenile courts, counselors, police, and youth mental health advocates should recognize and address that 90% of the youth involved in the juvenile justice system have experienced some form of trauma.[109] Trauma takes a toll on cognitive development, behavior, and mental health, and policymakers acknowledge this fact when they advocate for early intervention and rehabilitation of juvenile offenders rather than punitive measures.[110] Society needs to refocus its attention on rehabilitating traumatized youth rather than punishing them.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

The second statute that exists to mitigate the mental health crisis is the Individuals with Disabilities Education Act. This Act was implemented in order to identify disabilities in school-aged children. Children who have disabilities, especially social, behavioral, or emotional problems, are more likely to fall into one or more of four poor outcome categories: 1) low achievement; 2) suspension and expulsion; 3) school dropout; or 4) involvement in the juvenile justice system.[111]

Low achievement can come in the form of low academic performance at school and outside of the classroom in the early years of young adulthood. It is often attributed to a failure to identify special needs in the students early enough.[112] There is a reciprocal relationship between social, emotional, and behavioral challenges and low academic achievement.[113] Research has shown that the later in life a child is offered services, the greater the chance of an unsuccessful outcome. There is almost a doubled chance of an unsuccessful outcome in a child who was offered services at the age of eight versus the age of twelve.[114]

Suspensions and expulsions are often given to children with social, emotional, and behavioral challenges at an increased rate as well. One national study of elementary and middle school students with emotional disabilities found that 47.7% had been suspended or expelled. This study also found that 72.9% of secondary school students

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[109] *Id.*

[110] *Id.*

[111] Yael Cannon et al., *A Solution Hiding in Plain Sight: Special Education and Better Outcomes for Students with Social, Emotional, and Behavioral Challenges,* 41 FORDHAM URB. L.J. 403, 412 (2013).

[112] *Id.* at 415.

[113] *Id.* at 413.

[114] *Id.* at 415.

with emotional disabilities had been suspended or expelled.[115] Another study by the Child Mind Institute found that, on average, more than 77,000 children in special education receive suspensions or expulsions for more than ten cumulative days in a school year, and 5.7% of those 77,000 children have emotional disturbances.[116] Children who are suspended or expelled are at an increased risk of becoming involved with the juvenile justice system due to being stripped of any education or formal school setting during the time of suspension or expulsion.[117]

It is also common for students with social, emotional, and behavioral disabilities to drop out of school due to low academic achievement and suspensions and expulsions.[118] Students who are repeatedly targeted as "problem children" due to a behavioral disability are five times more likely to dropout than their peers. One study found that the general dropout rate for all students is 7%, but for students diagnosed with an emotional disturbance, the dropout rate skyrocketed to 38.7%.[119] Another 45,846 students with learning disabilities drop out of school each year, as well.[120] Students who drop out of school are also more likely to end up in prison. Sixty-eight percent of state prison inmates have not finished high school.[121]

Students with social, emotional, and behavioral disabilities are also more likely to become involved in the juvenile justice system. More than seventy percent of youth in the juvenile justice system meet criteria for a psychiatric diagnosis.[122] However, school systems often implement "zero tolerance policies," meaning that they seek punitive punishment whenever there is any sort of violence, no questions asked. Through these zero tolerance policies, school staff have historically overused punitive measures to suspend, expel, and criminalize the misbehavior of children with disabilities at a significantly higher rate than those measures are used with their peers.[123] This often contributes to the "school-to-prison pipeline" because police

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[115] *Id.* at 416.

[116] CHILD MIND INST., 2016 CHILDREN'S MENTAL HEALTH REPORT: MENTAL HEALTH IMPACTS IN SCHOOLS, https://childmind.org/report/2016-childrens-mental-health-report/mental-health-impacts-schools/.

[117] Cannon et al., *supra* note 111, at 417-18.

[118] *Id.* at 419.

[119] Child Mind Institute, *supra* note 116.

