Children Are Not Inmates

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The United States is in the midst of two troubling and intersecting crises: the youth mental health crisis and the mass incarceration of children. Yet, by categorizing children as inmates, federal law prohibits Medicaid funds from reaching youth in secure detention centers. Medicaid-eligible youth with diagnosable mental illnesses are disproportionately involved in the juvenile legal system and are nearly four times as likely to have a mental health diagnosis compared to the general adolescent population. However, Medicaid, the largest provider of youth mental health care, prevents states from using its funding for youth in secure settings due to the Medicaid Inmate Exclusion Policy (MIEP). As a result, youth in secure detention facilities often receive very little, if any, mental health treatment.

This Article is the first to examine the role of the MIEP within the unique context of the juvenile legal system. While increased access to Medicaid alone will not fix a very broken juvenile legal system, it is an achievable and important step toward providing youth with meaningful treatment, mitigating harm to system-involved youth, and ultimately moving the juvenile legal system toward its rehabilitative goal. This Article examines the interactions between Medicaid, the juvenile legal system, and mental health treatment; explores how reforms and proposed reforms of the MIEP are insufficient; and argues that the categorization of children as inmates is inconsistent with the history and purpose of both the juvenile legal system and Medicaid.

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I. INTRODUCTION

The United States is facing an adolescent mental health crisis.[1] While Americans are just beginning to grasp the full scope of this crisis for all youth and families, some of our country's most vulnerable youth—Medicaid-eligible youth with diagnosable mental illnesses involved in the juvenile legal system—continue to be most impacted.[2] Youth with mental health needs are channeled into the juvenile legal system at alarming rates.[3] At the same time, federal law prohibits funds from Medicaid, the largest mental health treatment provider in the United States, from reaching youth in secure detention centers.[4] The Centers for Medicare and Medicaid Services (CMS), the agency responsible for

[1] *See* U.S. OFF. OF THE SURGEON GEN., PROTECTING YOUTH MENTAL HEALTH (2021), https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf [https://perma.cc/Y49B-WA9X]; *Declaration of a National Emergency in Child and Adolescent Mental Health*, AM. ACAD. OF PEDIATRICS, https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health [https://perma.cc/ES2G-JQF5] (Oct. 19, 2021). During the COVID-19 pandemic, the American Academy of Pediatrics declared that the United States was in the midst of a national emergency "in child and adolescent mental health." *Id.* The declaration called for the government to increase federal funding for mental health treatment as a way to address this crisis. *Id.* How will this crisis impact the juvenile legal system? The number of system-involved youth will likely continue to rise as more vulnerable youth are pushed to the juvenile legal system for "treatment."

[2] *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID AND THE CRIMINAL JUSTICE SYSTEM 2 (2018), https://macpacmedicaid.pdf [https://perma.cc/KZB7-LYFM]. *See generally* Keisha April et al., *Conceptualizing Juvenile Justice Reform: Integrating the Public Health, Social Ecological, and Restorative Justice Models*, CHILD. & YOUTH SERVS. REV., Feb. 22, 2023, Article No. 106887, at 1 ("[T]he juvenile justice system is still permeated with significant challenges, including the overrepresentation of vulnerable youth . . . ."); Keidra McGriff, *The Overrepresentation of Youth with Disabilities in the Juvenile Justice System*, 11 CONTEMP. ISSUES JUV. JUST. 105, 106 (2021) ("The juvenile justice system encompasses youth with behavior attributed to their disability that has been criminalized and thereby labeled as a delinquent.").

[3] OFF. OF JUV. JUST. & DELINQ. PREVENTION, U.S. DEP'T OF JUST., INTERSECTION BETWEEN MENTAL HEALTH AND THE JUVENILE JUSTICE SYSTEM 1 (2017) [hereinafter OJJDP, INTERSECTION], https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/intsection_between_mental_health_and_the_juvenile_justice_system.pdf [https://perma.cc/XC26-Z3VQ] (reporting that "[i]n a nationwide study, the prevalence of diagnosed disorders increased the further that youths were processed in the juvenile justice system" (citing Gail A. Wasserman, Larkin S. McReynolds, Craig S. Schwalbe, Joseph M. Keating & Shane A. Jones, *Psychiatric Disorder, Comorbidity, and Suicidal Behavior in Juvenile Justice Youth*, 37 CRIM. JUST. & BEHAV. 1316 (2010))); Jennifer A. Hoffmann et al., *Association of Youth Suicides and County-Level Mental Health Professional Shortage Areas in the US*, 177 J. AM. MED. ASS'N PEDIATRICS 71, 72 (2022) (noting that the mental health workforce shortage has a greater impact on those living in poverty); *see also infra* Part II.C.

[4] Christopher Scannell, Elaine Michelle Albertson, Neda Ashtari & Elizabeth S. Barnert, *Reducing Medicaid Coverage Gaps for Youth During Reentry*, 28 J. CORR. HEALTH CARE 39, 39 (2022).

implementing laws passed by Congress related to Medicaid,[5] makes no distinction between youth in secure facilities through involvement in the juvenile legal system and adults in the criminal legal system. CMS categorizes securely detained, system-involved youth as "inmates," and therefore, they are denied Medicaid coverage under the Medicaid Inmate Exclusion Policy (MIEP).[6]

Although the number of total youths involved in the juvenile legal system has decreased in the last thirty years,[7] the juvenile legal system continues to disproportionately harm Medicaid-eligible youth of color who have one or more diagnosable mental illnesses.[8] Research has consistently demonstrated that youth involved with the juvenile legal system, especially those placed in secure settings, are not "rehabilitated."[9] As a result of this research and tireless advocacy from dedicated lawyers, activists, and affected youth, the juvenile legal system has shifted significantly over the last twenty years to focus on reducing system involvement and increasing community-based approaches for system-involved youth.[10] In fact, arrests of juveniles fell 68% between 1996 and

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[5] *Federal Policy Guidance*, CTR. FOR MEDICAID & MEDICARE SERVS., https://www.medicaid.gov/federal-policy-guidance#:~:text=The%20Centers%20for%20Medicare%20%26%20Medicaid,and%20the%20Basic%20Health%20Program [https://perma.cc/R6PB-MYUP].

[6] *See* Ohio Dep't of Medicaid v. Price, 864 F.3d 469, 482 (6th Cir. 2017); MEDICAID & CHIP PAYMENT & ACCESS COMM'N, ACCESS IN BRIEF: HEALTH CARE NEEDS AND USE OF SERVICES BY ADOLESCENTS INVOLVED WITH THE JUVENILE JUSTICE SYSTEM 1 (2021) [hereinafter MACPAC, ACCESS], https://www.macpac.gov/wp-content/uploads/2021/08/Access-in-Brief-Health-Care-Needs-and-Use-of-Services-by-Adolescents-Involved-with-the-Juvenile-Justice-System-1.pdf [https://perma.cc/8RBQ-3LNU] ("Medicaid and CHIP cover 60.4 percent of children or youth who had stayed overnight in jail or juvenile detention."); *see also infra* Part II.

[7] *The Facts Report: The Geography of America's Dysfunctional & Racially Disparate Youth Incarceration Complex*, NO KIDS IN PRISON [hereinafter *The Facts Report*], https://www.nokidsinprison.org/the-facts [https://perma.cc/N3A3-VRV8].

[8] When referring to mental illness, this paper is referring to a mental, behavioral, or emotional disorder that meets the diagnostic criteria for a mental disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). *See generally* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STAT. MANUAL OF MENTAL DISORDERS: DSM-5 (5th ed. 2013); Dan J. Stein et al., *What Is a Mental/Psychiatric Disorder? From DSM-IV to DSM-V*, 40 PSYCH. MED. 1759, 1760 (2011) ("[E]ach of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.").

[9] RICHARD MENDEL, SENT'G PROJECT, WHY YOUTH INCARCERATION FAILS: AN UPDATED REVIEW OF THE EVIDENCE 12–19 (2022), https://www.sentencingproject.org/app/uploads/2023/03/Why-Youth-Incarceration-Fails.pdf [https://perma.cc/FT55-2ZLB].

[10] *See OJJDP Priorities*, U.S. OFF. OF JUV. JUST. & DELINQ. PREVENTION, https://ojjdp.ojp.gov/about/ojjdp-priorities [https://perma.cc/9SCE-FVHM].

2016.[11] However, not all youth have benefited equally from this movement. Predictably, our most vulnerable youth remain more likely to face the most punitive measures within the juvenile legal system. As many as 80% of system-involved youth have one or more diagnosable mental illnesses,[12] compared to around 20% of all adolescents in the United States.[13] And, unsurprisingly, youth of color are significantly more likely to be arrested and ultimately incarcerated than their white peers.[14] Despite the overall decrease in system-involved youth since 1996, racial disparities have increased within the juvenile legal system.[15] The juvenile legal system not only fails to provide meaningful mental health treatment to involved youth but also causes significant harm to children and their families.[16] Critically, however, the system does not harm all children and families equally. The juvenile legal system is disproportionally harming Medicaid-eligible youth of color with one or more diagnosable mental illnesses.

Take, as an example, J.T.,[17] an artistic, kind, and thoughtful young person I represented while working as a staff attorney at a Protection & Advocacy (P&A)

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[11] *The Facts Report*, *supra* note 7.

[12] Lee A. Underwood & Aryssa Washington, *Mental Illness and Juvenile Offenders*, INT'L J. ENV'T RSCH. & PUB. HEALTH, Feb. 18, 2016, Article No. 228, at 2–3 ("Estimates reveal that approximately 50 to 75 percent of the 2 million youth encountering the juvenile justice system meet criteria for a mental health disorder. Approximately 40 to 80 percent of incarcerated juveniles have at least one diagnosable mental health disorder." (footnotes omitted)); Sara McDermott, *Calibrating the Eighth Amendment:* Graham*,* Miller*, and the Right to Mental Health Care in Juvenile Prison*, 63 UCLA L. REV. 712, 718 (2016) ("[E]xperts estimate that between 65 and 80 percent of youth in lockup have mental health disorders.").

[13] Rebecca T. Leeb et al., *Support for Transition from Adolescent to Adult Health Care Among Adolescents with and Without Mental, Behavioral, and Developmental Disorders — United States, 2016–2017*, 69 MORBIDITY & MORTALITY WKLY. REP. 1156, 1156 (2020); OJJDP, INTERSECTION, *supra* note 3, at 2–3.

[14] *The Facts Report*, *supra* note 7.

[15] *Id.*

[16] BARRY HOLMAN & JASON ZIEDENBERG, JUST. POL'Y INST., THE DANGERS OF DETENTION: THE IMPACT OF INCARCERATING YOUTH IN DETENTION AND OTHER SECURE FACILITIES 2 (2006), https://justicepolicy.org/wp-content/uploads/2022/02/06-11_rep_dangersofdetention_jj.pdf [https://perma.cc/HCZ4-XKK9] ("A recent literature review of youth corrections shows that detention has a profoundly negative impact on young people's mental and physical well-being, their education, and their employment."); OFF. OF JUV. JUST. & DELINQ. PREVENTION, U.S. DEP'T OF JUST., ALTERNATIVES TO DETENTION AND CONFINEMENT 2 (2014) [hereinafter OJJDP, ALTERNATIVES], https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/alternatives_to_detection_and_confinement.pdf [https://perma.cc/5XTR-Q74W] ("[R]esearch has demonstrated that detention and confinement facilities negatively affect a child's mental state, academic aptitude, and employment prospects.").

[17] J.T., whose name has been changed, was a client of mine when I was working as a staff attorney at a Protection and Advocacy (P&A) office.

office.[18] J.T. was seventeen when he first became involved with the juvenile legal system after getting into a fight with a classmate at school.[19] Like the majority of youth involved with the juvenile legal system, he had a diagnosable mental illness.[20] And, like most system-involved youth, he was Medicaid-eligible. He had been receiving his health care via Medicaid prior to his secure detention. When I first met him, he had been securely detained for two months before his adjudication.[21] He was confined in a facility indistinguishable from an adult prison, away from his friends and his family.[22]

As a result of the Medicaid Inmate Exception Policy (MIEP), health providers could not bill Medicaid for any services provided to J.T. while he was detained.[23] Therefore, J.T.'s only access to mental health treatment was what the state funded in the detention center. J.T. reported that, during the two months he was securely detained, he saw a mental health counselor twice for three- to five-minute "check-ins" each time.[24] Despite his diagnosed mental illness, and

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[18] P&A systems are federally funded agencies within each state and territory charged with protecting the rights of individuals with disabilities through legal advocacy. *About*, NAT'L DISABILITY RTS. NETWORK, https://www.ndrn.org/about [https://perma.cc/6BL9-FF96]. The P&A Systems were created by the Development Disabilities Assistance and Bill of Rights Act of 1975. Through additional legislation, the scope has extended beyond just individuals with developmental disabilities. *Id.* As a whole, the P&A System is the largest provider of legally based advocacy services for individuals with disabilities in the United States. *Id.* (click "About," then choose "NDRN Member Agencies" from the dropdown).

[19] While a full discussion of the role of school resource officers and the criminalization of school-based behavior is beyond the scope of this Article, it is still essential to acknowledge. *See* Kristin Henning, *Criminalizing Normal Adolescent Behavior in Communities of Color: The Role of Prosecutors in Juvenile Justice Reform*, 98 CORNELL L. REV. 383, 430 (2013); Janel George, *Populating the Pipeline: School Policing and the Persistence of the School-to-Prison Pipeline*, 40 NOVA L. REV. 493, 511–12 (2016).

[20] OJJDP, INTERSECTION, *supra* note 3, at 1; Underwood & Washington, *supra* note 12, at 2–3.

[21] Being held in a secure detention center prior to adjudication is not unusual. Christopher Thomas, Kevin T. Wolff & Michael T. Baglivio, *Understanding Juvenile Pre-Adjudicatory Detention and Front-End Juvenile Case Processing: The Moderating Role of Race*, J. CRIM. JUST., Apr. 7, 2022, Article No. 101916, at 1. In 2019, nearly 187,000 juveniles were held in a detention center prior to adjudication. *Id.* The average length of stay in a secure detention facility prior to adjudication is twenty-seven days. *See* HOLMAN & ZIEDENBERG, *supra* note 16, at 2 ("Detained youth . . . can spend anywhere from a few days to a few months in locked custody.").

[22] *See* HOLMAN & ZIEDENBERG, *supra* note 16, at 2 ("At best, detained youth are physically and emotionally separated from the families and communities who are the most invested in their recovery and success. Often, detained youth are housed in overcrowded, understaffed facilities—an environment that conspires to breed neglect and violence.").

[23] Scannell, Albertson, Ashtari & Barnert, *supra* note 4, at 39.

[24] Unfortunately, J.T.'s experience is not uncommon. For example, the U.S. Department of Justice's Civil Rights Division investigated the conditions of confinement at a youth facility in Mississippi and found that the facility was "deliberately indifferent to the

the ongoing traumatic experience of being placed in a secure detention facility with limited access to his community, he received no meaningful mental health treatment or support.

As J.T. prepared to transition back into his community, he wanted to continue seeing the therapist he had just begun seeing prior to his involvement with the juvenile legal system. It had taken him months to get connected to this therapist, whom he really trusted and liked. However, because he had been detained for two months and the provider, whose agency relied on Medicaid funding, had been unable to see him because of the MIEP, the services had been terminated. Unfortunately, his former therapist's agency was at capacity, so J.T. could not reconnect with the professional he trusted. Instead, he had to begin the process of getting connected to mental health services all over again with a completely different agency. This meant attending multiple burdensome intake appointments, each of which required J.T. to overcome barriers related to his school schedule and transportation. An essential component of effective mental health treatment is continuity of care, which means the uninterrupted delivery of mental health services.[25] Every time a patient changes providers, treatment starts over, and new therapeutic relationships must be formed.[26] J.T. received no meaningful treatment while he was detained, and when he was released, he had to start treatment with a new therapist. The idea of starting therapy over with a new person was a significant barrier to J.T.'s ability to access care.

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suicide risks and serious mental health needs of its youth." Letter from Thomas E. Perez, Assistant Att'y Gen., U.S. Dep't. of Just., to Phil Bryant, Governor of Mississippi 2 (Mar. 20, 2012), https://www.justice.gov/sites/default/files/crt/legacy/2012/04/09/walnutgrovefl.pdf [https://perma.cc/Z7N5-7A84]. In their investigation, the DOJ discovered the correctional facility denied youth adequate mental treatment services such as group therapy, one-on-one psychotherapy, or consistent treatment with the same medication that the youth had been on prior to their incarceration. C.R. DIV., U.S. DEP'T OF JUST., INVESTIGATION OF THE WALNUT GROVE YOUTH CORRECTIONAL FACILITY, WALNUT GROVE, MISSISSIPPI 23 (2012), https://www.justice.gov/sites/default/files/crt/legacy/2012/04/09/walnutgrovefl.pdf [https://perma.cc/Z7N5-7A84]. The DOJ further reported that "[i]t must be noted that most of these youth with their untreated or inadequately treated mental health problems are eventually going to be released in worse condition . . . than when they entered [the facility]." *Id.* at 21. Shortly after this investigation, the facility—the same facility that theoretically provided rehabilitation and not punishment—was used as an adult prison. *See Walnut Grove Correctional Facility*, MISS. DEP'T OF CORR., https://www.mdoc.ms.gov/facilities/walnut-grove-correctional-facility [https://perma.cc/9MT7-GPHZ].

[25] *See, e.g.*, Angela Sweeney et al., *Defining Continuity of Care from the Perspectives of Mental Health Service Users and Professionals: An Exploratory, Comparative Study*, 19 HEALTH EXPECTATIONS 973, 974 (2015); Jemimah Ride et al., *Impact of Family Practice Continuity of Care on Unplanned Hospital Use for People with Serious Mental Illness*, 54 HEALTH SERVS. RSCH. 1316, 1317 (2019) (finding that continuity of care results in lower hospitalizations for individuals with mental illnesses).

[26] *See generally* Marc S. Karver, Alessandro S. De Nadai, Maureen Monahan & Stephen R. Shirk, *Meta-Analysis of the Prospective Relation Between Alliance and Outcome in Child and Adolescent Psychotherapy*, 55 PSYCHOTHERAPY 341 (2018) (finding that a strong therapeutic relationship aids in positive outcomes in therapy with youth).

Moreover, as J.T. was preparing to return to his community, he learned that he would not receive credit for the classes he had attended while detained. He was further away from his goal of graduation than he otherwise would have been, and he had just been through a traumatic event.[27] J.T. left the secure detention facility in a worse position than when he entered.[28] He certainly was not "rehabilitated."

Building on the work of scholars across disciplines and advocates calling for the repeal of the MIEP,[29] this Article examines the MIEP in the context of the juvenile legal system, an issue that has received little attention in legal scholarship.[30] Given the disproportionate number of system-involved youth with at least one diagnosable mental illness who are eligible for Medicaid, a juvenile legal system designed to be distinct from a punitive adult system cannot be anything but punitive until, at the very least, all system-involved youth are allowed access to continuous Medicaid coverage.

As advocates continue to fight for children to remain in their communities, it is critical to remember that on any given day, over 35,500 youth in the United States are confined—twenty-five thousand within the juvenile legal system.[31]

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[27] *See generally* SUE BURRELL, NAT'L CHILD TRAUMATIC STRESS NETWORK, TRAUMA AND THE ENVIRONMENT OF CARE IN JUVENILE INSTITUTIONS 2 (2013), https://njjn.org/uploads/digital-library/NCTSN_trauma-and-environment-of-juvenile-care-institutions_Sue-Burrell_September-2013.pdf [https://perma.cc/2EBC-A6U7] ("Removal of a child from the home, even for a brief period, is itself a traumatic event. Loss of liberty, personal identity, and the familiar landscape of daily life is a frightening, disorienting, and life-changing event for a person of any age, but it is especially so for young people.").