[120] *Id.*

[121] *Id.*

[122] *Id.*

[123] Cannon, *supra* note 18, at 1074.

are called to handle a misbehaving child at school. This can lead to juvenile delinquency petitions being filed and the child being sent to the juvenile justice system – a very severe form of punishment.[124] Schools often choose to suspend, expel, or get the police involved with students with behavioral difficulties rather than implementing behavior management programs for them because there is a lack of resources to which the schools have access, especially mental health resources.[125] Unfortunately, this leads to mentally ill youth being overrepresented at every stage in the juvenile justice system.

The Individuals with Disabilities Education Act was enacted to prevent students with disabilities from falling into one of the above-mentioned poor outcome categories. The federal government decided that the school system was one of the most capable places to intervene in a child's life when there is a behavioral or emotional issue present. Congress recognized that, historically, the needs of children with disabilities had not been met. It recognized that "children have been excluded from the public school system and educated separately from their nondisabled peers; undiagnosed disabilities have prevented children from having a successful educational experience; and a lack of adequate resources within the public school system has forced families to seek services outside of that system."[126] Congress therefore implemented a federal law in order to address some of these systemic issues and create an educational atmosphere for children with disabilities to thrive.[127] In 1975, Congress enacted the Individuals with Disabilities Education Act ("IDEA") to mandate that school systems "identify, locate, and evaluate" children who require special education.[128] Also known as "Child Find," this places an affirmative obligation on schools to intervene early with students with disabilities and is the first step in ensuring the IDEA is carried out properly.[129]

Once a child has been determined to have a disability, the IDEA requires that an Individualized Education Plan ("IEP") be created with appropriate accommodations and services in order to carry out a free, appropriate, public education ("FAPE").[130] IEPs can consist of special

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[124] Cannon et al., *supra* note 111, at 417-18.

[125] *Id.* at 420-21.

[126] *Id.* at 425.

[127] *Id.* at 426.

[128] Erin M. Heidrich, *Expanding Access to Residential Treatments for Mentally Ill Youth Through the Individuals with Disabilities Education Act,* 41 N. KY. L. REV. 295, 295 (2014);

[129] Cannon et al., *supra* note 111, at, 426-27.

[130] Cannon, *supra* note 18, at 1071.

education teachers, counseling, social work services in the school, or therapeutic recreation.[131] The IDEA requires schools to provide children with disabilities a FAPE tailored to their individual needs.[132] A child qualifies for a FAPE under the IDEA when: "(1) the student has a disability, and (2) because of the disability, the student requires a special education and related services."[133] It is not enough for the child to merely have a disability; the disability must interfere with the child's ability to learn that only special education rather than medication can help fix.[134]

In 2006, Part B of the IDEA was introduced, which regulated children who suffer from "emotional disturbances" ("ED").[135] "A child whose functioning is significantly impaired as a result of a mental health disorder is characterized as having a 'serious emotional disturbance.'"[136] Under Part B of the IDEA, an ED is defined as:

(i) A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.[137]

This statute has caused some debate, as there is ambiguity as to the meaning of "a long period of time" and "socially maladjusted."[138] Socially maladjusted has been defined as "a repeated pattern of

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[131] *Id.* at 1075; 20 U.S.C. § 1414 (2016).

[132] Heidrich, *supra* note 128, at 296, 298.

[133] *Id.* at 298.

[134] *Id.* at 298; Dieterich et al., *supra* note 1, at 44.

[135] Dieterich et al., *supra* note 1, at 44.

[136] Cannon, *supra* note 18, at 1055.

[137] 20 U.S.C. § 1414.

[138] *Id.*

violating societal norms."[139] This does not qualify a student for disability under the IDEA. However, the IDEA does qualify an ED as "[i]nappropriate types of behavior or feelings under normal circumstances." These two definitions are very similar, if not interchangeable, creating hardships in distinguishing between children with an ED and children who are socially maladjusted.[140] According to case law, children can have an ED clinically or for treatment purposes, but not meet the legal definition of ED and therefore they are not entitled to special education.[141]

One of the main issues with the IDEA is that school districts are often slow to identify disabilities in children, if they identify them correctly at all. Oftentimes, school systems fail to identify or misidentify disabilities, leading to children not receiving the correct or any special education.[142] There are multiple reasons why schools fail to implement the IDEA correctly, including the lack of funding, the lack of specialized training for teachers and staff, the lack of access to the child's mental health and medical information, little to no parental involvement, little to no community support or collaboration, too high of a staff to student ratio, and the absence of stricter legal guidelines in carrying out the IDEA's goals and mandates.[143] In order to be successful, school districts require outside collaboration from mental health professionals, agencies, the government, and legal counsel which they often do not receive, especially school systems in poor communities.[144] Failure to identify these emotional and behavioral disabilities can lead to an exacerbation of symptoms and a point of crisis for the child, which then contributes to the school-to-prison pipeline when the school does not know how to handle the child any longer and implements punitive punishment.[145]

i. *REDEFINING THE TERMS OF THE STATUTE AND MODELING PLAIN LOCAL SCHOOLS' SPECIAL EDUCATION PROGRAM*

There are two major reforms that should take place in order for the IDEA to be more effective: 1) redefine the terms "a long period of time" and "socially maladjusted"; and 2) close residential treatment

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[139] Hicks, *supra* note 19, at 995.
[140] *Id.* at 995.
[141] Dieterich et al., *supra* note 1, at 52.
[142] Bullock, *supra* note 18, at 21.
[143] Dieterich et al., *supra* note 1, at 62-63.
[144] *Id.* at 64.
[145] Cannon, *supra* note 18, at 1074.

centers and redistribute their funding to the education systems. The IDEA should then recommend that jurisdictions adopt a system similar to that adopted by Plain Local Schools in Canton, Ohio for their Special Education Program.

The IDEA, as it is currently written, leaves room for misinterpretation and results in students who need services unable to get them. Part B of the 2006 regulations defines an emotional disturbance as "[a] condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance . . . ."[146] However, Congress has not defined "a long period of time." This leaves many children not meeting the legal definition of an emotional disturbance under the IDEA because the term "a long period of time" is imprecise. Therefore, these children do not receive a FAPE.[147] Congress needs to amend this language and either define what "a long period of time" is, or not require a time limit at all. If a time limit is required, it should not exceed one academic year. Since a child must be diagnosed with an emotional disturbance before receiving services under the IDEA, that child should not have to exhibit symptoms for more than one academic year so she does not fall behind in her studies and have to repeat a grade.

Congress should also consider including "socially maladjusted" children under the emotional disturbance definition because, under the statute, a child who is "socially maladjusted" does not qualify for services under the IDEA. However, the definition of "socially maladjusted" and "emotionally disturbed" are almost identical. "Socially maladjusted" is defined as "violating societal norms."[148] An "emotional disturbance" is defined as "[i]nappropriate types of behavior or feelings under normal circumstances."[149] Because children who are socially maladjusted and emotionally disturbed exhibit the same symptoms, it is only fair that both receive services under the IDEA. Therefore, Congress should delete the distinction that socially maladjusted children are not entitled to services. At the very least, the definitions should be clearer, and more guidelines should be given to distinguish the two conditions.

The second reform that the IDEA should undergo is redistributing funding in order to allocate better resources to the children it

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[146] Dieterich et al., *supra* note 1, at 44-45.

[147] *Id.* at 52.

[148] Hicks, *supra* note 19, at 996.

[149] *Id.* at 995.

serves. Currently, many school districts are underfunded and lack the money to carry out programs like the IDEA.[150] A 2016 study found that schools who reformed school finance policies in order to allocate more money to poverty-stricken school districts narrowed the achievement gap by an average of one-fifth from 1990 to 2011.[151] Re-allocation of money also helps implement programs like the IDEA.

With the reallocation of funds going directly towards education, school systems will have more money to implement special education programs that follow the IDEA guidelines. Plain Local Schools ("Plain"), a school district in Canton, Ohio, has implemented a model-worthy special education program that consists of four elements including Child Find, which is where the school screens children for disabilities starting in preschool; "Core Plus More," which is additional exposure to core classes taught by an intervention specialist; "Mild-to-Moderate Services," which are mental health intervention given to students who do not qualify for services under the IDEA; and "District Placement," which is where the child with special needs is placed at another school or facility if Plain does not have the services she needs. Plain's Special Education Program is overseen by Mark Parent, who ensures the district is compliant with the IDEA.