[28] School disruption and low high school graduation rates are a widespread consequence of youth incarceration. *See* MENDEL, *supra* note 9, at 15. Only about 33% of youth returning from residential facilities return to school. *Id.*

[29] *See, e.g.*, Kevin Fiscella, Leo Beletsky & Sarah E. Wakeman, *The Inmate Exception and Reform of Correctional Health Care*, 107 AM. J. PUB. HEALTH 384 (2017); Emily Widra, *Why States Should Change Medicaid Rules to Cover People Leaving Prison*, PRISON POL'Y INITIATIVE (Nov. 28, 2022), https://www.prisonpolicy.org/blog/2022/11/28/medicaid [https://perma.cc/DH3F-5DPD]; *Reform Needed for Medicaid Inmate Exclusion Policy*, NAT'L ASS'N OF CNTYS. (Feb. 14, 2020), https://www.naco.org/articles/reform-needed-medicaid-inmate-exclusion-policy [https://perma.cc/L7J3-EGWV]; Tyler Winkelman, Amy Young & Megan Zakerski, *Inmates Are Excluded from Medicaid – Here's Why It Makes Sense to Change That*, UNIV. MICH. INST. FOR HEALTHCARE POL'Y & INNOVATION (Feb. 27, 2017), https://ihpi.umich.edu/news/inmates-are-excluded-medicaid-%E2%80%93-here%E2%80%99s-why-it-makes-sense-change [https://perma.cc/92H3-TUYA].

[30] Mira Edmonds, *The Reincorporation of Prisoners into the Body Politic: Eliminating the Medicaid Inmate Exclusion Policy*, 28 GEO. J. ON POVERTY L. & POL'Y 279, 282 (2021) (self-identifying as "the first in the law review literature to address the MIEP in furtherance of decarceration and reduction of health inequities").

[31] Press Release, Wendy Sawyer & Peter Wagner, Prison Pol'y Initiative, Mass Incarceration: The Whole Pie 2024 (Mar. 14, 2024), https://www.prisonpolicy.org/reports/pie2024.html [https://perma.cc/RR4C-JTA9]; JOSH ROVNER, SENT'G PROJECT, YOUTH JUSTICE

The needs of these youth should not be ignored while system-wide reforms continue. Providing access to Medicaid for detained youth is only a partial solution and won't by itself resolve the problems in a deeply flawed juvenile legal system, but it is a feasible measure that would enable meaningful treatment for young people in secure settings, and it would lower the number of youths who are repeatedly channeled into these harmful secure environments.

Part II of this Article examines how the history, design, and structure of the juvenile legal system result in the disproportionate secure detainment of Medicaid-eligible youth—particularly youth of color—with one or more diagnosable mental illnesses. This Part then analyzes the requirements for mental health treatment within the juvenile legal system and explores what care is actually provided. Part III discusses the interaction between Medicaid, mental health treatment for youth, the juvenile legal system, and the MIEP. Finally, Part IV reviews the recent reforms and proposed reforms related to the MIEP, explains why they are not sufficient, and examines why the categorization of children as inmates is inconsistent with the history and purpose of both the juvenile legal system and Medicaid. This Part then calls for an end to categorizing system-involved youth as inmates, which would allow system-involved youth access to Medicaid, the largest provider of mental health treatment in the United States.

II. BACKGROUND

The total number of system-involved youth has decreased significantly in the last twenty years.[32] However, this push to decrease the size of the juvenile legal system has not benefited all youth equally. In her work, scholar Tamar Birckhead examines the influence of poverty on a needs-based juvenile legal system,[33] illustrating how youth living in poverty are more likely to become involved with the system.[34] Building on her work, this Article contends that the risk of system involvement is even higher for certain kids living in poverty:

BY THE NUMBERS 2 (2024), https://www.sentencingproject.org/app/uploads/2023/05/Youth-Justice-by-the-Numbers.pdf [https://perma.cc/MUC4-J2PF]; Joshua Rovner, *Too Many Locked Doors: The Scope of Youth Confinement Is Vastly Understated*, SENT'G PROJECT (Mar. 15, 2022), https://www.sentencingproject.org/reports/too-many-locked-doors-the-scope-of-youth-confinement-is-vastly-understated [https://perma.cc/X23F-V5HB] (describing how data collection regarding the number of detained youth is determined by a one-day count occurring in October and that at least 80% of incarcerated youth are not included in the one-day count).

[32] ROVNER, *supra* note 31, at 1.

[33] Tamar R. Birckhead, *Delinquent by Reason of Poverty*, 38 WASH. U. J.L. & POL'Y 53, 60 (2012). At many different junctions, decision-makers consider whether a youth needs rehabilitation, which determines the extent of the young person's involvement in the juvenile legal system. *Id.* at 58; *see also infra* Part II.C.

[34] *See generally* Birckhead, *supra* note 33 (describing poverty as a core factor of delinquency).

youth of color with a diagnosable mental illness.[35] These youth are perceived as even more in need of rehabilitation[36] and consequently are at a heightened risk of receiving punitive "rehabilitation" within the juvenile legal system.[37] Alarmingly, even while operating under the purported goal of rehabilitation, this system then denies these youth Medicaid-funded services and provides only minimal—if any—mental health care.[38]

Understanding the history and evolution of the juvenile legal system is essential to understanding why categorizing youth as "inmates" is inappropriate. This Part begins by examining how the very foundation of the juvenile legal system has created a modern apparatus that targets youth of color who live in poverty and have diagnosable mental illnesses.

A. *Disparity by Design*

The current overrepresentation of our most vulnerable young people in the juvenile legal system is rooted in the system's foundational design. Prior to

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[35] While a comprehensive analysis of the intersectionality of race, poverty, and mental illness is beyond the scope of this Article, it is essential to acknowledge. Coined by scholar Kimberle Crenshaw, the term intersectionality identifies the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood by conventional thinking. Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 149. The effects of the intersectionality between race, poverty, and mental illness are apparent within the juvenile legal system. *See infra* Part II.C; *Race and Juvenile Justice*, NAT'L ASS'N OF CRIM. DEF. LAWS. (Nov. 29, 2022), https://www.nacdl.org/Content/Race-and-Juvenile-Justice [https://perma.cc/7E4J-ZPYB] (reporting that, while overall juvenile placements decreased by 54% between 2001 and 2015, "[t]he racial disparity between Black and white youth in custody increased by 22%").

[36] See *infra* Part II.C for a discussion of juveniles within the legal system deemed "in need of rehabilitation."

[37] A national study of almost ten thousand system-involved youth conducted in 2010 demonstrates this disparity. *See generally* Gail A. Wasserman, Larkin S. McReynolds, Craig S. Schwalbe, Joseph M. Keating & Shane A. Jones, *Psychiatric Disorder, Comorbidity, and Suicidal Behavior in Juvenile Justice Youth*, 37 CRIM. JUST. & BEHAV. 1361 (2010). Researchers from Columbia University separated youth by their final "stage" in the juvenile legal system, categorizing the youth into one of three stages: (1) intake, (2) pre-adjudication secure detention, and (3) post-adjudication secure placement. *Id.* at 1365. Researchers found 35.1% of youth had a diagnosable mental health disorder at intake, compared to 58.9% in secure pre-adjudication settings and 63.7% in secure post-adjudication settings. *Id.* at 1366. "Rates of disorder and suicidality are greatly increased in detention and corrections settings relative to system intake settings; rates are also elevated for those in intake settings relative to their community counterparts, especially considering the restricted age and gender distribution of justice youth." *Id.* at 1373; *see also* OJJDP, INTERSECTION, *supra* note 3, at 11 (explaining that the Wasserman study demonstrates "the prevalence of diagnosed disorders increased the further that youths were processed in the juvenile justice system").

[38] 42 U.S.C. § 1396(d)(32)(A); *see infra* Part II.D.3.

1825, youth determined to be delinquent were treated the same as adults.[39] However, beginning in the early 1800s, led by advocates from the Society for the Prevention of Pauperism,[40] courts began to think differently about their role regarding juvenile offenders. Courts embraced the concept of *parens patriae*, which provides that the state has the authority to act as a guardian for children determined to be in need.[41]

The legislature authorized courts throughout New York to commit juveniles to a juvenile reformatory for poor or delinquent youth instead of committing them to adult prisons.[42] Thus began a movement. Between 1825 and the 1840s, approximately twenty-five additional youth reform schools were opened.[43] These reform schools were created both as an alternative to adult prisons and jails and as a response to poor children, to "save them" from their "deficient" parents.[44] Consequently, the present-day disproportionate representation in the juvenile legal system of youth from families living in poverty traces back to the system's very design.[45] As journalist Nell Bernstein writes, these newly created reformatories, despite their supposed benevolence, "came to function as a mechanism for gaining control over the children of the poor, depriving them of their liberty in the name of their own best interest while skirting the burdensome requirements of due process."[46]

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[39] Julian W. Mack, *The Juvenile Court*, 23 HARV. L. REV. 104, 106–07 (1909). Youth, just like adults, were "arrested [and] put into prison . . . with the aim of ascertaining whether [they] had done the specific act . . . . [The criminal system] put but one question: 'Has he committed this crime?' It did not inquire 'What is the best thing to do for this lad?'" *Id.*

[40] HOWARD N. SNYDER & MELISSA SICKMUND, U.S. DEP'T OF JUST., JUVENILE OFFENDERS AND VICTIMS: 1999 NATIONAL REPORT 96 (1999); *see* N.Y. STATE ARCHIVES, THE GREATEST REFORM SCHOOL IN THE WORLD: A GUIDE TO THE RECORDS OF THE NEW YORK HOUSE OF REFUGE 4 (1989), https://www.archives.nysed.gov/sites/archives/files/res topics_ed_reform.pdf [https://perma.cc/86QL-H8D8]; *The New-York House of Refuge for Juvenile Delinquents*, N.Y. TIMES (Jan. 23, 1860), https://www.nytimes.com/1860/01/23/ archives/our-city-charities-the-newyork-house-of-refuge-for-juvenile.html [https://perma.cc/ KE48-Y9P6].

[41] See Lexi Zerrillo, *Who's Your Sovereign?: The Standing Doctrine of* Parens Patriae *& State Lawsuits Defending Sanctuary Policies*, 27 WM. & MARY BILL RTS. J. 573, 575–76 (2018). *Parens patriae* is Latin for "parent of the country." *Id.* Under the *parens patriae* doctrine, dependents in need of special protection are under the control of the state. *Id.*

[42] N.Y. STATE ARCHIVES, *supra* note 40, at 4.

[43] *Juvenile Justice History*, CTR. ON JUV. & CRIM. JUST., https://www.cjcj.org/history-education/juvenile-justice-history [https://perma.cc/F4TC-XS9K].

[44] Esther K. Hong, *A Reexamination of the* Parens Patriae *Power*, 88 TENN. L. REV. 277, 283–88 (2021); *see* Birckhead, *supra* note 33, at 67–68.

[45] Birckhead, *supra* note 33, at 61–66. *See generally* JANE M. SPINAK, THE END OF FAMILY COURT: HOW ABOLISHING THE COURT BRINGS JUSTICE TO CHILDREN AND FAMILIES (Nancy E. Dowd ed., 2023).

[46] NELL BERNSTEIN, BURNING DOWN THE HOUSE: THE END OF JUVENILE PRISON 39 (2014).

These reform schools led to the establishment of the formal juvenile legal system in the United States. In 1899, Cook County, Illinois, became the first jurisdiction to establish a separate court process for juveniles.[47] Established by the Illinois Juvenile Court Act of 1899, this new and separate court was created not just for delinquent children but also for children determined to be abused or neglected.[48] At that time, the juvenile legal system was so far removed from the punitive criminal legal system that all youth "in need of care" were treated the same, whether the reason for the "need" was neglect, delinquency, or something else.[49] There was little distinction in how these three categories of children were treated. The stated goal of this new juvenile court was to provide rehabilitation and serve as *parens patriae* for all involved youth.[50] Unlike the adult criminal system, the driving question determining a youth's disposition was not the

[47] Birckhead, *supra* note 33, at 63.

[48] Illinois Juvenile Court Act of 1899, ILL. LAWS 131, *repealed by* Juvenile Court Act of 1987, 705 ILL. COMP. STAT. 405.

[49] Hong, *supra* note 44, at 297–301. Two early cases heard by the Supreme Court of Pennsylvania established what *parens patriae* meant within the context of the juvenile legal system in the United States. *Ex parte* Crouse, 4 Whart. 9 (Pa. 1839); Commonwealth v. Fisher, 62 A. 198 (Pa. 1905). In the first of these two cases, a mother filed a complaint based on her daughter Mary Ann's unmanageable behavior and asked a justice of the peace to send her to the House of Refuge. *Ex parte Crouse*, 4 Whart. at 9–10. Mary Ann's father disagreed and argued, through counsel, that Mary Ann's confinement to a House of Refuge was a violation of common law as well as the Sixth and Ninth Amendments. *Id.* at 10–11. In its 1839 opinion, the Supreme Court of Pennsylvania in *Ex parte Crouse* extended the financially-focused English common law understanding of *parens patriae* by asking "may not the natural parents, when unequal to the task of education, or unworthy of it, be superseded by the *parens patriæ*, or common guardian of the community?" *Id.* at 11. It is also noteworthy that the court distinguished a juvenile placement from an adult prison or jail placement by recognizing that "[t]he House of Refuge is not a prison, but a school." *Id.* In 1905, the Supreme Court of Pennsylvania then decided *Commonwealth v. Fisher*, which extended the idea of *parens patriae* the court previously established in *Ex parte Crouse*. *Fisher*, 62 A. at 200. Unlike Mary Ann, Frank, the child at the center of *Fisher*, had been involved in a crime. *Id.* at 198. Frank had also been sent to a House of Refuge. *Id.* Through counsel, Frank challenged the constitutionality of the Pennsylvania law defining the powers of the courts—including the juvenile legal system—by arguing that he was denied due process of law and his right to a trial by jury, and he also argued that the act punished individuals differently for the same offense solely based on age. *Id.* The court held that there were no constitutional violations because the state has the power to "save a child from becoming a criminal" even "without any process at all, for the purpose of . . . the state's guardianship and protection." *Id.* at 200. The court further affirmed the distinction between a juvenile facility and an adult prison or jail, even when a criminal charge was the basis for placement in the facility. "The objection that [the act creates] 'different punishments for the same offense by a classification of individuals,' overlooks the fact . . . that it is not for the punishment of offenders but for the salvation of children . . . ." *Id.* at 199.

[50] NAT'L RSCH. COUNCIL & INST. OF MED., JUVENILE CRIME, JUVENILE JUSTICE 154 (Joan McCord et al. eds., 2001).

severity of any alleged criminal activity, but what the juvenile needed to be "guided toward good citizenship."[51]

Other states quickly followed suit. By 1925, all but two states had established separate juvenile courts or probation services, or both.[52] The courts embraced their *parens patriae* role; the perceived need for the court's "benevolent intervention" was central to the outcomes for involved youth.[53] *Parens patriae* was used to provide youth in need with "care, custody and discipline" that would "approximate as nearly as may be that which should be given by its parents."[54] What resulted was a system intended to "save" poor children: "[O]nly lower-class families were evaluated as to their competence, whereas the propriety of middle-class families was exempt from investigation and recrimination."[55]

B. *Evolution of* Parens Patriae

Even as the juvenile legal system progressed through four eras—the Progressive Era, the Due Process Era, the "Get Tough" Era, and the present-day Developmental Era[56]—the goal of rehabilitation has remained at its core. And, just as in 1899, poor children remain overrepresented.[57] States have used the doctrine of *parens patriae* to disproportionately involve poor youth—particularly youth of color with mental illnesses—in the juvenile legal system.[58]

In the Progressive Era of the late nineteenth and early twentieth centuries, states continued to rely on *parens patriae* power to "save" children in the

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[51] ARTHUR E. MOORE, JOHNNY "DELINQUENT": A STUDY OF UNDERPRIVILEGED YOUTH, at iii, 39 (1958).

[52] SHAY BILCHIK, U.S. DEP'T OF JUST., 1999 NATIONAL REPORT SERIES: JUVENILE JUSTICE BULLETIN 2 (1999), https://www.ojp.gov/pdffiles1/ojjdp/178995.pdf [https://perma.cc/M67P-R4NX].

[53] *Id.* ("A key element [of the doctrine] was the focus on the welfare of the child. Thus, the delinquent child was also seen as in need of the court's benevolent intervention.").

[54] Illinois Juvenile Court Act of 1899, ILL. LAWS 131, 137, *repealed by* Juvenile Court Act of 1987, 705 ILL. COMP. STAT. 405.

[55] ANTHONY M. PLATT, THE CHILD SAVERS: THE INVENTION OF DELINQUENCY 135 (1969).

[56] Hong, *supra* note 44, at 279 n.6. ("Scholars generally agree that there are four eras of juvenile law. While the characteristics of the eras may overlap and the exact years for each era are not always agreed upon, there is widespread consensus on the defining features of each era."); *see also* Elizabeth S. Scott, *Criminal Responsibility in Adolescence: Lessons from Developmental Psychology*, *in* YOUTH ON TRIAL: A DEVELOPMENTAL PERSPECTIVE ON JUVENILE JUSTICE 291, 291 (Thomas Grisso & Robert G. Schwartz eds., 2000); David S. Tanenhaus, *The Elusive Juvenile Court: Its Origins, Practices, and Re-Inventions*, *in* THE OXFORD HANDBOOK OF JUVENILE CRIME AND JUVENILE JUSTICE 419, 419–20 (Barry C. Feld & Donna M. Bishop eds., 2012) (discussing the three eras prior to the Developmental Era).

[57] *See infra* Part II.C.

[58] *See infra* Part II.C.

juvenile legal system.[59] By the early 1900s, states had established for themselves far-reaching power to remove children from their families—without any process—because they were not *punishing* the children; they were *saving* them. Under the *parens patriae* doctrine, the state is tasked not with punishing children but with acting as surrogate parents in the "child's best interests with the primary goal of rehabilitation."[60]

During this time, courts throughout the United States were upholding this far-reaching application of *parens patriae* power.[61] This began to shift in the 1960s, during the Due Process and "Get Tough" Eras of the juvenile legal system. The idea that *parens patriae* made due process unnecessary was challenged because, instead of being provided with parent-like care, youth were facing court intervention. In the landmark 1967 case *In re Gault*, the Supreme Court held that while there are reasons to treat juveniles and adults differently, juveniles facing an adjudication of delinquency are, just like adults in the criminal legal system, entitled to Fourteenth Amendment due process protections, including the right to counsel.[62] Even as the Supreme Court recognized the limitations of *parens patriae* power in the juvenile legal system,[63] it held on to this power as a rationale for providing juveniles with

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[59] *In re* Gault, 387 U.S. 1, 16–17 (1967) ("The Latin phrase [*parens patriae*] proved to be a great help to those who sought to rationalize the exclusion of juveniles from the constitutional scheme; but its *meaning is murky* and its *historical credentials are of dubious relevance*. . . Accordingly, the highest motives and most enlightened impulses led to a peculiar system for juveniles, unknown to our law in any comparable context." (emphasis added)).

[60] Hong, *supra* note 44, at 287.

[61] *See, e.g.*, Wis. Indus. Sch. for Girls v. Clark County, 79 N.W. 422, 428 (Wis. 1899); *In re* Ferrier, 103 Ill. 367, 372 (1882); County of McLean v. Humphreys, 104 Ill. 378, 383 (1882); Roth v. House of Refuge, 31 Md. 329, 335 (1869); *Ex parte* Crouse, 4 Whart. 9, 11 (Pa. 1839).

[62] *In re Gault*, 387 U.S. 1. This idea of the "worst of both worlds" is illustrated in the facts underlying the Supreme Court's 1967 groundbreaking decision in *In re Gault*. There, a fifteen-year-old, Gerald Francis Gault, was accused of making obscene phone calls. *Id.* at 4. He was on probation and was taken into custody. *Id.* His parents were not home and were not notified of his arrest. *Id.* at 5. He was committed to the state industrial school for six years, until he was twenty-one years old. *Id.* at 7. The "school" was so much like a prison that in 1974, after becoming part of Arizona's Department of Corrections in 1968, it became an adult correctional facility. *See Agency History*, ARIZ. DEP'T OF JUV. CORR., https://adjc.az.gov/about-adjc/agency-history [https://perma.cc/Y563-LHD9]. The sentence for an adult convicted of making obscene phone calls would have been, at most, $50 and two months in jail. *In re* Gault, 387 U.S. at 8–9.