First, Child Find is a law-mandated obligation for schools to "identify, locate, and evaluate" all children with disabilities.[152] Plain begins their Child Find at the preschool level, or as early as age three, and it continues until the child graduates high school, or in some extreme cases, until the child's twenty-second birthday.[153] This means that all children get screened for learning impairments and disabilities when they begin preschool, and any child who begins to demonstrate difficulties in the classroom can be evaluated again, no matter what grade he or she is in.[154] While Child Find is already law-mandated for schools' special education programs across the nation, the program can be enhanced by starting it sooner and continuing it throughout the primary education. School districts should start their Child Find screenings for all children in their preschools and continue screening for any child showing signs and symptoms of disability

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[150] Dieterich et al., *supra* note 1, at 62-63.

[151] Carmel Martin et. al, *A Quality Approach to School Funding,* CTR. FOR AM. PROGRESS, (Nov. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/education-k-12/reports/2018/11/13/460397/quality-approach-school-funding/.

[152] Cannon et al., *supra* note 111, at, 426-27.

[153] Interview with Mark Parent, Special Education Program Director, Plain Local Schools in Canton, Ohio (March 30, 2018).

[154] *Id.*

throughout their primary education. This is because children with disabilities will benefit more the earlier their disability is identified, and services are implemented. However, other children may not develop or show signs of disability until later in their academic career and would benefit from additional screenings once these signs and symptoms appear.

Second, "Core Plus More" gives students the opportunity to take a second, modified version of core classes taught by an intervention specialist. These classes are held in 45-minute blocks in the afternoon, after the student attends the full 90-minute course in the morning. "Core Plus More" classes are optional for all subjects, and are offered to all students, whether they have a disability or not.[155] This program is beneficial to all students, but especially to those students with disabilities because it is essentially tutoring services built into the school day. Students with learning disabilities benefit from additional exposure to classroom materials, and this program gives them that opportunity during the school day with the help of an intervention specialist. Other school systems should offer a "Core Plus More" program by offering tutoring services for core curriculum classes during the school day, whether it be during a study hall or "free period," to at least their students with disabilities to help these children get additional exposure to these materials.

Third, the "Mild-to-Moderate Services" program is not considered an IEP, but it is implemented by Plain's special education program for emotionally disturbed students, homeless students, and students who have less than ideal home environments or who have been through a tragedy but do not qualify for services under the IDEA. Identified students attend general education classes, but also regularly meet with a mental health specialist, psychologist, and counselor.[156] This allows these students, while at school, to receive free mental health help to discuss their home life, school struggles, and receive information about help they can receive in their communities.[157] Time with their counselors become a safe haven for them. Other schools should implement a similar program by hiring mental health crisis counselors that are available to all students for emotional and mental support any time it is needed. These counselors should also be assigned to meet regularly with students who have emotional disturbances not eligible for services under the IDEA, students who

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[155] *Id.*
[156] *Id.*
[157] *Id.*

are homeless, and students who have a less than ideal home environments.

Lastly, Plain has a district placement program where Mr. Parent will find the child placement in a school district or other facilities outside of Plain if Plain does not offer the services the child needs. After the child is placed, Mr. Parent becomes their principal and service provider while they are away.[158] Because the child is still a Plain Local student, Mr. Parent keeps track of the child's attendance, grades, behavior, disciplinary actions, and the services being provided by the other school district or facility.[159] The goal is to get the child back to the Plain School District if her needs are met and her disability is under control, though this does not always occur.[160] This program ensures that all students with disabilities are receiving adequate services as required under the IDEA, even if that child's own school district is unable to provide the necessary services. Other schools should implement a similar program by collaborating with neighboring school districts and community facilities to help supplement services they might be lacking. This way, these school districts, especially those with low budgets, could send their students with disabilities to either neighboring school districts or community facilities in order for them to receive the services they need and stay compliant under the IDEA.

RESIDENTIAL TREATMENT CENTERS

Residential Treatment Centers ("RTCs") house federally-funded programs that exist to address the mental health crisis. They are institutions that hold juveniles with significant emotional, behavioral, psychological, psychiatric, or substance abuse problems who cannot be successful in nonsecure treatment settings, but who have not proved themselves dangerous enough to warrant a stay in a psychiatric hospital or a secure prison.[161] In 2019, according to a study done by the Prison Policy Initiative, there were 15,400 youth in residential style treatment facilities out of 48,000 total youth being held in facilities.[162] These RTCs ranged from boot camps to group homes, with 78% of the youth being held in locked facilities rather than staff-

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[158] *Id.*

[159] *Id.*

[160] *Id.*

[161] Office of Juvenile Justice and Delinquency Prevention, *Residential Treatment Centers*, OJJDP.gov, https://www.ojjdp.gov/mpg/litreviews/Residential_Treatment_Centers.pdf (last updated July 2011).

[162] Sawyer, *supra* note 79.

secured facilities.[163] RTCs offer many different treatment options for mental health and substance abuse, including counseling, family therapy, special education, behavioral management, medication management, psychoanalytic therapy, and twenty-four-hour supervision in a strictly structured environment.[164]

RTCs may describe themselves as "wilderness therapy programs, boarding schools, academies, behavioral modification facilities, and boot camps, among other names," as there are varying types of facilities that are considered RTCs.[165] RTCs lack a standard definition, and, according to a 2007 report from the Government Accountability Office ("GAO"), it is hard to differentiate residential programs because of the lack of a standardized definition.[166] Many are privately owned. This means parents, at least those with the financial capability, are able to send their child directly to these facilities. However, the children of most low-income families are sent to RTCs through a number of state or local agencies, including the juvenile justice system, child welfare, or special education agencies.[167] Research has shown that poverty-stricken children are disproportionately sent to RTCs. Medicaid and state mental health agencies pay for approximately 31% of RTC treatment, while other public agencies such as child welfare pay for another 50% of RTC treatment.[168] This means that state and federal funding, through taxpayers, bear the burden of these institutionalizations. These institutionalizations are not cheap; they can costs hundreds of dollars per day per child for the months or even years that the child remains in the facility.[169]

Residential Treatment Centers undermine the goal of deinstitutionalizing youth offenders. Juveniles often find themselves in an RTC when they lack access to community-based mental health services and reach a point of crisis.[170] Juvenile Court judges and juvenile justice agents often order youth to RTCs rather than to community-based treatment.[171] As Yael Zakai Cannon states, "[o]ne of the most troublesome consequences of the failure of public agencies to ensure that children are provided with these community-based services is

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[163] *Id.*

[164] Office of Juvenile Justice and Delinquency Prevention, *supra* note 161.

[165] Cannon, *supra* note 18, at 1056-57.

[166] Office of Juvenile Justice and Delinquency Prevention, *supra* note 161.

[167] Cannon, *supra* note 18, at 1056-57.

[168] *Id.* at 1057 n.34.

[169] *Id.* at 1057.

[170] *Id.* at 1071.

[171] *Id.* at 1091.

the unnecessary institutionalization of children."[172] Because of the shortage of mental health programs across communities, juveniles are often criminalized for behaviors due to their mental or behavioral challenges. RTCs are some of the most common places to put these juveniles, which can lead to further obstacles in the juveniles' treatment because of separation trauma, their failure to reconnect with the community and family upon reentry, and their failure to learn proper societal norms and behaviors.[173]

Another problem with RTCs is that the staff who are assigned to work with the youth on a daily basis are often not properly trained to deal with the types of behavioral and mental health issues that these youth have.[174] This lack of training can lead to frustrating situations in which a punitive rather than rehabilitative response is given by the staff, further exacerbating the youth's symptoms and stress.[175] There is a growing body of research that shows RTCs do not produce better results and outcomes for the juveniles who receive treatment there.[176] However, because the juvenile justice system has become the dumping grounds for youth with mental health needs to obtain necessary treatment, RTCs are unnecessarily used and funded.[177]

i. *REMODELING RTCS INTO CRISIS INTERVENTION CENTERS AND REALLOCATING FUNDS TO COMMUNITY-BASED PROGRAMS*

Residential Treatment Centers are functionally useless when it comes to rehabilitating mentally ill youth and need to be remodeled completely. RTCs need to be defunded, with the money being reallocated to community-based programs instead. The OJJDP has recognized that literature has called for RTCs to be remodeled entirely to become crisis intervention centers, where youth go temporarily to interrupt the downward spiral of a crisis from which they then return to their communities for further treatment.[178] A youth who is having a mental breakdown and can no longer remain in his home, school, or community may be placed in one of these RTCs to de-escalate, get