[63] Eduardo R. Ferrer, *Razing & Rebuilding Delinquency Courts: Demolishing the Flawed Philosophical Foundation of* Parens Patriae, 54 LOY. U. CHI. L.J. 885, 918–19 (2023) ("The Court sought to domesticate [*parens patriae*], not dismantle it.").

"fewer constitutional rights than adults."[64] The state's power, and therefore its responsibility to act *in loco parentis*, remained.

By the 1980s, momentum was building around the idea that juvenile crime was increasing and juvenile courts were too lenient.[65] Many remember the destructive narrative of the "superpredator" that began in 1995 and became widely used to invoke fear and increase punitive measures for juveniles.[66]

Responding to this perceived increase in violent crime, states began to add punitive language to legislation.[67] This punitive language moved the juvenile legal system even further away from an exclusive focus on rehabilitation. As juvenile legal systems expanded to include more punitive measures, states reconceived the system's purpose as more of an exercise of police power than *parens patriae*.[68] Still, the ideal of *parens patriae* and a distinction between the adult and juvenile legal systems remained. In 1984, the Supreme Court clarified this distinction: "[T]he juvenile's liberty interest may . . . be subordinated to the

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[64] Hong, *supra* note 44 at 289–90; *In re* Gault, 387 U.S. at 30–31 (citation omitted) ("'We do not mean . . . to indicate that the hearing to be held must conform with all of the requirements of a criminal trial or even of the usual administrative hearing; but we do hold that the hearing must measure up to the essentials of due process and fair treatment.' We reiterate this view . . . .").

[65] *See* Vincent Schiraldi, *Drop in Youth Crime Punctures 'Myth' About Failed Reforms*, CRIME REP., https://thecrimereport.org/2022/08/19/drop-in-youth-crime-punctures-myth-about-failed-reforms [https://perma.cc/CDP2-537L] (discussing how the increase in fear and the resulting increase in punitive measures were actually inconsistent with the data; even though youth crime was decreasing, exaggerated and selective media coverage led to the false—and destructive—public opinion of rising youth crime); Kristin Henning, *What's Wrong with Victims' Rights in Juvenile Court?: Retributive Versus Rehabilitative Systems of Justice*, 97 CALIF. L. REV. 1107, 1113 (2009).

[66] CAMPAIGN FOR THE FAIR SENT'G OF YOUTH, THE ORIGINS OF THE SUPERPREDATOR: THE CHILD STUDY MOVEMENT TO TODAY (2021), https://cfsy.org/wp-content/uploads/Superpredator-Origins-CFSY.pdf [https://perma.cc/2V8D-NKXZ]. Five years after the publication of his article coining the term, John Dilulio renounced the idea of the superpredator. *Id.* But, by then, it was too late: the move toward a more punitive juvenile legal system was already well under way. *Id.*

[67] For example, Texas includes the following language—originally added in 1973 and subsequently amended—in the "Purpose and Interpretation" section of its Juvenile Justice Code:

> (2) consistent with the protection of the public and public safety; (A) to promote the concept of punishment for criminal acts; (B) to remove, where appropriate, the taint of criminality from children committing unlawful acts; and (C) to provide treatment, training, and rehabilitation that emphasizes the accountability and responsibility of both the parent and the child for the child's conduct.

TEX. FAM. CODE ANN. § 51.01 (West 2023); *see also* Henning, *supra* note 65, at 113–14.

[68] Henning, *supra* note 65, at 113–14. During the 1990s, forty-seven state legislatures voted to make their juvenile statutes more punitive. BILCHIK, *supra* note 52, at 5. The federal government followed suit with the 2002 Reauthorization of the Juvenile and Delinquency Prevention Act of 1974, adding language discussing youth accountability. Juvenile Justice and Delinquency Prevention Act of 2002, Pub. L. No. 107-273, 116 Stat. 1869, 1871.

State's 'parens patriae interest in preserving and promoting the welfare of the child.'"[69]

Beginning in 2005, a series of Supreme Court decisions known as the *Miller* trilogy[70] focused on emerging research about the differences between adolescents and adults.[71] Noticeably absent from the *Miller* trilogy is the doctrine of *parens patriae*. As a result, recent scholarship has examined what, if any, role the doctrine plays in the modern juvenile legal system during what has become known as the Developmental Era.[72] Influenced by the work of Professor Esther Hong, this Article argues that the philosophy of the modern juvenile legal system continues to rely on *parens patriae* by applying this developmental framework to the *parens patriae* doctrine.[73] As of 2021, thirty-eight states include express *parens patriae* language when describing the purpose of the juvenile legal system.[74]

Throughout the evolution of the juvenile legal system, even when that system became more punitive, states have continued to rely on the doctrine of *parens patriae* and distinguish this system from the adult criminal system. Children are different and should be treated differently. Children should not be categorized as inmates.

C. Parens Patriae *in Action: Deciding Who Needs Rehabilitation*

Beyond the courts, the philosophy of *parens patriae* is entrenched in each stage of the juvenile legal system, with various decision-makers, including police officers and prosecutors, determining what an individual child "needs."[75] This Subpart discusses how each stage of the system plays out and demonstrates how the application of *parens patriae* in the juvenile legal system results in the disparate punishment of Medicaid-eligible youth of color with diagnosable mental illnesses.[76] Today, more than one hundred years after the juvenile legal system's founding, marginalized children remain the target of the system and are denied access to meaningful treatment or rehabilitation.

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[69] Schall v. Martin, 467 U.S. 253, 265 (1984) (quoting Santosky v. Kramer, 455 U.S. 745, 765 (1982)).

[70] The *Miller* trilogy includes *Roper v. Simmons*, 543 U.S. 551 (2005), *Graham v. Florida*, 560 U.S. 48 (2010), and *Miller v. Alabama*, 567 U.S. 460 (2012).

[71] Cara H. Drinan, *The* Miller *Trilogy and the Persistence of Extreme Juvenile Sentences*, 58 AM. CRIM. L. REV. 1659, 1661–62, 1666 (2021).

[72] *See, e.g.*, Hong, *supra* note 44, at 281–82; Ferrer, *supra* note 63, at 891.

[73] Hong, *supra* note 44 at 308.

[74] *Id.* at 298–301 (examining the role of *parens patriae* in purpose clauses and identifying that while only eight states identify *parens patriae* as the primary purpose of their juvenile legal systems, thirty additional states include "express *parens patriae* language").

[75] *See id.* at 285.

[76] *See generally* Henning, *supra* note 19 (reporting that decision makers, such as police, probation officers, and prosecutors, treat youth of color more harshly than white youth in part because of an implicit bias to ignore developmental immaturity in youth of color).

1. *Arrest and Referral to the Juvenile Legal System*

For most youth, involvement with the juvenile legal system begins with police contact.[77] If this contact results in an arrest, law enforcement officers have discretion to give a warning and release the youth, refer the matter to the juvenile legal system, or divert the case out of the system.[78] The disparities within the system begin here, as police officers—using their discretion—refer fewer than half of all juvenile arrests to the juvenile court.[79] This discretion does not benefit all children equally. Black and Brown youth in neighborhoods and schools with higher levels of poverty and a higher police presence are significantly more likely to be referred to the juvenile legal system.[80]

Overall, youth from racial and ethnic minority groups are "more likely to be arrested, detained, and ordered to residential placement than White youth."[81]Additionally, while research has consistently demonstrated that minor acts of adolescent "delinquency" are developmentally appropriate and to be expected, Black and Brown youth are more likely than their white peers to end up involved with the juvenile legal system.[82] This is especially true for youth with mental illnesses in schools; instead of getting treatment or working with a provider to develop a behavior plan, youth are often sent to school resource

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[77] *Statistical Briefing Book*, OFF. OF JUV. JUST. & DELINQ. PREVENTION (May 14, 2021), https://www.ojjdp.gov/ojstatbb/structure_process/case.html [https://perma.cc/NMC5-RDX2]. In addition, youth can be referred to the juvenile legal system by parents, victims, schools, or other individuals, including probation officers. Henning, *supra* note 19, at 420.

[78] CHARLES PUZZANCHERA, SARAH HOCKENBERRY & MELISSA SICKMUND, NAT'L CTR. FOR JUV. JUST., YOUTH AND THE JUVENILE JUSTICE SYSTEM: 2022 NATIONAL REPORT 105 (2022), https://www.ncjfcj.org/wp-content/uploads/2023/01/2022-national-report.pdf [https://perma.cc/2FXY-GSJL] ("Once a juvenile is apprehended for a law violation, it is the police officer who first determines if the juvenile will move deeper into the justice system or will be diverted."); OFF. OF JUV. JUST. & DELINQ. PREVENTION, U.S. DEP'T OF JUST., INTERACTIONS BETWEEN YOUTH AND LAW ENFORCEMENT 7 (2018) [hereinafter OJJDP, INTERACTIONS], https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/interactions_between_youth_and_law_enforcement.pdf [https://perma.cc/TF2E-3KY9].

[79] PUZZANCHERA, HOCKENBERRY & SICKMUND, *supra* note 78, at 134.

[80] George, *supra* note 19, at 511 ("These interactions between students of color and school police result in early youth involvement with the justice system. Students who are under increased surveillance and scrutiny by school police are more likely to be referred to or become involved with the juvenile justice system." (footnotes omitted)); PUZZANCHERA, HOCKENBERRY & SICKMUND, *supra* note 78, at 164–65.

[81] PUZZANCHERA, HOCKENBERRY & SICKMUND, *supra* note 78, at 163; *see* Mark Keierleber, *'The Students Were the Danger': In Racially Diverse Schools, Police Were More Likely to View Students as Threats, Study Shows*, THE 74 (June 16, 2020), https://www.the74million.org/the-students-were-the-danger-in-racially-diverse-schools-police-were-more-likely-to-view-students-as-threats-study-shows [https://perma.cc/5HAK-4F5C].

[82] *See* Henning, *supra* note 19, at 385–87.

offices when they demonstrate "problematic" behaviors.[83] Unsurprisingly, schools with school resource officers report more arrests overall, particularly for Black students with disabilities.[84]

Both school resource officers and patrol officers reported that a "youth's demeanor or 'contriteness' was the most crucial factor in police decisions to arrest."[85] A youth with an "attitude" that police perceive as disrespectful is four times more likely to be arrested.[86] Beyond the implicit racial bias that influences police officers as they make these decisions, ableism also impacts these decisions; the symptoms of many mental illnesses, including anxiety, depression, and ADHD, may be interpreted as "disrespect."[87]

2. *Petition and Secure Detention Preadjudication*

After a case is referred to the juvenile legal system, prosecutors determine whether to formally submit a document to the court, known as filing a petition, alleging that the youth has committed a delinquent act or a status offense.[88] During this decision-making process, prosecutors and other decision makers consider psychosocial factors beyond the legal elements of the crime at hand. At this stage, probation officers review information about the youth's "family,

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[83] Lucy Sorensen & Montserrat Avila-Acosta, *Navigating the Tradeoffs of Police in Schools*, BROOKINGS (Sept. 7, 2023), https://www.brookings.edu/articles/navigating-the-tradeoffs-of-police-in-schools [https://perma.cc/MKE4-KP3T] (stating that the arrest rate for youth with disabilities at schools with SROs is three times higher than for youth without).

[84] *See id.*

[85] OJJDP, INTERACTIONS, *supra* note 78, at 99; Robert A. Brown, Kenneth J. Novak & James Frank, *Identifying Variation in Police Officer Behavior Between Juveniles and Adults*, 37 J. CRIM. JUST. 200, 201 (2009).

[86] OJJDP, INTERACTIONS, *supra* note 78, at 99.

[87] Jared C. Pistoia, *Clearing the Air on ADHD and 'Disrespectful Behavior*,*'* PSYCHCENTRAL (May 27, 2022), https://psychcentral.com/adhd/adhd-and-disrespectful-behavior [https://perma.cc/3GHX-ENNW]; Caroline Miller, *Depression and Anger*, CHILD MIND INST., https://childmind.org/article/depression-and-anger [https://perma.cc/XYU8-9UPK] (Feb. 7, 2025); Amy C. Watson & Beth Angell, *The Role of Stigma and Uncertainty in Moderating the Effect of Procedural Justice on Cooperation and Resistance in Police Encounters with Persons with Mental Illnesses*, 19 PSYCH., PUB. POL'Y & L. 30, 31–32, 37 (2013); Caroline Miller, *How Anxiety Leads to Problem Behavior*, CHILD MIND INST. (Oct. 4, 2024), https://childmind.org/article/how-anxiety-leads-to-disruptive-behavior [https://perma.cc/AFY2-F89M] (illustrating that when a child feels anxious, they may try to avoid an interaction or enter into a "fight" mode and react to an interaction with police with aggression).

[88] *See generally* OFF. OF JUV. JUST. & DELINQ. PREVENTION, U.S. DEP'T OF JUST., LITERATURE REVIEW: STATUS OFFENDERS (2015) [hereinafter OJJDP, STATUS OFFENDERS], https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/status_offenders.pdf [https://perma.cc/TP6E-J9FN]; *Statistical Briefing Book*, *supra* note 77. If the decision is made to file a petition, prosecutors decide what type of petition to file: a petition to the delinquency (juvenile) court or a waiver petition requesting that the case be transferred to the adult criminal court. *Id.*

neighborhood, school, and academic performance."[89] In coordination with probation officers and other decision-makers, prosecutors—who are undoubtedly influenced by their own biases—have perhaps the biggest impact on a youth's experience in the juvenile legal system because they decide whether to file a petition, dismiss the case, or offer diversion.[90]

In addition, many states require decision-makers at this point to determine whether the juvenile requires or would benefit from the "support" of the juvenile legal system by filing a petition.[91] In New York, for example, a petition requires both reasonable cause to believe a crime has been committed and a "statement that the respondent requires supervision, treatment, or confinement."[92] As Tamar Birckhead writes, "In these systems, there are two explicit tracks: one for middle- and upper-class families who are able to secure private services for their children . . . , and the other for low-income . . . families . . . ."[93] But not all low-income families are treated equally here; those perceived as unable to provide

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[89] Henning, *supra* note 19, at 430.

[90] *See* Angela J. Davis, *Prosecution and Race: The Power and Privilege of Discretion*, 67 FORDHAM L. REV. 13, 35 (1998) (noting that prosecutors may unconsciously view a case involving a white victim as more serious than a case involving a black victim in making charging decisions).

[91] *See, e.g.*, N.Y. FAM. CT. ACT § 311.1 (McKinney 2024); ALASKA RULES OF CT.: CHILD IN NEED OF AID RULES OF PROC. 7(a), https://courts.alaska.gov/rules/docs/cina.pdf [https://perma.cc/WQV5-G5U3] ("The petition must be verified and must contain a statement of facts that would support a finding that the child is a child in need of aid . . . ."); ALA. R. JUV. P. 12(C)(2) ("Deliver a petition . . . if the juvenile court intake officer finds that the best interest of the child . . . requires judicial action."); COLO. REV. STAT. ANN. § 19-2.5-502(1) (West 2024) ("If the district attorney determines that the interests of the juvenile . . . require that further action be taken, the district attorney may file a petition in delinquency . . . ."); CONN. GEN. STAT. ANN. § 46b-128(a) (West 2024) ("[The Superior Court] shall make a preliminary investigation to determine whether . . . the interests of the public or the child require that further action be taken."); D.C. CODE ANN. § 16-2305(a), (d) (West 2024) ("[T]he Director of Social Services . . . shall conduct a preliminary inquiry to determine whether the best interests of the child or the public require that a petition be filed. . . . If delinquency . . . is alleged, a statement shall be included in the petition that the child appears to be in need of care or rehabilitation."); GA. CODE ANN. § 15-11-522(1) (West 2024) ("A petition alleging delinquency shall . . . [include] a statement that it is in the best interests of such child . . . [to] be brought and that such child is in need of supervision, treatment, or rehabilitation . . . ."); HAW. REV. STAT. § 571-21(d) (West 2024) ("[T]he petition . . . shall be suitably entitled so as to indicate that the proceeding is in the interest of rather than against the child or minor involved."); IND. CODE ANN. § 31-37-10-2(2)(B) (West 2024) ("[T]he juvenile court shall . . . . [a]pprove the filing of a petition if there is probable cause to believe that . . . it is in the best interests of the child or the public that the petition be filed."); KY. REV. STAT. § 610.030(5) (West 2024) ("The preliminary intake inquiry shall include the administration of an evidence-based screening tool and, if appropriate and available, a validated risk and needs assessment, in order to identify whether the child and his or her family are in need of services and the level of intervention needed.").

[92] N.Y. FAM. CT. ACT § 311.1(j) (McKinney 2024).

[93] Birckhead, *supra* note 33, at 82–83.

treatment for mental illness are more often identified as requiring "support" from the juvenile legal system.[94]

Prior to adjudication, youth can be held in a secure detention facility. Depending on the jurisdiction, various decision-makers decide if youth should be held pending a probable cause hearing.[95] At the hearing, a judge will decide if the youth should return to their community or remain securely detained.[96] Here, too, system actors are often required to consider the "needs" of the youth.[97] In Indiana, for example, a juvenile may be securely detained prior to adjudication if "the return of the child to the child's home is or would be: (A) contrary to the best interests and welfare of the child; and (B) harmful to the safety or health of the child."[98]

Additionally, many jurisdictions employ risk assessments at this stage that often classify minority youth, youth living in poverty, and youth with diagnosable mental illnesses as "higher risk."[99] A "high risk" designation can be the sole basis for placing a juvenile in secure detention.[100]

3. *Adjudication and Disposition*

At the adjudication hearing, a judge determines if a youth is "involved" or "not involved," the juvenile equivalents of "guilty" and "not guilty" in the adult legal system.[101] Juveniles have no constitutional right to a jury trial, so most

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[94] *See* Leen Cappon & Freya Vander Laenen, *Mental Health in Juvenile Judges' Decision-Making: Review of Literature*, 36 INT'L J.L. & PSYCHIATRY 65, 69 (2013).

[95] *Statistical Briefing Book*, *supra* note 77.

[96] *Id.*

[97] *See, e.g.*, MD. CODE ANN., CTS. & JUD. PROC. § 3-8A-15(b)(1)(i) (West 2024) (stating that a young person can be securely detained prior to adjudication if "[s]uch action is required to protect the child or others"); ARK. CODE ANN. § 9-27-326(d) (West 2024) ("Assess the following factors in determining whether to release the juvenile prior to further hearings in the case: . . . (B) Family Relationships; (C) References; . . . (G) The juvenile's character and reputation."); IND. CODE § 31-37-6-6(b) (West 2024) ("[T]he court may order the child detained if . . . return of the child to the child's home is or would be: (A) contrary to the best interests and welfare of the child; and (B) harmful to the safety or health of the child."); OR. REV. STAT. ANN. § 419C.145(2) (West 2024) ("A youth detained under subsection (1) of this section must be released . . . unless the court or its authorized representative make written findings that . . . describe why it is in the best interests of the youth to be placed in detention.").

[98] IND. CODE § 31-37-6-6(b) (2024).

[99] Li Lian Koh, Andrew Day, Bianca Klettke, Michael Daffern, & Chi Meng Chu, *The Predictive Validity of Youth Violence Risk Assessment Tools: A Systematic Review*, 26 PSYCH., CRIME & L. 776, 781 (2020).

[100] *Id.*; *see, e.g.*, KAN. STAT. ANN. § 38-2331(a) (West 2024) ("The court shall not enter an order removing a juvenile from the custody of a parent . . . unless the court first finds that a detention risk assessment conducted pursuant to K.S.A. 75-7023(d) . . . has assessed the juvenile as detention-eligible.").

[101] *See, e.g.*, *Statistical Briefing Book*, *supra* note 77.

trials in the juvenile legal system are bench trials.[102] Here, too, there is significant bias. While judges largely consider themselves racially unbiased, research suggests otherwise.[103] If the judge determines that the youth is "involved" or delinquent, the next step is a disposition hearing, similar to a sentencing hearing in the adult system.[104] The youth may then be placed on probation or into one of many different types of out-of-home placements until the age of eighteen or twenty-one, depending on the jurisdiction.[105]

At this stage, too, judges must consider the "needs" of the youth.[106] For example, in Texas, a child cannot be placed outside of his home unless the court finds that "the child, in the child's home, cannot be provided the quality of care and level of support and supervision that the child needs to meet the conditions of probation."[107] In 2017, 99.4% of youth committed to secure settings within the Texas Juvenile Justice Department (TJJD) were classified as needing

[102] McKeiver v. Pennsylvania, 403 U.S. 528, 545 (1971).