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[172] *Id.* at 1056.
[173] *Id.* at 1057-58.
[174] Meservey & Skowyra, *supra* note 14.
[175] *Id.*
[176] Cannon, *supra* note 18, at 1057-1058.
[177] Meservey & Skowyra, *supra* note 14.
[178] Office of Juvenile Justice and Delinquency Prevention, *supra* note 161.

immediate treatment, and prevent his involvement with the juvenile justice system. This new model would reduce the youth's stay in RTCs from months or years to days or hours. Less beds and staff would be necessary, significantly reducing the cost and allowing more funds to flow into the community-based programs and to the education systems. It would also standardize the definition of RTCs, creating more accurate data on their characteristics and outcomes.[179] Georgia has already shifted $30 million to community-based alternatives since 2013 by shutting down several RTCs in its state.[180] RTCs, as they currently function, should be eliminated, the funding should be reallocated to community-based treatment centers and school districts. The new model of RTCs should open as "crisis intervention centers."

POSITIVE YOUTH DEVELOPMENT

More recently, federally-funded programs have been implementing Positive Youth Development ("PYD") into their curriculum. PYD is a theory of youth development that emphasizes creating a positive support system, achieving goals set forth by the youth, and making a healthy transition into adulthood.[181] According to the U.S. Department of Health and Human Services, "PYD is not a specific curriculum but a model that can be used to enhance any youth-serving program."[182] Research has shown that incorporating PYD into these youth-serving programs can prevent risky behaviors, reduce health disparities, and contribute to a range of positive outcomes for the youth involved.[183]

PYD focuses on the adolescent's strengths and works to enhance them.[184] The five qualities that the program seeks to improve are referred to as "The Five C's:" 1) competence; 2) character; 3) connections; 4) confidence; and 5) caring/compassion.[185] Once an

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[179] *Id.*

[180] Sawyer, *supra* note 79.

[181] Office of Population Affairs, *Positive Youth Development,* HHS.gov (last visited June 19, 2020), https://www.hhs.gov/ash/oah/adolescent-development/positive-youth-development/index.html [https://web.archive.org/web/20200607180249/https://www.hhs.gov/ash/oah/adolescent-development/positive-youth-development/index.html].

[182] *Id.*

[183] *Id.*

[184] *Id.*

[185] Lugay, *supra* note 36, at 366.

adolescent conquers these five, she will then begin to show a sixth quality, which is contribution.[186]

Competence refers to the knowledge and skills that help people positively interact with their environment.[187] There are five different areas of competence: social, cognitive, vocational, health, and academic. Social competence is development of the youth's interpersonal skills. Cognitive competence is enhancement of the youth's cognitive abilities, such as decision-making skills. Vocational competence is the youth's ability to make career choices and adopt work habits. Health competence is the youth's ability to keep herself fit through diet, exercise, and rest. Lastly, academic competence is the youth's positive school performance, as shown through grades and attendance.[188]

Character is self-integrity and trying to do the right thing.[189] The youth must have respect for societal and cultural norms and try to correct her behaviors to follow those norms.[190] The connection goal is to have positive social connections with other people and institutions, such as schools, where both parties contribute to the relationship.[191] Confidence refers to an internal sense of self-worth that youth need to continue to build upon in order to demonstrate character and competence.[192] Lastly, caring and compassion refers to the youth's ability to have sympathy and empathy for others.[193] The sixth and final quality, contribution, is typically worked on after mastering "The Five C's." It refers to engaging in acts of selflessness to help one's community.[194]

PYD programs assess risk and protective factors at the individual, family, peer, and school/community levels that deter or help the child achieve "The Five C's."[195] Risk factors identify potential barriers to long-term success in adulthood and seek to identify early warning

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[186] Richard M. Lerner & Jacqueline V. Lerner, *The Five Cs Model of Positive Youth Development,* HARVARD UNIV., http://exploresel.gse.harvard.edu/frameworks/52 (last visited June 19, 2020).

[187] Lugay, *supra* note 36, at 366.

[188] Richard M. Lerner & Jacqueline V. Lerner, *The Five Cs Model of Positive Youth Development,* HARVARD UNIV., http://exploresel.gse.harvard.edu/frameworks/52/terms, (last visited June 19, 2020).

[189] Lugay, *supra* note 36, at 366.

[190] Lerner & Lerner, *supra* note 186.

[191] *Id.;* Lugay, *supra* note 36, at 366.

[192] Lerner & Lerner, *supra* note 186; Lugay, *supra* note 36, at 366.

[193] Lerner & Lerner, *supra* note 186.

[194] *Id.;* Lugay, *supra* note 36, at 366.

[195] Lugay, *supra* note 36, at 367.

signs of behavioral, emotional, and mental health disorders. Protective factors, on the other hand, seek to point out strengths the adolescent already has in his or her life.[196]

Risk factors at the individual level can consist of poor cognitive development, antisocial behavior, low IQ, hyperactivity, and defying authority. Protective factors at the individual level can consist of developing positive relations and social skills and having an average to high IQ.[197] Risk factors at the family level include the presence of abuse and neglect, family violence, improper child rearing practices, poverty, divorce, parental mental illness, and teen pregnancy. Protective factors at the family level include having an open family forum for discussing problems in the home, an adult family member that serves as a role model and ally, economic stability, shared activities and bonding between siblings, and exposure to multiple positive experiences, such as youth recreational leagues.[198] Risk factors at the peer level include having friends and acquaintances who engage in delinquent behaviors and involvement in gang activity. Protective factors at the peer level are having positive and healthy relationships with peers who are good influences and who are engaging in age-appropriate leisure time activities.[199] Lastly, risk factors at the school and community level involve poor academic performance, having a low commitment to one's education, and living in a high crime and/or low-income neighborhood. Protective factors at the school and community level involve having a safe school and neighborhood environment, living in a community that provides healthy activities for youth to participate in, and attending a school that addresses the academic and emotional needs of its students.[200]

The use of Positive Youth Development gained widespread support due to its scientific reliability. However, programs that tried to implement PYD struggled due to a lack of clarity and guidelines on how to actually use this method.[201] The problem with PYD is that no one knows how to use it properly because there is no "correct" way to use it; it is simply a model to follow. There are no structural guidelines or uniformity amongst its users. Therefore, each program that uses this model could use it in a different way, leading to inaccurate

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[196] *Id.*
[197] *Id.* at 367-68.
[198] *Id.*
[199] *Id.*
[200] *Id.*
[201] *Id.* at 368.

results and outcomes.[202] According to the OJJDP, one of the main problems with PYD programs is the lack of measures of success.[203] The evidence surrounding the impact of PYD programs is small but growing.[204]

i. *UNIFORMLY INCORPORATING THE EIGHT KEY PRACTICES OF PYD THEORY*

A uniform model for PYD programs to follow would eliminate the confusion, thereby creating more successful PYD programs. The U.S. Department of Health & Human Services recommends eight key practices for incorporating PYD theory into youth-serving programs: 1) create space for physical and psychological safety; 2) maintain an appropriate structure; 3) encourage supportive relationships; 4) provide opportunities to belong; 5) model positive social norms; 6) provide opportunities to make a difference; 7) provide opportunities for skill-building; and 8) integrate family, school, and community efforts.[205] These eight practices should be set as the guidelines to implement PYD theory in all youth-serving programs in order to standardize the model and get accurate outcome results.

First, youth-serving programs must provide physical and psychological safety to its participants. They must protect the youth from bullying and confrontation with other youth, and promote confidentiality among information shared by the youth with staff.[206] This means training staff on privacy laws so that the youth can share information and it be managed appropriately. Programs can prevent and stop bullying and conflicts amongst the youth through alternative dispute resolution ("ADR").[207] Second, the structure of the program should provide clear guidelines, expectations, and rules. These should all be age appropriate. For every rule given, an explanation

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[202] *Id.* at 366.