[103] *See, e.g.*, Justin D. Levinson, Mark W. Bennett & Koichi Hioki, *Judging Implicit Bias: A National Empirical Study of Judicial Stereotypes*, 69 FLA. L. REV. 63, 113 (2017) (analyzing an original empirical study of 259 judges and finding that "automatic biases and cognitions indeed influence a much broader range of judicial decisions than has ever been considered"); Allison P. Harris & Maya Sen, *Bias and Judging*, 22 ANN. REV. POL. SCI. 241, 253 (2019) ("Our review clarifies that the research in political science supports the idea that judges' backgrounds—including their race, gender, ethnicity, and religion—shape their decision making."); Mary Smith, Michael B. Hyman & Sarah E. Redfield, *Addressing Bias Among Judges*, STATE CT. REP. (Sept. 14, 2023), https://statecourtreport.org/our-work/analysis-opinion/addressing-bias-among-judges#:~:text=One%20study%20found%20that%20a,that%20of%20the%20general%20population [https://perma.cc/2R43-L6JV] ("One study found that a whopping 97 percent of judges consider themselves above average in their ability to avoid racial prejudice in decision-making. In contrast, studies also have found judges' susceptibility to the influence of cognitive bias is no better than that of the general population.").

[104] *Statistical Briefing Book*, *supra* note 77.

[105] *Id.*

[106] *See. e.g.*, IND. CODE ANN.§ 31-37-2-1 (West 2024) ("A child is a delinquent child if, before becoming eighteen (18) years of age, the child: (1) commits a delinquent act described in this chapter; and (2) needs care, treatment, or rehabilitation that: (A) the child is not receiving; (B) the child is unlikely to accept voluntarily; and (C) is unlikely to be provided or accepted without the coercive intervention of the court."); 237 PA. CODE § 409(A)(1)(a) (2024) (requiring that, after finding a youth involved, "the court shall conduct a hearing to determine if the juvenile is in need of treatment, supervision, or rehabilitation," and if it is found that the youth is not in need, "the petition shall be dismissed and the juvenile shall be released"); TEX. FAM. CODE ANN. § 54.04(c) (West 2024) ("No disposition may be made under this section unless the child is in need of rehabilitation or the protection of the public or the child requires that disposition be made."); D.C. CODE ANN. 16-2317(d)(1) (West 2024) ("If the [court] finds that the child is not in need of care or rehabilitation, it shall terminate the proceedings and discharge the child.").

[107] TEX. FAM. CODE ANN. §54.04(c) (West 2023).

"specialized treatment."[108] Certainly, this is more than mere coincidence. Texas youth who had been identified as in need of "specialized treatment" were more likely to be found "in need" of the services that juvenile legal system claims to provide. Although research on this subject is limited, available research finds that this is true throughout the juvenile legal system. A 2013 literature review of studies examining the factors that influence juvenile judges found "[e]vidence of an association between a mental disorder in the juvenile offender and a sentence of residential placement."[109] It is therefore not surprising that as many as 80% of youth in secure placements, either pre-adjudication detention facilities or post-adjudication facilities, have diagnosable mental illnesses.[110]

The disproportionate representation of Black and Brown youth from families living in poverty in the juvenile legal system is well established. But it is not just youth of color and youth living in poverty who are more likely to be placed in secure settings within the juvenile legal system—youth of color living in poverty with diagnosable mental illnesses face a significant risk of more punitive outcomes.[111] As a result, the juvenile legal system removes our country's most vulnerable youth from their homes and communities, denies them access to meaningful treatment, and causes harm to these youth and their families. The juvenile legal system uses the doctrine of *parens patriae* to target these youth. It then denies them the very care the system claims it exists to provide.[112]

D. *Lack of Meaningful Mental Health Care in the Juvenile Legal System*

Given the alarmingly high percentage of system-involved youth with diagnosable mental illnesses, and given the system's purported focus on *parens patriae* and rehabilitation, one might expect that the system would allocate significant resources for evidence-based mental health treatment. This Subpart explains how this is far from the reality, beginning with an examination of what mental health treatment is required in the juvenile legal system. Next, this

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[108] TEX. JUV. JUST. DEP'T, YOUTH CHARACTERISTICS: NEW ADMISSIONS FY 2013–2017 (2017), https://www2.tjjd.texas.gov/statistics/youth-characteristics1317.pdf [https://perma.cc/DYL6-VN6Z]. The TJJD includes the following subcategories of treatment: "capital and serious violent offender treatment," "sexual behavior treatment," "alcohol or other drug treatment," and "overall treatment needs." *Id.* Each of these could meet the DSM-V criteria for a mental illness, though it is impossible to know for sure without more information how the TJJD defines each. Importantly, however, regardless of actual DSM-V diagnosis, almost all youth in the TJJD are perceived as in need of some type of "treatment."

[109] Cappon & Vander Laenen, *supra* note 94, at 69.

[110] Underwood & Washington, *supra* note 12, at 3.

[111] OJJDP, INTERSECTION, *supra* note 3, at 6; PUZZANCHERA, HOCKENBERRY & SICKMUND, *supra* note 78, at 7 ("Youth who grow up in families or communities with limited resources are at a higher risk of offending than those who are raised under more privileged circumstances.").

[112] See *infra* Part III for a full discussion of the lack of available mental treatment in the juvenile legal system.

Subpart examines the distressingly inadequate delivery of mental health treatment within the juvenile legal system. Finally, while acknowledging that research has consistently identified community-based placements as best for youth,[113] this Subpart then discusses what meaningful treatment could look like in the context of secure facilities.

1. *The Right to Mental Health Treatment: The Juvenile Justice and Delinquency Act*

Although the Juvenile Justice and Delinquency Prevention Act (JJDPA) provides funding to state juvenile justice agencies, the JJDPA does not require states to provide meaningful mental health treatment to receive this funding. JJDPA was initially passed in 1974 to create a centralized federal agency, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), to support state juvenile legal systems.[114] Any authority OJJDP has over state juvenile legal systems comes exclusively from the state's participation in the optional JJDPA formula grant program.[115] In order to receive formula grant[116] funding under the JJDPA, states must fulfill the Act's four "core requirements": (1) deinstitutionalization of status offenders,[117] (2) removal of juveniles from adult jails and detention facilities, (3) separation of juveniles from adult inmates, and (4) reduction of racial and ethnic disparities.[118] Despite the high percentage of system-involved youth with diagnosable mental illnesses, none of the core

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[113] OJJDP, ALTERNATIVES, *supra* note 16, at 1–2 ("In terms of the negative impact [of detention and confinement facilities] on the community, research has shown that juveniles who are kept in the community recidivate less often than previously detained youths . . . .").

[114] *About OJJDP*, OFF. OF JUV. JUST. & DELINQ. PREVENTION, https://ojjdp.ojp.gov/about [https://perma.cc/D9N9-P2C4].

[115] *See id.* ("The JJDP Act authorizes OJJDP to provide an annual grant to each state to improve its juvenile justice system and to support juvenile delinquency prevention programs."); KRISTIN FINKLEA & EMILY J. HANSON, CONG. RSCH. SERV., RL33947, JUVENILE JUSTICE: LEGISLATIVE HISTORY AND CURRENT LEGISLATIVE ISSUES (2015) ("To receive funding under this grant program, the states were required to submit plans for how they were going to disburse the funding."); *Legislation*, OFF. OF JUV. JUST. & DELINQ. PREVENTION, https://ojjdp.ojp.gov/about/legislation [https://perma.cc/HA83-WW4R].

[116] *Formula Grants*, U.S. DEP'T OF EDUC., https://www.ed.gov/grants-and-programs/formula-grants [https://perma.cc/EU2M-KGDJ] (Nov. 4, 2024) ("Formula grant programs are noncompetitive awards based on a predetermined formula determined by Congress. These programs are sometimes referred to as state-administered programs.").

[117] A status offense is a "noncriminal act that is considered a law violation only because of a youth's status as a minor." OJJDP, STATUS OFFENDERS, *supra* note 88, at 1.

[118] *State Compliance with JJDP Act Core Requirements*, OFF. OF JUV. JUST. & DELINQ. PREVENTION, https://ojjdp.ojp.gov/states/state-compliance-jjdp-act-core-requirements [https://perma.cc/54Q2-3W42]. *See generally* Eloise Pasachoff, *Agency Enforcement of Spending Clause Statutes: A Defense of the Funding Cut-Off*, 124 YALE L.J. 248 (2014).

requirements explicitly focuses on mental health treatment.[119] In 2021, forty-six states and the District of Columbia received JJDPA formula grant funding.[120]

In addition to complying with these four core requirements, states receiving JJDPA funding must create state plans regarding their administration of their juvenile legal systems, designate a state agency to administer the plan, create a State Advisory Group to support the administration of the state plan, and provide annual updates.[121] JJDPA funding requirements address mental health only in these state plans; states must include in their plans ideas to increase their provision of mental health services for involved youth.[122] However, these state plan requirements fall far short of being meaningful. Nothing is in place to ensure that states implement their plans with fidelity, and compliance with the JJDPA for continued funding is determined only by the four "core requirements."[123] Therefore, JJDPA formula funding is not tied to states implementing the mental health services identified in their plans. Thus, OJJDP, through its JJDPA funding, has no enforceable requirement for states to provide meaningful mental health services to their system-involved youth.

2. *The Right to Mental Health Treatment: Eighth and Fourteenth Amendments*

The juvenile legal system is ambiguously situated between civil and criminal courts. As a result, there is debate among scholars and inconsistency among courts on how the Eighth and Fourteenth Amendments should be applied in the context of the juvenile legal system. Nevertheless, there is broad agreement that juveniles are entitled to at least the basic medical care guaranteed by the Eighth Amendment and established in *Estelle v. Gamble*.

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[119] *State Compliance with JJDP Act Core Requirements*, *supra* note 118.

[120] *See* John Kelly, *What's in the 2024 Spending Deal for Youth and Families*, THE IMPRINT (Apr. 3, 2024), https://imprintnews.org/youth-services-insider/2024-spending-deal-youth-families/248618 [https://perma.cc/YB2G-PCSR] (noting that Connecticut, Nebraska, Texas and Wyoming did not participate in the JJDPA formula grant program).

[121] *Formula Grants*, *supra* note 116.

[122] 34 U.S.C. § 11133(a)(7)(B)(iv) (requiring states to provide alternatives to detention for youth with mental health needs); *id.* § 11133(a)(9)(M)(i) (encouraging courts to develop a continuum of detention alternatives, including utilizing community-based mental health support services); *id.* § 11133(a)(9)(T) (encouraging states to develop programs to provide "mental health or co-occurring disorder" services).

[123] 28 C.F.R. § 31.303(6) (2025) ("The State must demonstrate the extent to which the requirements of sections 223(a)(11), (12), and (13) of the Act are met."); OFF. OF JUV. JUST. & DELINQ. PREVENTION, U.S. DEP'T OF JUST., POLICIES AND PROCEDURES MANUAL FOR MONITORING COMPLIANCE WITH CORE REQUIREMENTS OF THE FORMULA GRANTS PROGRAM AUTHORIZED UNDER TITLE II, PART B, OF THE JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT 1 (2021), https://ojjdp.ojp.gov/compliance-monitoring-manual [https://perma.cc/NPE7-5HKG] (describing how states should demonstrate compliance to the four core requirements described in 34 U.S.C. § 11133 in order to be eligible to receive funding).

Some courts and advocates argue that the Eighth Amendment standard prohibiting "cruel and unusual" punishment in the adult legal system is the most appropriate standard to use when determining what care is required in secure juvenile facilities.[124] In *Estelle v. Gamble*, the Supreme Court established that to make a claim of inadequate medical care under the Eighth Amendment, prison administrators must have acted with deliberate indifference toward an objectively serious medical condition.[125] The Supreme Court elaborated on how this should be applied in *Farmer v. Brennan*, clarifying that deliberate indifference occurs when a prison administrator "knows of and disregards an excessive risk to inmate health or safety."[126]

Because system-involved youth are not formally convicted of crimes but instead found to be involved or delinquent, others argue that a Fourteenth Amendment analysis is more fitting.[127] In *Bell v. Wolfish*, the Supreme Court recognized that the Due Process Clause of the Fourteenth Amendment protects liberty interests of individuals who are detained pending trial because they have not been convicted of a crime.[128] Here, the Supreme Court held that preconviction detention is not a punishment unless such punishment is reasonably related to a legitimate government interest.[129] In *Youngberg v. Romeo*, the Supreme Court addressed the rights of individuals involuntarily committed to an inpatient facility.[130] The Court, finding that the goal of an involuntary commitment (like in the juvenile legal system) was to provide care and treatment and not punishment, held that individuals who are "involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."[131] *Youngberg* established a professional judgment standard that some argue should apply to the juvenile legal system.[132]

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[124] A.M. *ex rel.* J.M.K. v. Luzerne Cnty. Juv. Det. Ctr., 372 F.3d 572, 579, 584 (3d. Cir. 2004) (applying the deliberate indifference analysis).

[125] Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).

[126] Farmer v. Brennan, 511 U.S. 825, 837 (1994); Edmonds, *supra* note 30, at 296 ("In practice, the deliberate indifference standard has proven to be a powerful gatekeeper to all but the most egregious violations . . . .").

[127] *See* Milonas v. Williams, 691 F.2d 931, 939 (10th Cir. 1982); *see also* Santana v. Collazo, 714 F.2d 1172, 1179 (1st Cir. 1983); A.J. *ex rel.* L.B. v. Kierst, 56 F.3d 849, 854 (8th Cir. 1995).

[128] Bell v. Wolfish, 441 U.S. 520, 539 (1979).

[129] *Id.*

[130] Youngberg v. Romeo *ex rel.* Romeo, 457 U.S. 307, 321–22 (1982).

[131] *Id.*; *see* Doe 4 *ex rel.* Lopez v. Shenandoah Valley Juv. Ctr. Comm'n, 985 F.3d 327, 353 (4th Cir. 2021) (expressing uncertainty as to what standard was most appropriate for assessing adequacy of mental health treatment for detained juveniles).

[132] *See, e.g.*, Matthew Skolnick, Note, *The Doctor Will See You Now: The Fourth Circuit Revives the Juvenile Detainee's Right to Treatment by Adopting the Professional Judgment Standard in* Doe 4, 67 VILL. L. REV. 377, 383 (2022); Lydia G. Mrowiec, Note, *Kids,*

Additionally, some scholars have argued that juveniles have a right to meaningful rehabilitation as a result of the Supreme Court decisions known as the *Miller* trilogy.[133] In *Roper v. Simmons*, relying on newly emerging social science research on the developing adolescent brain, the Supreme Court held that imposing a death sentence on offenders who were under the age of eighteen at the time they committed a capital crime violated the Eighth Amendment.[134] Then, in 2011, the Supreme Court held in *Graham v. Florida* that mandatory life sentences without parole for juveniles who had committed nonhomicide crimes were unconstitutional.[135] Again, the Court relied heavily on research on adolescent brain development, noting that "developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds."[136] Like the *Simmons* Court, the *Graham* Court emphasized a juvenile's potential for rehabilitation.[137] The Court declared that states must provide juvenile offenders with "some meaningful opportunity to obtain release based on demonstrated maturity and rehabilitation."[138] Less than two years later, in *Miller v. Alabama*, the Court held that the Eighth Amendment prohibited mandatory life-without-parole sentences for juveniles convicted of murder. Such sentences can be imposed only after considering the juvenile's age at the

Cognition, and Confinement: Evaluating Claims of Inadequate Access to Mental Health Care in Juvenile Detention Facilities, 29 WM. & MARY J. RACE, GENDER, & SOC. JUST. 691, 693 (2023).

[133] McDermott, *supra* note 12, at 718. However, because the Eighth Amendment provides for the prohibition of "cruel and unusual punishment," this argument relies on an understanding that the juvenile legal system is punitive—rather than rehabilitative—in nature. *Id.* A full analysis of rehabilitation versus punishment is beyond the scope of this Article. *See generally* Neelum Arya, *Using* Graham v. Florida *to Challenge Juvenile Transfer Laws*, 71 LA. L. REV. 99 (2010); Aaron Sussman, *The Paradox of* Graham v. Florida *and the Juvenile Justice System*, 37 VT. L. REV. 381, 383 (2012); Meghan J. Ryan, *Finality and Rehabilitation*, 4 WAKE FOREST J.L. & POL'Y 121, 122 (2014); Martin Gardner, *Youthful Offenders and the Eighth Amendment Right to Rehabilitation: Limitations on the Punishment of Juveniles*, 83 TENN. L. REV. 455, 460 (2016) (arguing that these cases established a "new constitutional right to rehabilitation for adolescents" facing a secure placement).

[134] Roper v. Simmons, 543 U.S. 551, 578 (2005). The Court relied on two rationales; first, the Court found that, based on social science research on adolescent brain development, juveniles are less culpable than adults. *Id.* at 570 (first citing ERIK H. ERIKSON, IDENTITY: YOUTH AND CRISIS (1968); and then citing Laurence Steinberg & Elizabeth S. Scott, *Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty*, 58 AM. PSYCH. 1009, 1014 (2003)). Second, the Court identified a greater likelihood of rehabilitation among juvenile offenders compared to adult offenders, noting "it would be misguided to equate the failings of a minor with those of an adult, for a greater possibility exists that a minor's character deficiencies will be reformed." *Id.*

[135] Graham v. Florida, 560 U.S. 48, 75 (2010).

[136] *Id.* at 68.

[137] *Id.*

[138] *Id.* at 75.

time of the crime, his family and home environment, the circumstances of the homicide, and the possibility of rehabilitation.[139]

Taken together, these cases firmly establish what was identified when a separate juvenile legal system was first created in 1899: kids are different than adults. Because youth must have meaningful opportunities to be released upon demonstrating maturity and rehabilitation, it follows that dispositions in the juvenile legal system must include meaningful opportunities for rehabilitation. As Professor Martin Gardner said of the *Miller* trilogy, "[J]uvenile offenders now appear to have a constitutional right to a meaningful opportunity for rehabilitation . . . ."[140] For youth with mental illnesses, that must include effective, evidence-based mental health treatment.

What standard applies in condition-of-confinement cases within the juvenile legal system remains an open question. Neither the right to rehabilitation[141] nor the professional judgment standard[142] has been widely adopted. Therefore, the constitutionally required treatment for youth in the juvenile legal system is simply the right to basic medical care established in *Estelle v. Gamble*. While mental health treatment in secure juvenile facilities is alarmingly lacking,[143] nothing requires states to provide more meaningful treatment.

3. *Mental Health Treatment in the Juvenile Legal System Is Disturbingly Lacking*

As it stands, "only a small percentage of those in need of services can access treatment" within the juvenile legal system.[144] One study[145] revealed that fewer than 5% of system-involved youth who would benefit from evidence-based treatment receive it.[146] Another study, looking specifically at Medicaid-eligible youth, found that only 35.3% of youth reported receiving any type of mental health treatment while in a secure facility.[147] The Northwestern Juvenile Project

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[139] Miller v. Alabama, 567 U.S. 460, 479 (2012).

[140] Gardner, *supra* note 133, at 504.

[141] *See supra* text accompanying notes 133–40.

[142] *See supra* notes 130–32 and accompanying text.

[143] *See infra* Part II.D.3.

[144] OJJDP, INTERSECTION, *supra* note 3, at 4.

[145] The lack of recent data on mental health and the juvenile legal system is problematic. The data used in this Article is the most recent available data that I could find. The Northwestern Juvenile Project study is widely cited and relied on and provides valuable data. However, the study was originally conducted almost thirty years ago. *See Health Disparities & Public Policy Program*, NW. UNIV. FEINBERG SCH. OF MED., https://www.psychiatry.northwestern.edu/research/health-disparities.html [https://perma.cc/JU8D-EVBP] (choose "The Northwestern Juvenile Project (NJP)" from the "Current Studies" dropdown).

[146] Scott W. Henggeler & Sonja K. Schoenwald, *Evidence-Based Interventions for Juvenile Offenders and Juvenile Justice Policies That Support Them*, 25 SOC. POL'Y REP. 1, 8 (2011).

[147] MACPAC, ACCESS, *supra* note 6, at 2.

found that of 1,829 randomly selected youth in a secure detention center in Cook County, Illinois, only 15.4% of youth with "major mental disorders and associated functional impairments" received treatment in the detention center.[148]

The nonprofit National Commission on Correctional Health Care (NCCHC) has developed a set of standards identifying the best practices for providing health services—including mental health services—in secure juvenile facilities.[149] The American Academy of Pediatrics endorses these standards, and NCCHC uses them for its voluntary accreditation program.[150] Revealingly, fewer than 2% of all juvenile residential facilities in the United States have received this accreditation.[151] A 2007 study of 726 residential juvenile facilities found that "[v]ery few detention centers meet a minimum standard of care."[152]

For example, the NCCHC identifies initial health screening as a best practice for juvenile facilities.[153] Obviously, given the unexpected nature of an arrest, youth do not come to secure facilities prepared with their health records. It was not until the 1990s that the juvenile legal system began to recognize how problematic this lack of information was for the provision of mental health care.[154] In the last thirty years, significant effort and research have gone into

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[148] Linda A. Teplin, Karen M. Abram, Gary M. McClelland, Jason J. Washburn & Ann K. Pikus, *Detecting Mental Disorder in Juvenile Detainees: Who Receives Services*, 95 AM. J. PUB. HEALTH 1773, 1776 (2005). States must fund medical care, including mental health care, for system-involved youth. *Id.* at 1773. For the majority of states, a "mental health professional" is part of the staff of the secure facility. *Id.* at 1777. The staff may float between facilities, only respond to crisis situations, or be only part-time. *Id.* at 1775.

[149] WENDY HABERT, NAT'L COMM'N ON CORR. HEALTH CARE, 2022 STANDARDS FOR HEALTH SERVICES IN JUVENILE DETENTION & CONFINEMENT FACILITIES: WHAT'S NEW? (2022), https://www.ncchc.org/wp-content/uploads/2022-Standards-for-Health-Services-Whats-New.pdf [https://perma.cc/4LKC-PP2T].

[150] Catherine A. Gallagher & Adam Dobrin, *Can Juvenile Justice Detention Facilities Meet the Call of the American Academy of Pediatrics and National Commission on Correctional Health Care? A National Analysis of Current Practices*, 119 PEDIATRICS e991, e992 (2007).

[151] *Id.*

[152] *Id.* at e991 ("Multivariate models predicting high levels of service provision were estimated. . . . Juvenile detention centers partially meet some of the minimum standards. Most services can be garnered at some level; however, they tend to be provided on an ad hoc basis for portions of the population rather than systematically for the whole population. Detention centers most likely to provide a higher tier of services tend to be those that have longer average lengths of stay, are larger, and are government owned.").

[153] *Initial Health Assessment*, NAT'L COMM'N ON CORR. HEALTH CARE, https://www.ncchc.org/spotlight-on-the-standards/initial-health-assessment [https://perma.cc/QVL5-M8TN].

[154] NAT'L CTR. FOR MENTAL HEALTH & JUV. JUST., MENTAL HEALTH SCREENING IN JUVENILE JUSTICE SETTINGS 2 (2016), https://csgjusticecenter.org/wp-content/uploads/2021/04/Mental-Health-Screening-in-Juvenile-Justice-Settings-for-WEBSITE-1.pdf [https://perma.cc/QCN5-8WV7].

developing mental health screening tools.[155] The existing screening measures have substantial research supporting their validity and are designed to be simple to administer.[156] Yet, only 61% of youth report receiving a mental health screening upon entering a facility, while almost all youth, 97%, reported receiving a physical health screening.[157]

The U.S. Department of Justice's Special Litigation Section within the Civil Rights Division advocates for the rights of children in the juvenile legal system.[158] The lack of adequate mental health treatment is identified as a recurrent concern; of the thirteen findings letters the Section has issued since 2008, nine identified failures in mental health services in secure facilities.[159]

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[155] *Id.*; *see, e.g.*, Michael S. Martin, Ian Colman, Alexander I.F. Simpson & Kwame McKenzie, *Mental Health Screening Tools in Correctional Institutions: A Systematic Review*, BIOMED CENT. PSYCHIATRY, Oct. 29, 2013, Article No. 275, at 7–8. *See generally* Alexis E. Whitton et al., *Mental Health Screening in General Practices as a Means for Enhancing Uptake of Digital Mental Health Interventions: Observational Cohort Study*, J. MED. INTERNET RSCH., Sept. 16, 2021, Article No. 9.

[156] NAT'L CTR. FOR MENTAL HEALTH & JUV. JUST., *supra* note 154, at 4.

[157] Kira Pyne, *Mental Health in Youth Facilities*, COAL. FOR JUV. JUST. (May 13, 2020), https://www.juvjustice.org/blog/1163 [https://perma.cc/VWA2-DEN6].

[158] *Children's Rights in the Juvenile Justice System*, U.S. DEP'T OF JUST., https://www.justice.gov/crt/rights-juveniles [https://perma.cc/B2VU-M6HU] (June 11, 2024) (noting that the Special Litigation Section is authorized by the Violent Crime Control and Law Enforcement Act of 1994 and the Civil Rights of Institutionalized Person Act).

[159] *See Special Litigation Section Cases and Matters*, U.S. DEP'T OF JUST., https://www.justice.gov/crt/special-litigation-section-cases-and-matters#juv [https://perma.cc/976R-PD4S] (Jan. 8, 2025) (providing an overview of the Section's work, including a list of all finding letters and reports); *see also* C.R. DIV., U.S. DEP'T OF JUST., TEXAS JUVENILE JUSTICE DEPARTMENT INVESTIGATION FINDINGS (2024), https://www.justice.gov/crt/media [https://perma.cc/FZ8U-JPD2] (summarizing the Texas 2024 Findings Report and noting "[c]hildren do not receive adequate mental health assessments, treatment planning, and counseling"); C.R. DIV., U.S. DEP'T OF JUST., INVESTIGATION OF THE SHELBY COUNTY JUVENILE COURT 58–59 (2012), https://www.justice.gov/sites/default/files/crt/legacy/2012/04/26/shelbycountyjuv_findingsrpt_4-26-12.pdf [https://perma.cc/N6YF-BGCQ]; C.R. DIV., U.S. DEP'T OF JUST. & U.S. ATT'Y'S OFF., DIST. OF S.C., INVESTIGATION OF SOUTH CAROLINA DEPARTMENT OF JUVENILE JUSTICE'S BROAD RIVER ROAD COMPLEX 1 (2022), https://www.justice.gov/crt/case-document/file/1495151/dl [https://perma.cc/BRQ9-DR4U]; Letter from Loretta King, Acting Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to David A. Paterson, Governor of N.Y. 15 (Aug. 14, 2009), https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/NY_juvenile_facilities_findlet_08-14-2009.pdf [https://perma.cc/EN8B-DJJS] (notifying New York of the results of a 2009 investigation that found "failure to provide adequate mental health care and treatment"); C.R. DIV., U.S. DEP'T OF JUST., INVESTIGATION OF THE ST. LOUIS COUNTY FAMILY COURT, ST. LOUIS, MISSOURI 2–4 (2015), https://www.justice.gov/sites/default/files/crt/legacy/2015/07/31/stlouis_findings_7-31-15.pdf [https://perma.cc/BU79-8DKD]; Letter from Thomas E. Perez, *supra* note 24, at 1–2 (finding that the "[f]acility lacks sufficient qualified mental health professionals to provide proper mental health care and current staff is not appropriately trained"); Letter from Vanita Gupta, Principal Deputy

The circumstances surrounding the Department of Justice's involvement are disturbing and often heartbreaking.[160] For example, in 2012, the DOJ found that a juvenile facility in Indiana violated the constitutional rights of the detained youth, tragically resulting in one youth's death by suicide.[161] Although the youth, A.A., had a long and well-documented history of suicidal ideation, he was determined to be "low risk" and was provided limited mental health treatment.[162] A month before his death, he ingested several pills, and although he received physical health care, the facility did not refer him to any mental

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Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to Phil Bryant, Governor of Mississippi, and Jim Hood, Mississippi Att'y Gen. 2 (Jan. 12, 2016), https://www.justice.gov/crt/file/812646/dl [https://perma.cc/LE45-CCHA] (notifying Mississippi of the results of a 2016 investigation into Leflore County); Letter from Thomas E. Perez, Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to Robert Moore, Chair, Leflore Cnty. Bd. of Supervisors 2 (Mar. 31, 2011), https://www.justice.gov/sites/default/files/crt/legacy/2011/04/14/LeFloreJDC_findlet_03-31-11.pdf [https://perma.cc/F9HR-BZC8] (notifying Mississippi of the results of a 2011 investigation into Leflore County that found "[s]uicidal youth are not assessed by mental health professionals despite known risks"); Letter from Thomas E. Perez, Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to Phil Bryant, Governor of Mississippi et al. 2 (Aug. 10, 2012), https://www.justice.gov/sites/default/files/crt/legacy/2012/08/10/meridian_findletter_8-10-12.pdf [https://perma.cc/C4TD-W35Q] (notifying Mississippi of the results of a 2012 investigation into the Mississippi Division of Youth Services); Letter from Thomas E. Perez, Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to Mitch Daniels, Governor of Indiana 25 (Jan. 29, 2010), https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/Indianapolis_findlet_01-29-10.pdf [https://perma.cc/534B-YPXZ] (notifying Indiana of the results of a 2010 investigation into the Indianapolis Juvenile Correctional Facility finding the mental health care to be "constitutionally inadequate"); Letter from Thomas E. Perez, Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to Mitch Daniels, Governor of Indiana 4 (Aug. 22, 2012), https://www.justice.gov/sites/default/files/crt/legacy/2012/08/23/pendleton_findings_8-22-12.pdf [https://perma.cc/8AJJ-B35U] (notifying Indiana of the results of a 2012 investigation into the Pendleton Juvenile Correctional Facility that found "[f]ailure to provide adequate mental health screening and assessment"); C.R. DIV., U.S. DEP'T OF JUST., INVESTIGATION OF MANSON YOUTH INSTITUTE 8 (2021) [hereinafter C.R. DIV., MANSON INVESTIGATION], https://www.justice.gov/crt/case-document/file/1458101/dl?inline [https://perma.cc/PFX7-VZLX] (reporting results of a 2021 investigation into the Manson Youth Institution finding that "Manson fails to provide adequate mental health services"); Letter from Grace Chung Becker, Acting Assistant Att'y Gen., C.R. Div., U.S. Dep't of Just., to Yvonne B. Burke, Chairperson, L.A. Cnty. Bd. of Supervisors 38 (Oct. 31, 2008), https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/lacamps_findings_10-31-08.pdf [https://perma.cc/ZH4L-FNHS] (notifying Los Angeles of the results of a 2008 investigation into the Los Angeles County Probation Camps finding inadequate suicide prevention and mental health care).

[160] In Los Angeles County, for example, youth expressing suicidal ideation faced often weeks-long waits to see a mental health professional. Letter from Grace Chung Becker, *supra* note 159, at 40–42. Some youth were placed in the Special Housing Unit—a disciplinary unit called a SHU—for expressing suicidal thoughts, without any contact with a mental health professional. *Id.*

[161] *See generally* Letter from Thomas E. Perez to Mitch Daniels (2012), *supra* note 159, at 1.

[162] *Id.* at 7.

health staff.[163] Nine days later, A.A. attempted suicide using a sheet from his bed.[164] He was taken to a nurse; the nurse asked him to sign a safety contract promising not to harm himself.[165] Again, no referral was made to mental health staff.[166] Two weeks later, A.A. again attempted suicide using a bedsheet.[167] He was found unconscious and died four days later.[168] This preventable tragedy was a direct result of the failures of the juvenile legal system.

More recently, in 2021, at the Manson Youth Institute (Manson) in Connecticut, the DOJ found that "children at Manson suffer the debilitating effects of untreated mental illness. Many children are also subjected to harmful isolation as punishment for behaviors that are symptoms of their untreated mental illness."[169] Alarmingly, the DOJ found that while staff at Manson did conduct mental health screening assessments, staff would lower youth scores to justify discontinuing mental health services.[170]

The limited mental health treatment provided in the juvenile legal system falls far short of meaningful care.

4. *Providing Meaningful Treatment Can Work*

Several evidence-based models of care for youth with diagnosable mental illnesses have demonstrated promising results. Research on Functional Family Therapy, Multisystemic Therapy (MST), Assertive Community Treatment, and Wraparound Services has demonstrated efficacy specifically for system-involved youth in community placements.[171] While there are differences among

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[163] *Id.*

[164] *Id.*

[165] *Id.*

[166] *Id.*

[167] Letter from Thomas E. Perez to Mitch Daniels (2012), *supra* note 159, at 6.

[168] *Id.* at 6–7.

[169] C.R. DIV., MANSON INVESTIGATION, *supra* note 159, at 9. One youth, Tyler, received a diagnosis of conduct disorder while at Manson and was frequently punished with days in isolation. For almost a year, he did not meet with a mental health professional; it was not until he requested a meeting that he met with a clinician. *Id.* at 10. The clinician indicated he had some symptoms of PTSD, but did not "adequately follow up to determine whether Tyler exhibited additional symptoms." *Id.* at 10–11.

[170] *Id.* at 13.

[171] Katarzyna Celinska, Hung-En Sung, Chunrye Kim & Margret Valdimarsdottir, *An Outcome Evaluation of Functional Family Therapy for Court-Involved Youth*, 41 J. FAM. THERAPY 251, 251 (2019) ("[Y]ouths in [Functional Family Therapy] had significantly lower odds of recidivism as measured by reconvictions for drug offences, property offences and technical violations"); Scott W. Henggeler & Cindy M. Schaeffer, *Multisystemic Therapy®: Clinical Overview, Outcomes, and Implementation Research*, 55 FAM. PROCESS 514, 519 (2016) ("MST improved family relations and peer relations at posttreatment, and decreased recidivism by 43% and out-of-home placement by 64% at a 59-week follow-up."); Richard

these models, they all involve families and youth, working with the youth as part of a larger system rather than in isolation.[172]

As discussed above, very little mental health treatment is provided in secure juvenile facilities.[173] Given this, there is no wide-scale research on the efficacy of these evidence-based treatment models in secure settings. However, anecdotal evidence suggests that providing meaningful, evidence-based treatment in a secure facility can improve outcomes for youth. One notable model demonstrating significant success is the Missouri Model, which is "generally regarded as one of the best approaches to juvenile justice practice available today."[174] Among other reforms—including building several small facilities through the state—all youth are required to participate in therapy,[175] and 25% to 30% participate in some form of family therapy funded by the Missouri Department of Youth Services.[176] In addition, Missouri's Department of Youth Services provides funding to and works closely with community treatment providers to ensure additional support for youth upon return to their communities.[177] Recidivism in Missouri is significantly lower when compared to states using similar methods of measurement. For example, in 2005, the recidivism rate within three years for youth release was 24.4% in Missouri compared to 43.3% in Texas and 51.8% in Arizona.[178]

However, there are considerable obstacles to replicating this model in other states. Although Missouri has ultimately reported a decrease in overall expense,[179] significant upfront costs make the Missouri Model difficult to

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Vijverberg, Robert Ferdinand, Aartjan Beekman & Berno van Meijel, *The Effect of Youth Assertive Community Treatment: A Systematic PRISMA Review*, BIOMED CENT. PSYCHIATRY, Aug. 2, 2017, Article No. 284, at 16 (2017) (finding that initial research indicates that "Youth-ACT is effective in reducing severity of psychiatric symptoms, improving general functioning, and reducing duration and frequency of psychiatric hospital admissions").

[172] Underwood & Washington, *supra* note 12, at 7.

[173] *See infra* Part II.D.3.

[174] Beth M. Huebner, *The Missouri Model: A Critical State of Knowledge*, *in* REFORMING JUVENILE JUSTICE: A DEVELOPMENTAL APPROACH 411 app. B, at 422 (Richard J. Bonnie et al. eds., 2013), https://nap.nationalacademies.org/read/14685/chapter/16#422.

[175] *Id.* at 414–15, 419.

[176] RICHARD A. MENDEL, THE ANNIE E. CASEY FOUND., THE MISSOURI MODEL: REINVENTING THE PRACTICE OF REHABILITATING YOUTHFUL OFFENDERS 34 (2010), https://assets.aecf.org/m/resourcedoc/aecf-MissouriModelFullreport-2010.pdf [https://perma.cc/A8LM-JFHP].

[177] Huebner, *supra* note 174, at 421.

[178] MENDEL, *supra* note 176, at 9.

[179] *The Missouri Model: Worthwhile Reform Benefits Youth and States*, THE ANNIE E. CASEY FOUND. (Oct. 4, 2010), https://www.aecf.org/blog/the-missouri-model-worthwhile-reform-benefits-youth-states [https://perma.cc/AAD4-UH56] ("Missouri spends $87 million on [Department of Youth Services]: the equivalent to $155 for each young person in the state

reproduce. Allowing youth in secure facilities access to Medicaid-funded services, however, would remove the immediate financial barrier states face in providing therapy to system-involved youth. This would allow for an immediate increase in access to evidence-based care, as demonstrated by Bernalillo County, New Mexico, in 2002.[180] Although the county was ultimately not allowed to continue using Medicaid funds, as discussed further in Part IV.C, Bernalillo County used Medicaid funding to open a mental health clinic for youth in pre-adjudication detention.[181] Prior to the clinic's creation, youth received little, if any, mental health treatment.[182] As the director of the detention center reported, "The facility's two mental health staff weren't even degreed people . . . . we didn't have a strong treatment program."[183] After the creation of the clinic, youth were able to access evidence-based treatment they could

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of juvenile age (10 to 16 years old). This figure represents a cost to tax-payers that is lower than or comparable to the juvenile corrections systems in most states. As important, [Department of Youth Services] has saved the state millions of dollars by reducing the recidivism of juvenile offenders into adult prisons.").

[180] RICHARD A. MENDEL, THE ANNIE E. CASEY FOUND., BERNALILLO COUNTY MENTAL HEALTH CLINIC CASE STUDY: A GUIDE TO JUVENILE DETENTION REFORM #6, at 11, 18 (2013), https://assets.aecf.org/m/resourcedoc/aecf-JDAIBernalilloCountyCaseStudy-2013.pdf [https://perma.cc/545C-56MU]. Certainly, it is important to address the shortage of community-based providers who accept Medicaid and the impact of increased demand that would result from increased funding for reimbursement for servicers for youth in secure facilities. And while a full discussion of the supply of community-based mental health treatment providers is outside the scope of this Article, the results of the Medicaid expansion on the availability of mental health providers accepting Medicaid suggests that if the funding is available, the number of providers will be available too. *See, e.g.*, JENNIFER SULLIVAN, MIRIAM PEARSALL & ANNA BAILEY, CTR. ON BUDGET & POL'Y PRIORITIES, TO IMPROVE BEHAVIORAL HEALTH, START BY CLOSING THE MEDICAID COVERAGE GAP 5 (2021), https://www.cbpp.org/sites/default/files/9-9-21health.pdf [https://perma.cc/84RS-A6QA] ("Coverage expansion also contributes to increased access to behavioral health services by increasing behavioral health provider capacity. The more likely providers are to receive adequate reimbursement for their services, the greater their capacity to accept various forms of coverage."); Elson Oshman Blunt, Johanna Catherine Maclean, Ioana Popovici & Steven C. Marcus, *Public Insurance Expansions and Mental Health Care Availability*, 55 HEALTH SERVS. RSCH. 615, 624 (2020) (concluding that insurance expansion increases the availability of mental health care providers). Similarly, MST, an evidence-based treatment model, credits availability of Medicaid funding with its growth. Sarah Vidal, Christine M. Steeger, Colleen Caron, Leanne Lasher & Christian M. Connell, *Placement and Delinquency Outcomes Among System-Involved Youth Referred to Multisystemic Therapy: A Propensity Score Matching Analysis*, 44 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 853, 862 (2017) ("Many jurisdictions have primarily relied on Medicaid funding for implementation of MST programs . . . Medicaid funding has played a critical role in facilitating and sustaining the growth of MST.").

[181] *See* MENDEL, *supra* note 180, at 8.