[203] Office of Juvenile Justice and Delinquency Prevention, *Positive Youth Development*, OJJDP.gov, 2, https://www.ojjdp.gov/mpg/litreviews/PositiveYouthDevelopment.pdf (last updated Aug. 2014).

[204] *Id.* at 4.

[205] Office of Population Affairs, *Positive Youth Development*, HHS.gov (last visited June 19, 2020), https://www.hhs.gov/ash/oah/adolescent-development/positive-youth-development/index.html [https://web.archive.org/web/20200616012949if_/https://www.hhs.gov/ash/oah/adolescent-development/positive-youth-development/putting-positive-youth-development-into-action/index.html].

[206] *Id.*

[207] *Id.*

should accompany it so the youth gathers an understanding of why she must obey, and not just blindly follow rules without any real understanding.[208] A sufficient number of adults should always be available to supervise the youth and oversee activities to enforce these rules.[209]

Third, Positive Youth Development requires creating and maintaining positive relationships. The PYD program should foster these relationships with other youth, adults, and mentors. These relationships are built as youth interact with one another through structured and unstructured activities set up by the program, as the program engages the youth in hobbies that give opportunities to meet peers, and as it allows the staff to become trusting and reliable adults in whom the child can confide.[210]

Fourth, a PYD program should be inclusive to youth of all backgrounds, cultures, and skill types to allow the youth to create a positive identity. This means setting up activities that encourage sharing and listening, planning special cultural celebration events, and having staff complete cultural competence training.[211]

Fifth, a PYD program should create positive social norms by encouraging behaviors that promote respect. This can be done by creating "ground rules" before every activity to avoid "free-for-alls," having staff model respectful, acceptable behavior, and encouraging the youth to do the same, and teaching the youth to think critically about the influences on their decisions.[212]

Sixth, a youth should have an opportunity to make a difference in order to gain a sense of autonomy, leadership, and self-worth. This can be done through setting up "jobs" at the program and allowing each youth to take a turn as the leader, creating goals with the youth for education and careers, and referring youth to organizations at which they can volunteer.[213]

Seventh, a PYD program should allow youth to learn physical, intellectual, emotional, and social skills to help them make informed decisions about their health, education, career, and any other aspect of their lives. The program should help the youth establish life goals, and it should celebrate milestones as the youth move toward

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[208] *Id.*
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] *Id.*
[213] *Id.*

achieving that goal. Activities such as role-play can also be implemented to help the youth practice these skills.[214]

Lastly, the PYD program should coordinate and collaborate with the youth's school, parents, and community. This can be done by inviting parents to participate in certain activities with their child either at home or at the facility, and by creating professional development opportunities for the staff to engage with the schools and communities.[215] The U.S. Department of Health and Human Services offers an entire checklist filled with ideas for activities that can be implemented in order to fulfill these eight practices.[216] These eight practices should be standardized as the model for PYD programs in order to create uniformity across the nation and to allow PYD programs to reach their full potential.

IV. Conclusion

Mental health is a crisis amongst the youth in this nation. The juvenile justice system has been reformed numerous times, going from an understanding and rehabilitative model to an accountability and punitive one. This alternation has made juveniles with mental illnesses at risk of being incarcerated due to symptoms that went undetected when they were younger and whose symptoms are now being confused with delinquency. There are a multitude of early intervention programs that have been designed to combat the mental health of juveniles, but they are not being implemented to their full potential. The juvenile justice response to the mental health crisis of juveniles has fallen short due to underfunding, the lack of a clear definition of emotional disturbance, and the lack of standardization of program implementation. However, there is a solution. As discussed above, with a little bit of reallocation of funds, new legislation to clarify the meaning of the statutes governing the juvenile justice system, and the adoption of uniformity among early intervention programs, the U.S. could see a steep downward trend in juvenile violence, arrest rates, and, most importantly, untreated mental illness.

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[214] *Id.*
[215] *Id.*
[216] *Id.*