[182] *Id.*

[183] *Id.*

continue upon release, and recidivism dropped among youth with identified "mental health problems" from 88% to 33%.[184]

Because the majority of states have not provided funding for such services on their own, the MIEP makes the consistent provision of evidence-based treatment for Medicaid-eligible youth in secure settings essentially impossible. Mental health treatment providers who rely on Medicaid funding are unable to continue or even start any such services during a youth's secure placement.[185] The result for youth in secure facilities is untreated and often worsening mental health during a time when they are supposed to be "rehabilitated."

Under the pretense of care and rehabilitation, the juvenile legal system funnels the young people most in need of mental health treatment into secure facilities at a disproportionate rate. However, states are not required to provide meaningful mental health treatment, and unsurprisingly, very little is actually offered.

III. DENYING CARE, HARMING YOUTH

Medicaid is the "single largest payer for mental health services" in the United States.[186] Of the approximately 73 million Americans under eighteen in the United States, nearly 30.5 million are enrolled in Medicaid; this number is expected to increase to 31 million by 2027.[187] Accordingly, Medicaid plays a central role in providing youth mental health treatment.[188] While there is a significant need for improvement in Medicaid-funded mental health care,[189] Medicaid-funded services are central to any discussion of mental health treatment because the program is a primary provider of such treatment. The very

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[184] John Kelly, *Medicaid's Buried Treasure for Juvenile Justice*, YOUTH TODAY (Apr. 1, 2008), https://youthtoday.org/2008/04/medicaids-buried-treasure-for-juvenile-justice [https://perma.cc/WVR5-A6ZN].

[185] *See* Vidal, Steeger, Caron, Lasher & Connell, *supra* note 180, at 862.

[186] *Behavioral Health Services*, MEDICAID, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html [https://perma.cc/4QJZ-TBHM].

[187] Preeti Vankar, *Projected Number of Children Enrolled in Medicaid in the United States from 2020 to 2027*, STATISTA (June 20, 2022), www.statista.com/statistics/578323/projected-number-of-children-enrolled-in-medicaid [https://perma.cc/2ZD9-U6GS]; PUZZANCHERA, HOCKENBERRY & SICKMUND, *supra* note 78, at 2.

[188] *See generally* GEO. UNIV. CTR. FOR CHILD. & FAMS., MEDICAID'S ROLE IN CHILD, YOUTH AND ADULT MENTAL HEALTH (2025), https://ccf.georgetown.edu/wp-content/uploads/2025/02/Medicaids-Role-in-Child-Youth-and-Adult-Mental-Health-%E2%80%93-Center-For-Children-and-Families.pdf [https://perma.cc/RGK5-W97V].

[189] *See generally* OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., A-02-22-01016, CMS DID NOT ENSURE THAT SELECTED STATES COMPLIED WITH MEDICAID MANAGED CARE MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY REQUIREMENTS (2024); Mary Giliberti, *Fix the Foundation: Unfair Rate Setting Leads to Inaccessible Mental Health Care*, MENTAL HEALTH AM. (Feb. 10, 2023), https://mhanational.org/blog/fix-foundation-unfair-rate-setting-leads-inaccessible-mental-health-care [https://perma.cc/D2GJ-9PGZ].

design of the juvenile legal system drives youth living in poverty (and therefore eligible for Medicaid) to be disproportionately involved in the juvenile legal system.[190] Despite the alarmingly high rate of Medicaid-eligible, system-involved youth with mental illnesses, and despite the central role of Medicaid in providing mental health treatment in the United States, youth in secure facilities are excluded from Medicaid-funded services.[191]

This Part begins with an overview of Medicaid generally and Medicaid eligibility within the juvenile legal system. It then discusses the history and current application of the Medicaid Inmate Exclusion Policy and identifies the Medicaid services denied to youth in secure facilities. Finally, this Part explores the significant harm resulting from a lack of effective, evidence-based mental health treatment in the juvenile legal system—care that could be provided through Medicaid funding.

A. *Presumed Medicaid Eligibility of System-Involved Youth*

Although complete data are unavailable, the data that are available suggest that a majority of youth involved in the juvenile legal system are eligible for Medicaid.[192] Medicaid is funded jointly by each state and the federal government.[193] As a result, eligibility criteria vary by state.[194] The income criteria used to determine eligibility are inconsistent even within states by age.[195] For example, in Arizona, the income eligibility is 147% of the federal poverty line (FPL) for children under the age of one, 141% of the FPL for children ages one to five, and 133% of the FPL for children age six to eighteen.[196] Complicating the issue further, states can elect to combine their Medicaid program with another large provider of health care for children, the Children's Health Insurance Program (CHIP).[197] For youth ages six to eighteen,

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[190] *See supra* Part II.A.

[191] *See supra* notes 3–6 and accompanying text.

[192] *See* MACPAC, ACCESS, *supra* note 6, at 1.

[193] *Eligibility Policy*, MEDICAID, https://www.medicaid.gov/medicaid/eligibility-policy/index.html [https://perma.cc/87VW-ZCMH]. In addition, there are groups that are considered to be mandatory eligibility groups. *Id.* Individuals must also be residents of the states where they are receiving Medicaid and must be citizens or "qualified non-citizens." *Id.*

[194] *Id.*

[195] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 97–99 (2022), https://www.macpac.gov/wpcontent/uploads/2022/12/MACSTATS_Dec2022_WEB-508.pdf [https://perma.cc/ED8R-WU6P].

[196] *Id.*; ARIZ. HEALTH CARE COST CONTAINMENT SYS., AHCCS ELIGIBILITY REQUIREMENTS, JANUARY 1, 2025 (2025), https://www.azahcccs.gov/Members/Downloads/EligibilityRequirements.pdf [https://perma.cc/2QGG-HUGR].

[197] ANDY SCHNEIDER, HANNAH KLUKOFF & MACLAINE LEHAN, CTR. FOR CHILD. AND FAMS., GEO. UNIV., AN INTRODUCTION TO MANAGED CARE IN CHIP 1, 2 (2023), https://ccf.georgetown.edu/wp-content/uploads/2023/11/CCF-Brief-An-Introduction-to-Managed-

most states have adopted the lowest eligibility threshold at 133% of the FPL,[198] or $42,759.50 for a family of four.[199] At the other extreme, the District of Columbia has set the eligibility income threshold at 319% of the FPL, or $102,558.50 for a family of four.[200]

While the Office of Juvenile Justice and Delinquency Prevention collects data on many characteristics of system-involved youth, including race, age, offense, and length of stay in a secure facility, OJJDP does not collect data on family income levels of system-involved youth.[201] Therefore, while it is largely understood that most system-involved youth live in poverty and meet the income eligibility requirements for Medicaid,[202] the exact numbers are unknown.[203] Available data on eligibility for public defenders confirms this understanding. As with family income of system-involved youth, data on

Care-in-CHIP-March-2023-v2.pdf [https://perma.cc/B8MC-5SUM]. Unlike the Federal Financial Participation (FFP) model of Medicaid, CHIP is funded as a block grant, and states can elect how to use their grant. *Id.* at 2. As of July 2022, only two states, Washington and Connecticut, have completely separate CHIP programs. *Id.* Ten states and the District of Columbia use funding from Medicaid expansion while the remaining states and territories have combined programs. *Id.*

198 *Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, MEDICAID (Dec. 1, 2023), https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html [https://perma.cc/2LH7-3TXJ] (showing that Arizona, Delaware, Florida, Georgia, Idaho, Kansas, Mississippi, Nevada, Oregon, Pennsylvania, Tennessee, Texas, Utah, and West Virginia have adopted the lowest eligibility threshold).

199 *2025 Poverty Guidelines: 48 Contiguous States (All States Except Alaska and Hawaii)*, U.S. DEP'T OF HEALTH & HUM. SERVS. (2025), https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf [https://perma.cc/D5YM-9HXB].

200 *Id.*; *Infants & Children (0–20)*, D.C. DEP'T OF HEALTH CARE FIN., https://dhcf.dc.gov/service/infants-children-0-20 [https://perma.cc/R8NT-D5VN].

201 *See generally* PUZZANCHERA, HOCKENBERRY & SICKMUND, *supra* note 78 (reporting data on youth characteristics in the juvenile legal system but only reporting national proportion of children living in poverty generally).

202 NAT'L CONF. OF STATE LEGISLATURES, MEDICAID FOR JUVENILE JUSTICE-INVOLVED CHILDREN 2, https://www.ncsl.org/documents/cj/jjguidebook-medicaid.pdf [https://perma.cc/2XWF-8N9R] (explaining that juvenile offenders have a probable eligibility for public insurance program); MENDEL, *supra* note 180, at 8; MACPAC, ACCESS, *supra* note 6, at 1 ("Medicaid and CHIP cover 60.4 percent of children or youth who had stayed overnight in jail or juvenile detention.").

203 *See, e.g.*, LESLIE ACOCA, JESSICA STEPHENS & AMANDA VAN VLEET, THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, HEALTH COVERAGE AND CARE FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM: THE ROLE OF MEDICAID AND CHIP 2 (2014) ("Although it is generally recognized that a majority of youth in juvenile justice facilities are from low-income families, there is a lack of national, comprehensive data on family income of youth offenders.").

indigent defense in the juvenile legal system are limited,[204] but these data confirm that a large majority of youth involved in the juvenile legal system meet the eligibility criteria for Medicaid.[205] In Texas, for example, 76% of system-involved youth are eligible for a court-appointed attorney, with eligibility capped at 125% of the FPL.[206] In Texas, eligibility for Medicaid for children is

[204] After the groundbreaking Supreme Court case *In re* Gault, 387 U.S. 1 (1967), established the right to counsel in delinquency cases, each state has a system of indigent defense for the juvenile legal system. Katayoon Majd & Patricia Puritz, *The Cost of Justice: How Low-Income Youth Continue to Pay the Price of Failing Indigent Defense Systems*, 16 GEO. J. ON POVERTY L. & POL'Y 543, 564 (2009). Systems of juvenile defense vary even within a state; only twenty-one states have a statewide system. NAT'L. JUV. DEF. CTR., THE FRAGMENTED STATE OF JUVENILE INDIGENT DEFENSE, http://njdc.info/wp-content/uploads/2016/10/The-Fragmented-State-of-Juvenile-Indigent-Defense.pdf [https://perma.cc/6AWV-WN9W]. States approach the assignment of public defenders in the juvenile-legal system in two ways. In eleven states, all youth are presumed to be eligible and are provided counsel. NAT'L JUV. DEF. CTR., ACCESS DENIED: A NATIONAL SNAPSHOT OF STATES' FAILURE TO PROTECT CHILDREN'S RIGHT TO COUNSEL 9 (2017), https://www.defendyouthrights.org/wp-content/uploads/2017/05/Snapshot-Final_single-4.pdf [https://perma.cc/KC3H-RYHU]. In the remaining majority of states, a case-by-case determination is made based on family income. *Id.* at 11. In several states, judges may also appoint counsel if they find that paying for an attorney would cause the family hardship. Majd & Puritz, *supra* note 204, at 564. Predictably, there are significant differences among judges as to how such a standard is applied. *Id.*; NAT'L JUV. DEF. CTR., ACCESS DENIED, *supra* note 204, at 11 ("Eligibility determinations are generally conducted by court personnel, public agencies, or public defender offices and are usually based on some percentage of the federal poverty guidelines. On average, that percentage hovers at 125 percent."); OFF. OF JUV. JUST. & DELINQ. PREVENTION, U.S. DEP'T OF JUST., INDIGENT DEFENSE FOR JUVENILES 2 (2018), https://ojjdp.ojp.gov/model-programs-guide/literature reviews/indigent_defense_for_juveniles.pdf [https://perma.cc/KX85-HX87]. There are significant issues with the system of providing public defenders to youth that are outside the scope of this Article and are discussed at length elsewhere. *See, e.g.*, NAT'L JUV. JUST. NETWORK, *Brief: Charting U.S. Minimum Ages of Jurisdiction, Detention, and Commitment* (2023), https://nyjn.org/publications/brief-charting-u-s-minimum-ages-of-jurisdiction-detention-and-commitment [https://perma.cc/92WW-577V]; THE GAULT CTR., https://www.defendyouthrights.org [https://perma.cc/FT4R-SKUE]; Jesse Kelley, *A Child's Right to Counsel: Juvenile Public Defenders*, R ST. SHORTS, Oct. 2020, Article No. 95, at 1; ANDREW WACHTER, JUV. JUST. GEOGRAPHY, POL'Y, PRAC. & STAT., INDEFENSIBLE: THE LACK OF JUVENILE DEFENSE DATA 4 (2015), https://www.ncjj.org/pdf/JJGPS%20StateScan/JJGPS_Indefensible_The_Lack_of_Juvenile_Defense_Data_2015_5.pdf [https://perma.cc/8ADL-DMGA].

[205] *See* MACPAC, ACCESS, *supra* note 6, at 1.

[206] *Juvenile Defense – Texas*, JUV. JUST. GEOGRAPHY, POL'Y, PRAC. & STAT. (2017), http://www.jjgps.org/juvenile-defense/texas#defense-structure [https://perma.cc/GG2B-BLDX] (showing that, as of 2015, 76% of juvenile defendants in Texas qualified for a court-appointed attorney); ANDREW L.B. DAVIES, BLANE SKILES, PAMELA R. METZGER, JANELLE GURSOY & ALEX ROMO, DEASON CRIM. JUST. REFORM CTR., GETTING *GIDEON* RIGHT: ELIGIBILITY FOR APPOINTED COUNSEL IN TEXAS MISDEMEANOR CASES 15 (2022), https://www.smu.edu/-/media/site/law/deason-center/publications/public-defense/getting-gideon-right.pdf [https://perma.cc/XE5J-VLBV] ("A defendant is considered indigent if . . . [t]he defendant's net household income does not exceed 125% of the Poverty Guidelines . . . .").

capped at 133% of the FPL, the lowest allowable cap on Medicaid eligibility.[207] Therefore, it follows that at least 76% of system-involved youth in Texas are eligible for Medicaid.[208]

B. *The Medicaid Inmate Exclusion Policy*

Medicaid and Medicare were both proposed by President Lyndon Johnson as part of his Great Society program.[209] Though created simultaneously, the differences in how the two programs were established and subsequently viewed are illuminating. All Americans aged sixty-five and older are eligible for Medicare, which is primarily funded by the federal government.[210] Unlike Medicaid, Medicare does not involve cost-sharing with the states.[211]

Medicaid, in contrast, provides health care only to those who meet limited eligibility criteria, and it requires significant funding from the states. Entrenched in the creation of Medicaid is perceived distinction between the "deserving" and "undeserving" poor.[212] Prior to the expansion of Medicaid under the Affordable Care Act of 2010 (ACA), only families, children, pregnant women, seniors, and individuals with disabilities—the "deserving poor"—were eligible for Medicaid.[213] This distinction between who deserved assistance and who did not

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[207] *Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, *supra* note 198.

[208] In California, 92% of system-involved youth are eligible for a public defender. *Juvenile Defense – California*, JUV. JUST. GEOGRAPHY, POL'Y, PRAC. & STAT. http://www.jjgps.org/juvenile-defense/california#defense-structure [https://perma.cc/3R83-X3AQ] ("The availability of publicly reported juvenile defense data is quite limited. Most of the available data, published by state public defender agencies, highlight the number or proportion of cases that are served by indigent defense systems across the country."); *Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, *supra* note 198 (showing that the Medicaid eligibility criteria in California is one of the highest in the country at 261% of the FPL).

[209] Tomiko Brown-Nagin, *Two Americas in Healthcare: Federalism and Wars over Poverty from the New Deal–Great Society to Obamacare*, 62 DRAKE L. REV. 981, 989 (2014); *see* 42 C.F.R. § 411.4 (2024).

[210] *Budget Basics: Medicare*, PETER G. PETERSON FOUND., https://www.pgpf.org/article/medicare [https://www.perma.cc/N2KR-WQKW] (Aug. 20, 2024).

[211] *See id.*

[212] Brown-Nagin, *supra* note 209, at 995 ("[T]he public and most government officials viewed [Medicaid] as welfare rather than medical care. Precisely the opposite was true of Medicare, the insurance program for the aged. Congress furthered these dual perceptions, specifically the unfavorable view of Medicaid, with the language it used to identify each program's recipients. It allocated Medicare to 'beneficiaries,' the same designation applied to holders of private insurance. It designated those who received Medicaid as 'recipients,' like those who receive public charity.").

[213] CTR. ON BUDGET & POL'Y PRIORITIES, POLICY BASICS: INTRODUCTION TO MEDICAID (2020), https://www.cbpp.org/research/health/introduction-to-medicaid [https://perma.cc/44GR-ZN8N].

meant that less than half of individuals living in poverty in the United States were even eligible for Medicaid.[214]

The MIEP is a provision of the federal 1965 Social Security Amendments Act, forbidding "inmates of a public institution" from receiving Medicaid benefits.[215] Medicaid does not provide medical services or directly reimburse individuals; instead, it acts through state agencies to reimburse providers.[216] The federal government funds a portion of state Medicaid expenses as long as states comply with federal requirements.[217] Participation in the state–federal Medicaid partnership program is optional, but all fifty states, the District of Columbia, and the territories choose to participate, albeit at different levels of coverage.[218]

Inmates of a public institution such as a jail or prison are categorically ineligible for Medicaid unless they become a patient of a medical institution for twenty-four or more hours.[219] As discussed above, most young people involved with the juvenile legal system are income-eligible for Medicaid.[220] Yet, the inmate exception includes young people involved with the juvenile legal system.[221] Federal regulations define an inmate of a public institution as "a

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[214] Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 67, 70 (2015).

[215] The second Medicaid exclusion is the exclusion of Institutions for Mental Disease (IMD). The purpose of the IMD exclusion was to prioritize funding for community mental health facilities. Certainly, as Scholar Mira Edmonds describes, there is a relationship between the two exclusions, as the failure to build out the promised system of community mental health services has led to an increase in incarceration of individuals with mental illness and limited treatment options in the adult criminal system. Edmonds, *supra* note 30, at 286–90; *See* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS., QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) REIMBURSEMENT: FAMILY FIRST PREVENTION SERVICES ACT (FFPSA) REQUIREMENTS Q & A (2021), www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf [https://perma.cc/U95J-P6NP].

[216] ALISON MITCHELL ET AL., CONG. RSCH. SERV., R43357, MEDICAID: AN OVERVIEW 16 (2023), https://crsreports.congress.gov/product/pdf/R/R43357 [https://perma.cc/CA9R-5E57].

[217] *See* Federal Financial Participation in State Assistance Expenditures, 84 Fed. Reg. 66204, 66205, tbl.1 (Dec. 3, 2019) (illustrating state percentages of FFP).

[218] EVELYN P. BAUMRUCKER ET AL., CONG. RSCH. SERV., R48075, CONSOLIDATED APPROPRIATIONS ACT, 2024 (P.L. 118-42): MEDICAID AND MEDICARE PROVISIONS 2 (2024), https://crsreports.congress.gov/product/pdf/R/R48075 [https://perma.cc/62X7-XK4N].

[219] 42 U.S.C. § 1396d(a)(32) (providing that "medical assistance" does not include "any such payments with respect to care or services for any individual who is an inmate of a public institution . . . except as a patient in a medical institution . . . ."); *see* Edmonds, *supra* note 30, at 301 (analyzing the role of the "deserving poor" rhetoric in the creation of Medicaid and the MIEP).

[220] *See supra* Part III.A.

[221] VIKKI WACHINO, CTR. FOR MEDICAID & CHIP SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS., SHO NO. 16–007, GUIDANCE LETTER TO FACILITATE SUCCESSFUL RE-ENTRY

person who is living in a public institution" and define public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control."[222]

The ostensible purpose of the MIEP is to prevent state governments from shifting the costs of inmates' health care to the federal government; the argument is that states should pay the cost of their own criminal legal systems.[223] However, this defense of the MIEP falls apart upon recognizing the ways in which the federal government does subsidize state criminal legal systems. For example, through the Violent Offender Incarceration and Truth-in-Sentencing Incentive Formula Grant Program, $2.7 billion of federal funding was given to states to increase the capacity of their jails and prisons between 1996 and 2001.[224] It is difficult to ignore how the MIEP unjustly categorizes only some individuals living in poverty as "deserving" of assistance. Inmates were, and continue to be, viewed as "undeserving." Notably, while the ACA expanded eligibility to include "able-bodied" adults without dependent children, pushing back on earlier ideas of who deserves assistance, the MIEP remained in place.[225]

FOR INDIVIDUALS TRANSITIONING FROM INCARCERATION TO THEIR COMMUNITIES 3 (2016), https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf [https://perma.cc/A96Y-CGGW]. CMS explicitly explained in 2016 subregulatory guidance that the definition of "inmate" includes young people. "CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution." *Id.* CMS recognized that federal, state, and local authorities may "attach different names, conditions, and requirements" to the custody arrangements of detained individuals. *Id.* However, "[r]egardless of the label attached to any particular custody status," CMS emphasized an individual's "legal ability to exercise personal freedom" as a key consideration as to whether that individual is an inmate. *Id.* at 3. "The voluntary nature of the residence is critical." *Id.* at 5. Youth in secure settings are unable to exercise personal freedom to leave the detention facility. Therefore, CMS asserted that the MIEP applied and states cannot receive Medicaid funding to provide services for youth in secure settings within their juvenile legal systems. *Id.* at 3–5.

[222] 42 C.F.R. § 435.1010 (2007).

[223] Edmonds, *supra* note 30, at 286–87.

[224] BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST., REPORT TO CONGRESS: VIOLENT OFFENDER INCARCERATION AND TRUTH-IN-SENTENCING INCENTIVE FORMULA GRANT PROGRAM 1 (2012), https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/voitis-final-report.pdf [https://perma.cc/2XAM-EP9L].

[225] Edmonds, *supra* note 30, at 281–82.

C. *The Harm of Denying Medicaid to System-Involved Youth*

1. *Disrupting Care*

Continuity of care refers to the constancy of health care received, looking at either frequency of care or consistency of provider (or both).[226] This idea has long been widely regarded as critical to the provision of medical care, and research has demonstrated that continuity of care in both physical and mental health care results in improved outcomes among all demographics studied. In 1974, for example, researchers examining continuity of care with primary care physicians wrote that "the need to provide 'continuity of care' is a basic public health and medical care tenet . . . and a sine qua non to what is currently viewed as 'good' medical care."[227]

Because most incarcerated system-involved youth are eligible for Medicaid and likely do not have private health insurance, the MIEP makes continuity of care for these youth impossible. As illustrated by J.T.'s experience in the juvenile legal system, described in the introduction of this Article, disruptions in care create significant barriers to receiving effective treatment.[228] This is especially true for youth who have experienced significant trauma and may be hesitant to engage with any care provider, much less multiple new and short-term providers. Frequently being asked to establish a new—likely short-lived—therapeutic relationship is not conducive to treatment: "Relational patient-provider continuity is a core component of quality care for pediatric mental health conditions."[229] Even in geographically large states with limited detention and secure placement facilities, access to Medicaid funding for mental health treatment can still allow for continuity of care through the use of technology.

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[226] JP Sturmberg, *Continuity of Care: Towards a Definition Based on Experiences of Practising GPs*, 17 FAM. PRAC. 16, 16 (2000) (explaining that despite its widely accepted importance, there is no universal definition of medical "continuity of care").

[227] Marshall H. Becker, Robert H. Drachman & John P. Kirscht, *A Field Experiment to Evaluate Various Outcomes of Continuity of Physician Care*, 64 AM. J. PUB. HEALTH 1062, 1062 (1974).

[228] *See supra* notes 17–28 and accompanying text.

[229] Dinci Pennap et al., *Continuity of Care and Mental Health Service Use Among Medicaid-Enrolled Youths*, 58 MED. CARE 199, 206 (2020); Thomas L. Hafemeister, *Parameters and Implementation of a Right to Mental Health Treatment for Juvenile Offenders*, 12 VA. J. SOC. POL'Y & L. 61, 69–70 (2004) (noting that failure to address the mental health needs of juvenile offenders can bring about severe, long-term adult psychiatric problems such as "anxiety, depression, substance use, antisocial personality, mania, schizophreniform, and eating disorders").

Researchers have found that virtual participation in therapy, including family therapy, can be just as effective as in-person therapy.[230]

The lack of access to continuity in treatment is profoundly detrimental to system-involved youth. Research from the family regulation system demonstrates the harm.[231] A 2015 study of continuity of care in mental health services for youth with "serious emotional disturbances"[232] in the family regulation system found that youth with continuity of care were seven times more likely to receive monthly treatment, demonstrating "the importance of having a usual source of care, particularly a relationship with the same provider to promote ongoing continuity of care."[233] Additionally, this study identified frequent changes in placement and the resulting fragmented medical records as significant barriers to consistent care.[234] Youth in the juvenile legal system face this same barrier.[235] Additionally, a 2019 study examining continuity of care and mental health care among youth enrolled in Medicaid found that "patients who saw the same providers over multiple episodes of care had significantly lower odds of experiencing symptom exacerbation that warranted hospitalization."[236] Not only is this better for youth, but providing continuity of care reduces the cost of unnecessary hospitalizations.

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[230] Aurelie M.C. Lange, Sajid Humayun & Tom Jefford, *The Feasibility of Providing Remote Functional Family Therapy with Adolescents During the COVID-19 Pandemic: A Mixed-Method Study*, 52 CHILD & YOUTH CARE F. 441, 461 (2022) (finding that, although therapists did experience challenges while conducting Functional Family Therapy virtually, the researchers "did not find any indication that teletherapy would be less effective than in-person therapy. On the contrary, we found that a mix of remote and in-person was related to lower drop-out rates and better outcomes").

[231] In addition to a high number of youths involved in both systems, there are similarities between these two groups. For example, much like in the juvenile legal system, as many as 80% of youth in the family regulation system have a diagnosable mental illness. Barbara J. Burns et al., *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*, 43 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 960, 961 (2004).

[232] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CTR. FOR BEHAVIORAL HEALTH STAT. & QUALITY, SERIOUS EMOTIONAL DISTURBANCE (SED) EXPERT PANEL MEETINGS: SUMMARY OF PANEL DISCUSSIONS AND RECOMMENDATIONS 1–2 (2014) (discussing what mental disorders should be included in the definition of SED).

[233] Cynthia A. Fontanella, Lipi Gupta, Danielle L. Hiance-Steelesmith & Sedona Valentine, *Continuity of Care for Youth in Foster Care with Serious Emotional Disturbances*, 50 CHILD. & YOUTH SERVS. REV. 38, 39, 41 (2015); Cynthia A. Fontanella et al., *Factors Associated with Timely Follow-Up Care After Psychiatric Hospitalization for Youths with Mood Disorders*, 67 PSYCHIATRIC SERVS. 324, 327 (2016).

[234] Fontanella, Gupta, Hiance-Steelesmith & Valentine, *supra* note 233, at 39.

[235] Medicaid coverage after leaving foster care led to significant disruptions in care. According to a 2009 study, 67% of youth in the family regulation system lose Medicaid coverage within three months, and those who regain coverage do so only after an "inordinate period of time." *Id.*

[236] Pennap et al., *supra* note 229, at 205.

Delaying or denying treatment leads to worse health outcomes. Failure to address the mental health needs of system-involved youth can result in severe psychiatric illnesses that last throughout adulthood.[237] The lack of continuous, effective mental health care exposes system-involved youth to "unnecessary suffering and increase[s] the likelihood that they continue to offend as adults."[238] Youth who do not receive appropriate treatment are more likely to reoffend.[239] A mental illness diagnosis "while involved in the system can increase youths' likelihood of recidivating or engaging in other problem behavior."[240] As a result, the gap in Medicaid coverage caused by the MIEP creates a "significant public health problem" in the juvenile legal system.[241]

2. *Overreliance on Inpatient Treatment Facilities*

Secure facilities for youth provide, at best, limited mental health treatment, and they cannot receive Medicaid funding for any treatment provided. However, Medicaid does fund certain services provided to youth committed to inpatient treatment centers, including Psychiatric Residential Treatment Facilities (PRTFs).[242] While there is no standard definition of these treatment centers, there are widely accepted commonalities among secure facilities for youth. They are highly structured inpatient facilities designed to serve individuals who require a high level of care. Critically, states can use Medicaid funding for

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[237] *See* David Lawrence & Stephen Kisely, *Inequalities in Healthcare Provision for People with Severe Mental Illness*, 24 J. PSYCHOPHARMACOLOGY 61, 61 (2010).

[238] Skolnick, *supra* note 132, at 380 n.18 (citing McDermott, *supra* note 12, at 726–29).

[239] Svetlana Yampolskaya & Emmeline Chuang, *Effects of Mental Health Disorders on the Risk of Juvenile Justice System Involvement and Recidivism Among Children Placed in Out-of-Home Care*, 82 AM. J. ORTHOPSYCHIATRY 585, 590 (2012). One study of Florida youths found that "having a conduct disorder diagnosis and a self-reported previous suicide attempt predicted subsequent recidivism to detention placement." OJJDP, INTERSECTION, *supra* note 3, at 5. Another study of almost one hundred thousand youths whose cases had been processed by the South Carolina Department of Juvenile Justice found that an early diagnosis of an aggressive disorder was the strongest predictor of recidivism. David E. Barrett, Antonis Katsiyannis, Dalun Zhang & Dake Zhang, *Delinquency and Recidivism: A Multicohort, Matched-Control Study of the Role of Early Adverse Experiences, Mental Health Problems, and Disabilities*, 22 J. EMOTIONAL & BEHAV. DISORDERS 3, 7 (2014).

[240] OJJDP, INTERSECTION, *supra* note 3, at 5.

[241] Scannell, Albertson, Ashtari & Barnert, *supra* note 4, at 39.

[242] MEGAN B. HOUSTON, CONG. RSCH. SERV., IF10222, MEDICAID'S INSTITUTION FOR MENTAL DISEASES (IMD) EXCLUSION (2023), https://crsreports.congress.gov/product/pdf/IF/IF10222 [https://perma.cc/F5UZ-TE3E]; MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID COVERAGE OF QUALIFIED RESIDENTIAL TREATMENT PROGRAMS FOR CHILDREN IN FOSTER CARE 2 (2021), https://www.macpac.gov/wp-content/uploads/2021/08/Medicaid-Coverage-of-Qualified-Residential-Treatment-Programs-for-Children-in-Foster-Care.pdf [https://perma.cc/A924-P6UH].

PRTFs.[243] As a result, many system-involved youth are sent to inpatient treatment centers, even if they do not require this high level of care.[244] This is often because there are no other options for Medicaid-funded mental health treatment for youth in secure settings.

Youth in PRTFs are often isolated from their families and communities. Despite research demonstrating the importance of engaging a youth's community in the treatment process, and despite the demonstrated efficacy of treatment models that work with youth and their communities, system-involved youth have limited access to their families while in these centers.[245] Often, states place system-involved youth in facilities requiring travel by plane.[246] Additionally, only 50% of the centers in the Center for Health Care Strategies survey contract with the youth's home state to provide services to support the transition back to the community.[247] This resulting isolation is itself a significant harm, compounded by the harm caused by the lack of continuity of care.

3. *Denial of the EPSDT Benefit and Lack of CMS Oversight in Juvenile Secure Settings*

As discussed in Part II, it remains an open question what constitutional right to care applies to system-involved youth in secure facilities. Allowing youth access to Medicaid in secure juvenile facilities would provide an avenue to require states to provide meaningful treatment through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The EPSDT benefit is the "gold standard coverage for children,"[248] requiring states to provide periodic screenings and all medically necessary services to individuals under the age of twenty-one, even if their state's Medicaid program does not cover such

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[243] CTR. FOR HEALTH CARE STRATEGIES, HOW CAN MEDICAID SUPPORT THE TREATMENT COSTS FOR YOUTH IN RESIDENTIAL PROGRAMS? 2 (2020), https://www.casey.org/media/20.07-KM-LFOF-Residential-reimbursement_fnl.pdf [https://perma.cc/QVX9-9LPZ] ("States primarily use Medicaid to pay for residential treatment for Inpatient Psychiatric Services for individuals under age 21 . . . .").

[244] KAMALA D. ALLEN, SHEILA A. PIRES & JONATHAN BROWN, CTR. FOR HEALTH CARE STRATEGIES, INC., SYSTEM OF CARE APPROACHES IN RESIDENTIAL TREATMENT FACILITIES SERVING CHILDREN WITH SERIOUS BEHAVIORAL HEALTH NEEDS 1–3 (2010), https://www.chcs.org/media/System_of_Care_Approaches_in_RTFs.pdf [https://perma.cc/ERN9-WH8H].

[245] *See* Paul Lanier et al., *A Systematic Review of the Effectiveness of Children's Behavioral Health Interventions in Psychiatric Residential Treatment Facilities*, CHILD. & YOUTH SERVS. REV. Mar. 20, 2020, Article No. 104951, at 2.

[246] *See* David Jackson & Duaa Eldeib, *Thousands of Foster Children Were Sent out of State to Mental Health Facilities Where Some Faced Abuse and Neglect*, PROPUBLICA (Mar. 11, 2020), https://www.propublica.org/article/illinois-dcfs-children-out-of-state-placements [https://perma.cc/TS8Y-42RD].

[247] ALLEN, PIRES & BROWN, *supra* note 244, at 8.

[248] Jane Perkins & Sarah Somers, *Medicaid's Gold Standard Coverage for Children and Youth: Past, Present, and Future*, 30 ANNALS HEALTH L. & LIFE SCIS. 153, 153 (2021).

services.[249] The goal of EPSDT is a financial one: Medicaid's focus on early identification, prevention, and treatment aims to "reduce health care costs across an individual's lifespan."[250] Since establishing EPSDT in 1967, Congress has amended the requirement many times to emphasize Congress' intent for EPSDT to be "implemented aggressively."[251] For example, in the 1981 amendment, Congress added a requirement that states must inform all Medicaid recipients under the age of twenty-one of this benefit and provide or arrange for screening and treatment services under it.[252] The requirements of EPSDT are far-reaching, extending far beyond what Medicaid requires for adults.

EPSDT includes "[a]ll mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults."[253] Since the 1984 amendment, this provision includes providing resources that reduce barriers to screening and treatment. State Medicaid agencies must assist with identifying treatment providers, scheduling appointments, and providing transportation assistance as necessary.[254]

As discussed in Part II.D., there are limited requirements for states to provide mental health treatment in the juvenile legal system. Treatment requirements under the EPSDT, meanwhile, are firmly established. Denying system-involved youth access to Medicaid denies these youth access not only to the EPSDT benefits but also to private enforcement of the EPSDT mandate. Private enforcement has been essential to improvements in implementing EPSDT. Litigation began in the 1970s as families and children asked courts to require states to actually create policies establishing the provision of EPSDT benefits.[255] These efforts succeeded, and litigation then turned to the provision of these services, ensuring that they were more than just policies on paper.[256] Courts have clarified that the EPSDT benefit is a "proactive" benefit. As the

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[249] JANE PERKINS & AMANDA AVERY, NAT'L HEALTH L. PROGRAM, FACT SHEET EPSDT LITIGATION TRENDS & DOCKET 1, 2 (2023), https://healthlaw.org/resource/epsdt-litigation-trends-and-annotated-docket [https://perma.cc/G9CG-7DQ5].

[250] CINDY MANN, U.S. DEP'T OF HEALTH & HUM. SERVS., PREVENTION AND EARLY IDENTIFICATION OF MENTAL HEALTH AND SUBSTANCE USE CONDITIONS 1 (2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-27-2013.pdf [https://perma.cc/JL47-RY6R]. The goal of EPSDT is to ensure that youth enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions—"the right care to the right child at the right time in the right setting." CTRS. FOR MEDICARE AND MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS., EPSDT - A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS 1, 36 (2014).

[251] Perkins & Somers, *supra* note 248, at 153–54.

[252] *See* 42 U.S.C. § 1396a(a)(43) (originally codified at 42 U.S.C. § 1396a(a)(44) (1981)).

[253] PERKINS & AVERY, *supra* note 249, at 2.

[254] 42 C.F.R. § 441.56 (2025).

[255] Stanton v. Bond, 504 F.2d 1246, 1246 (7th Cir. 1974).

[256] Frew v. Gilbert, 109 F. Supp. 2d 579, 588 (E.D. Tex. 2000); Salazar v. District of Columbia, 954 F. Supp. 278, 281 (D.D.C. 1996).

Ninth Circuit declared, "[T]he ultimate responsibility to ensure treatment remains with the state."[257] System-involved youth do not have access to these services, and, therefore, they do not have the right to enforce them.

Additionally, denying system-involved youth Medicaid coverage denies them CMS oversight. While imperfect, this monitoring would provide additional protections for system-involved, Medicaid-eligible youth. For example, CMS oversees the minimum health and safety standards that providers participating in Medicaid must meet. No such requirements exist in the juvenile legal system.[258]

The majority of youth involved in the juvenile legal system are eligible for Medicaid. However, CMS' categorization of youth as inmates prohibits the use of Medicaid funding for youth in secure facilities. This denial causes significant harm to affected youth as a result of a lack of continuity of care and an overreliance on psychiatric residential treatment facilities. Furthermore, this denial prevents youth in secure facilities from accessing EPSDT benefits and CMS oversight.

IV. CHILDREN ARE NOT INMATES

Categorizing children as inmates is incongruent with the rehabilitative philosophy of the juvenile legal system and *parens patriae*. This categorization is more than just harmful rhetoric; categorizing children as inmates results in significant harm to some of our country's most marginalized youth. This Part explores a path forward by first examining why current and proposed reforms remain insufficient. This Part then demonstrates that the language of the MIEP does not require the categorization of youth as inmates. Finally, this Part ends by calling for CMS to stop categorizing youth as inmates.

A. *Current Reform Efforts Are Not Sufficient*

Legislators have introduced several bipartisan proposals to expand access to Medicaid to incarcerated individuals. Unfortunately, all of these reform efforts are too limited in scope. Recognizing that kids are different, the proposed reforms suggest differing approaches to the MIEP exclusion in the adult criminal and the juvenile legal systems. Yet, none of the proposals would fully address the harm caused by the MIEP in either system. This Subpart begins by detailing how legislative reform efforts advocating for suspension versus termination of Medicaid are insufficient. Next, this Subpart details the MIEP

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[257] Katie A. *ex rel.* Ludin v. Los Angeles County, 481 F.3d 1150, 1159 (9th Cir. 2007).

[258] Winkelman, Young & Zakerski, *supra* note 29 ("Hospitals and clinics in the civilian sector that receive federal funding from Medicaid must abide by guidelines set by the Center for Medicaid & Medicare Services. Prisons and jails don't. Repealing the exclusion policy would improve the quality of care provided in jails and prisons because they would have to adhere to federal health care standards.").

proposals exclusively for the juvenile legal system, again identifying why they are not sufficient. Finally, this Subpart ends by discussing another opportunity to increase Medicaid access in the juvenile legal system—Section 1115 waivers—and why this, too, is insufficient.

1. *Legislative Efforts*

The expansion of Medicaid eligibility as a result of the ACA[259] has called attention to the significant harms caused by denying Medicaid to incarcerated adults.[260] This harm is not just to the individuals, but also to both state and federal budgets.[261] Ninety-five percent of all adult inmates will ultimately return to their communities.[262] The disruption in medical coverage caused by the MIEP negatively "influence[s] key health and social outcomes associated with recidivism."[263] Higher rates of recidivism are costly. In addition, because of limited access to quality medical care—including mental health treatment—while incarcerated, individuals returning to their communities often have untreated or undertreated medical needs.[264] Predictably, delayed health care is

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[259] LAURA HARKER & BREANNA SHARER, CTR. ON BUDGET AND POL'Y PRIORITIES, MEDICAID EXPANSION: FREQUENTLY ASKED QUESTIONS 1 (2024), https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions-0 [https://perma.cc/53KJ-BP5S].

[260] Sarah Wang, *Prison Health Care Is Broken Under the Medicaid Inmate Exclusion Policy*, BILL OF HEALTH (Jan. 26, 2022), https://blog.petrieflom.law.harvard.edu/2022/01/26/medicaid-inmate-exclusion-policy [https://perma.cc/CHR8-BGN4]. In addition, the Medicaid expansion under the ACA has most dramatically impacted childless adults. Lindsey Rose Bullinger, Kosali Simon & Brownsyne Tucker Edmonds, *Coverage Effects of the ACA's Medicaid Expansion on Adult Reproductive-Aged Women, Postpartum Mothers, and Mothers with Older Children*, 26 MATERNAL & CHILD HEALTH J. 1104, 1107 (2022). Given the disproportionate number of incarcerated Black men that do not claim dependents, repealing the MIEP is also a racial justice issue.

[261] *See Report: Federal Policy on Inmate Health Care Leads to Poor Health Outcomes and Increased Likelihood of Reoffending*, NAT'L ASS'N OF CNTYS. (Mar. 2, 2020), https://www.naco.org/resources/press/report-federal-policy-inmate-health-care-leads-poor-health-outcomes-and-increased [https://perma.cc/4KTX-EH58] (noting that MIEP results in increased recidivism); Christopher Zoukis, *The Cost of Recidivism: Victims, the Economy, and American Prisons*, ZOUKIS CONSULTING GRP. (Feb. 10, 2014), https://federalcriminaldefenseattorney.com/cost-recidivism-victims-economy-american-prisons [https://perma.cc/4CPH-VZVF] (noting that recidivism is costly).

[262] NAT'L ASS'N OF CNTYS. & NAT'L SHERIFFS' ASS'N, NACO-NSA JOINT TASK FORCE REPORT: ADDRESSING THE FEDERAL MEDICAID INMATE EXCLUSION POLICY (2020), https://www.naco.org/sites/default/files/documents/NACo-NSA-Report-FINAL-v3.pdf [https://perma.cc/HL73-RH4N].

[263] Elaine Michelle Albertson, Christoper Scannell, Neda Ashtari & Elizabeth Barnert, *Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration*, 110 AM. J. PUB. HEALTH 317, 317 (2020).

[264] *See* Ingrid A. Binswanger et al., *Release from Prison — A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 164–65 (2007).

linked to "worse health outcomes and more costly care."[265] This understanding has led to growing bipartisan support for changes to the MIEP.[266] Legislative attempts to reform the MIEP range from eliminating the MIEP altogether to providing only limited access to Medicaid prior to reentry.[267] While bills exclusively focused on reforming the MIEP have failed,[268] some MIEP reform has been successful as part of larger legislation.[269] As discussed below, however, these reforms are too limited.

2. *Kids Are Different: MIEP Reforms Within the Juvenile Legal System*

Again highlighting the widespread understanding that the juvenile legal system is distinct from the adult criminal legal system, there are additional MIEP reform efforts focused exclusively on the juvenile legal system. In 2018, Congress passed, and the President signed, the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Community (SUPPORT) Act.[270] In addition to increasing the availability of federal Medicaid funding for the treatment of substance use disorders generally, the SUPPORT Act includes an explicit requirement prohibiting states from terminating system-involved youths' Medicaid while in secure facilities.[271] Instead, states are required to suspend, not terminate, Medicaid for eligible

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[265] Alexander Thomas et al., *Forgone Medical Care Associated with Increased Health Care Costs Among the U.S. Heart Failure Population*, 9 J. AM. COLL. CARDIOLOGY: HEART FAILURE 710, 711 (2021).

[266] Blaire Bryant, *Bipartisan Legislation Introduced in House and Senate to Address Medicaid Inmate Exclusion Policy*, NAT'L ASS'N OF CNTYS. (May 9, 2023), https://www.naco.org/blog/bipartisan-legislation-introduced-house-and-senate-address-medicaid-inmate-exclusion-policy [https://perma.cc/Z3DQ-78TU].

[267] The Humane Correctional Health Care Act would eliminate the MIEP altogether. S. 1820, 118th Cong. (2023). It has been introduced multiple times, first in 2019 with sixteen cosponsors (including two Republicans), H.R. 4141, 116th Cong. (2019), again in 2021, S. 1821, 117th Cong. (2021), and again in June of 2023, S. 1820, 118th Cong. (2023). In 2021, Senator Tammy Baldwin introduced a bipartisan Medicaid Reentry Act that would have allowed states to receive federal funding for Medicaid services thirty days prior to release. S. 285, 117th Cong. (2021); Due Process Continuity of Care Act, H.R. 3074, 118th Cong. (2023).

[268] *See* H.R. 4141; *see also* S. 2305, 116th Cong. (2019); H.R. REP. NO. 116-713, at 277 (2020) (discussing the Greater Mental Health Access Act, H.R. 4428, 116th Cong. (2020)).

[269] SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, §1001, 132 Stat. 3894, 3900 (2018).

[270] *Id.*; H.R. 6, 115th Cong. (2018) (enacted).

[271] ANNE MARIE COSTELLO, U.S. DEP'T OF HEALTH & HUM. SERVS., SMD 23-002, IMPLEMENTATION OF AT-RISK YOUTH MEDICAID PROTECTIONS FOR INMATES OF PUBLIC INSTITUTIONS (SECTION 1001 OF THE SUPPORT ACT) 1 (2021) (prohibiting "states from terminating Medicaid eligibility for 'eligible juveniles'").

youth.[272] Although guidance from CMS had previously clarified that states were permitted to suspend an inmate's Medicaid rather than fully terminate Medicaid, nothing had required states to suspend rather than terminate coverage for young people in secure settings within the juvenile legal system[273]—that is, until the SUPPORT Act.[274]

The SUPPORT Act could have gone further and mandated that the MIEP no longer apply to youth in the juvenile legal system. Unfortunately, the SUPPORT Act did not extend Medicaid-funded care: "The SUPPORT Act does not make any changes to this payment exclusion, which takes effect upon a beneficiary becoming an inmate of a public institution."[275]

More significant legislative changes occurred with the Consolidated Appropriations Act of 2023 (CAA), but these were too limited. The CAA contained the Strengthening Public Health Act of 2022, which requires that Medicaid coverage be made available to system-involved youth—but only some youth.[276] Specifically, this Act allows for two exceptions to the MIEP. First, as of January 1, 2025, all system-involved youth, regardless of whether they meet the CMS definition of "inmate," have access to services that fall under the Early Periodic Screening Diagnostic and Treatment (EPSDT) requirements, beginning thirty days prior to their release.[277] States are required to have plans

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[272] *Id.* at 5 (detailing the suspension versus termination requirement); MARYBETH MUSUMECI & JENNIFER TOLBERT, KAISER FAM. FOUND., FEDERAL LEGISLATION TO ADDRESS THE OPIOID CRISIS: MEDICAID PROVISIONS IN THE SUPPORT ACT 2 (2018).

[273] WACHINO, *supra* note 221, at 3.

[274] SUPPORT for Patients and Communities Act §1001; Subsequently, the Consolidated Appropriations Act of 2024 extended this requirement to all incarcerated individuals. That the first such requirement was in a distinct piece of legislation and focused exclusively on juveniles demonstrates that legislators see young people as distinct from adults. *See* BAUMRUCKER ET AL., *supra* note 218, at 9.

[275] COSTELLO, *supra* note 271, at 3.

[276] Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, Pub. L. 117-328, § 5121, 136 Stat. 5627, 5942.

[277] EDWIN PARK, ANNE DWYER, TRICIA BROOKS, MAGGIE CLARK & JOAN ALKER, CONSOLIDATED APPROPRIATIONS ACT, 2023: MEDICAID AND CHIP PROVISIONS EXPLAINED 8 (2023). In the case of an individual who is an eligible juvenile described in subsection (nn)(2) and is within thirty days of the date on which such eligible juvenile is scheduled to be released from a public institution following adjudication, the State shall have in place a plan, and in accordance with such plan, provide for

> (i) in the 30 days prior to the release of such eligible juvenile from such public institution (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with such institution, any screening or diagnostic service which meets reasonable standards of medical and dental practice, as determined by the State, or as indicated as medically necessary, in accordance with paragraphs (1)(A) and (5) of section 1905(r), including a behavioral health screening or diagnostic service; and

in place demonstrating how the EPSDT requirements will be met and how they will provide targeted case management during both the thirty days prior to release and the thirty days following release.[278] Second, states have the option to provide Medicaid coverage to youth during the period of time pending adjudication of their case. Previously, the MIEP prohibited youth from receiving such coverage.[279] While this is a significant change and would have allowed youth like J.T. to have continuity of care, it does not address the full scope of the problem and instead creates significant administrative burdens.[280]

These exceptions to the MIEP in the Strengthening Public Health Act are included in Subtitle C, Medicaid and CHIP Mental Health.[281] This is noteworthy for a couple of reasons. First, implicit in this exception being placed within the mental health subtitle is an understanding of the significant role of mental health and mental illness in the juvenile legal system. While not outright conceding that "[t]here is growing reliance on local correctional facilities to provide

> (ii) in the 30 days prior to the release of such eligible juvenile from such public institution, and for at least 30 days following the release of such eligible juvenile from such institution, targeted case management services, including referrals for such eligible juvenile to the appropriate care and services available in the geographic region of the home or residence of such eligible juvenile (where feasible).

Strengthening Public Health Act of 2022 § 5121, 136 Stat. at 5941–42.

[278] *Id.*

[279] 42 U.S.C. § 1396d(A); WACHINO, *supra* note 221, at 3–5. A 2023 report from the Georgetown University Health Policy Institute's Center for Children and Families observed the following:

> Under section 5121 of the Consolidated Appropriations Act, starting January 1, 2025, state Medicaid and CHIP programs are required to have a plan in place and in accordance with such plan provide: (1) in the 30 days prior to release, or within one week or soon as practicable after release, certain screenings and diagnostic services in accordance with Early Periodic Screening Diagnostic and Treatment (EPSDT) requirements, including behavioral health screenings or diagnostic services to eligible juvenile youth in public institutions and (2) in the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services. The Consolidated Appropriations Act also makes Medicaid federal financial participation available under the provision for these activities. Section 5121(c) of the Act also aligns CHIP rules with existing Medicaid rules regarding suspension rather than termination of coverage while a child is an inmate of a public institution and related requirements regarding redeterminations of coverage. These provisions could be particularly helpful for youth in the juvenile justice system who are more likely to have mental health needs.

PARK, DWYER, BROOKS, CLARK & ALKER, *supra* note 277, at 8 (footnotes omitted).

[280] *See* PAMELA HERD & DONALD MOYNIHAN, HEALTH AFFS., HOW ADMINISTRATIVE BURDENS CAN HARM HEALTH 1 (2020), https://www.healthaffairs.org/do/10.1377/hpb20200904.405159 [https://perma.cc/R446-YHSY].

[281] *See generally* PARK, DWYER, BROOKS, CLARK & ALKER, *supra* note 277.

necessary [mental health] treatment for our youth,"[282] including this exception in the mental health subtitle acknowledges the mental health crisis within the juvenile legal system. Second, providing these exceptions for youth who likely meet diagnostic criteria for mental illnesses reinforces the distinction between the "deserving" and "undeserving" poor. That such a distinction still matters is further evidenced by the second exception, which allows states to receive federal funding for Medicaid services for youth only before adjudication. Once a system-involved youth has been found to be involved in crime, and as a result, arguably less "deserving," this funding exception no longer applies.[283]

3. *Section 1115 Waivers*

California has had success in increasing access to Medicaid for inmates through Medicaid's Section 1115 demonstration waivers, and other states are following suit.[284] Section 1115 was added to the Social Security Act in 1962 to "test out new ideas and ways of dealing with the problems of public welfare recipients."[285] It provides that the Secretary of Health and Human Services may "waive compliance with any of the requirements" of certain sections of the Act "[i]n the case of any experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives" of the program.[286] "Under Section 1115, the HHS Secretary can waive almost any Medicaid state plan requirement . . . to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program."[287]

The District of Columbia and Illinois were the first to seek Section 1115 waivers to waive part of the MIEP: D.C. in 2019 and Illinois in 2018.[288] Unfortunately, both waivers were denied, and the decision letters did not give

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[282] NAT'L ASS'N OF CNTYS. & NAT'L SHERIFFS' ASS'N, *supra* note 262.

[283] *See* Consolidated Appropriations Act of 2023, 136 Stat. at 5942.

[284] *See Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Dec. 19, 2024), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state [https://perma.cc/4J2R-AQY6].

[285] S. Rep. No. 87-1589, at 19–20 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961–62, 1962 WL 4692. The Social Security Act was then amended to include Medicaid and Medicare in 1965. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286.

[286] 42 U.S.C. § 1315(a).

[287] *Section 1115 Research and Demonstration Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (June 24, 2019), https://www.macpac.gov/subtopic/section-1115-research-and-demonstration-waivers [https://perma.cc/NR9K-GK4X].

[288] Letter from Seema Verma, Adm'r, U.S. Dep't of Health & Hum. Servs., to Melisa Byrd, Senior Deputy Dir. & State Medicaid Dir., Dep't of Health Care Fin. 1 (Nov. 5, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/behavioral-health-transformation/dc-behavioral-health-transformation-cms-appvl-11062019.pdf [https://perma.cc/3Z3X-MQ7G]; Letter from Seema Verma, Adm'r, U.S. Dep't of Health & Hum. Servs., to Felicia F. Norwood, Director, Ill. Healthcare & Fam. Servs. 1 (May 7, 2018) (on file with the *Ohio State Law Journal*).

any reason.[289] Then, in 2023, California made history when it became the first state to get approval to waive the MIEP ninety days prior to release for inmates with certain medical diagnoses.[290] In April 2023, the Department of Health and Human Services, through CMS, issued new guidance encouraging states to apply for similar Section 1115 waivers in response to a stakeholder working group convened as part of the SUPPORT Act.[291] As of October 2024, twenty-five states submitted similar waivers; eleven have been approved.[292] While this rapid increase in access to Medicaid for individuals in secure facilities is promising, demonstrating a recognition of the importance of increasing Medicaid coverage for individuals involved in both the adult criminal and juvenile legal systems, the current waivers limit coverage to only the reentry period.[293]

B. *Limited Access to Medicaid-Funded Services Is Not Enough*

While the exceptions discussed above are important, they do not solve all of the problems created by the MIEP in the juvenile legal system, and they create implementation confusion and increased administrative costs. System-involved youth must have access to Medicaid-funded treatment throughout their involvement with the system. The lack of meaningful care requirements, disruption in continuity of care, and the ultimate negative impacts on health outcomes are not resolved with limited, short-term coverage. Equally problematically, this system of allowing care for some youth during certain periods of time in a secure setting becomes a logistical nightmare.[294] First, youth are often committed for indeterminate lengths of time; their release date is affected by many factors, including the availability of spaces in community-based placements and determinations by the juvenile legal system agency of their rehabilitation progress.[295] Determining an exact release date can be nearly impossible. Second, even if release dates were certain, providing Medicaid

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[289] Letter from Seema Verma to Felicia F. Norwood, *supra* note 288, at 2.

[290] Blaire Bryant, *CMS Approves First-Ever MIEP Waiver for the State of California*, NAT'L ASS'N OF CNTYS. (Feb. 27, 2023), https://www.naco.org/news/cms-approves-first-ever-miep-waiver-state-california#:~:text=On%20January%2026%2C%20the%20U.S.,connect%20justice%2Dinvolved%20people%20in [https://perma.cc/TQ7G-RPG7].

[291] DANIEL TSAI, U.S. DEP'T OF HEALTH & HUM. SERVS., SMD 23-003, OPPORTUNITIES TO TEST TRANSITION-RELATED STRATEGIES TO SUPPORT COMMUNITY REENTRY AND IMPROVE CARE TRANSITIONS FOR INDIVIDUALS WHO ARE INCARCERATED 1–2 (2023).

[292] *See Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, *supra* note 284.

[293] *Id.*

[294] *See generally*, *e.g.*, HERD & MOYNIHAN, *supra* note 280; *see* U.S. OFF. OF MGMT. & BUDGET, STRATEGIES FOR REDUCING ADMINISTRATIVE BURDEN IN PUBLIC BENEFIT AND SERVICE PROGRAMS 1 (2022), https://bidenwhitehouse.archives.gov/wp-content/uploads/2022/12/BurdenReductionStrategies.pdf [https://perma.cc/5UU9-TDEG].

[295] Rabindra Bhattarai, *Sentencing in the Realm of Juvenile Justice*, 7 NAT'L JUD. ACAD. NEPAL L.J. 205, 207 (2023).

coverage only during the reentry period would create significant implementation challenges. Juvenile legal services agencies accessing federal Medicaid funding would need to create two different systems of care, one for those not in the reentry period created and another funded by Medicaid, resulting in substantial administrative burdens.[296]

C. *CMS' Categorization of Children as Inmates Is Inappropriate*

Juvenile legal systems and Medicaid agencies did not always include children in their definitions of "inmate." Prior to CMS' 2016 guidance explicitly categorizing youth as inmates, some states excluded juveniles from the MIEP not through Section 1115 waivers but through an alternate interpretation of the language of the MIEP. This Subpart begins by examining the language of the MIEP and how it has historically been interpreted to exclude juveniles, demonstrating that the language itself does not require categorizing youth as inmates. This Subpart then asserts that CMS can, and should, change its categorization of youth as inmates.

1. *The Language of the MIEP*

A 2003 study of juvenile legal systems found that 58% of local agencies used Medicaid to pay for at least some physical or mental health services for juvenile detainees.[297] Fifty-four percent of state Medicaid agencies reported that they were aware of this use of Medicaid funding.[298] It is unlikely that the majority of local juvenile legal system agencies and their state Medicaid agencies were knowingly violating the MIEP. Instead, it seems states largely assumed that the MIEP did not apply to juveniles.

The language in the Social Security Act and its implementing regulations demonstrate the ambiguity. The Social Security Act provides,

> (a) The term "medical assistance" means payment of part or all of the cost of the following care and services . . . or both . . .
> (32) . . . such term does not include—

[296] Just suspending (and not terminating) Medicaid coverage has resulted in a significant administrative burden. *See* HERD & MOYNIHAN, *supra* note 280, at 2. Actually identifying and providing Medicaid-funded care would only increase that burden. *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 2, at 5 (discussing how suspending Medicaid benefits requires significant coordination).

[297] Alison Evans Cuellar, Kelly J. Kelleher, Jennifer A. Rolls & Kathleen Pajer, *Medicaid Insurance Policy for Youths Involved in the Criminal Justice System*, 95 AM. J. PUB. HEALTH 1707, 1710 (2005).

[298] *Id.*

> (A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution . . .).[299]

The implementing regulations define an inmate as "a person who is living in a public institution"[300] with some exceptions: for example, the regulations include an exception for certain childcare institutions.[301] Given that the juvenile legal system was founded on the power of *parens patriae*, it would seem appropriate for this exception to apply to the care of youth determined to be in need of rehabilitation. However, the regulations explicitly state that "child-care" does not include "detention facilities . . . or any other facility operated primarily for the detention of children who are determined to be delinquent."[302] Two additional exceptions to the inmate definition, however, are not explicitly barred from being applied to "detention facilities." The regulations also exclude "[a]n individual . . . in a public educational or vocational training institution for purposes of securing education or vocational training"[303] and individuals in a "public institution for a temporary period pending other arrangements appropriate to his needs."[304]

2. *Children as Children in New Mexico*

In Bernalillo County, New Mexico, the juvenile legal system agency interpreted the "temporary period" exception as applicable to youth in secure facilities.[305] In 2002, the agency opened a Medicaid-funded mental health clinic for system-involved youth, both those in the community and those in secure settings.[306] This clinic received significant publicity, becoming the focus of case studies by the National Association of Counties[307] and the Annie E. Casey Foundation.[308] Given the unique nature of the juvenile legal system and the

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[299] 42 U.S.C. §1396d(a).

[300] 42 C.F.R. § 435.1010 (2025). A public institution is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." *Id.*

[301] *Id.*

[302] *Id.*

[303] *Id.*

[304] *Id.*

[305] MENDEL, *supra* note 180, at 11.

[306] *Id.* at 13.

[307] *See, e.g.*, Nastassia Walsh, *Bernalillo County, NM Takes Control of Behavioral Health System*, NAT'L ASS'N OF CNTYS. (July 8, 2015), https://www.naco.org/blog/bernalillo-county-nm-takes-control-behavioral-health-system [https://perma.cc/2G3V-DY8Q].

[308] *See generally* MENDEL, *supra* note 180.

relatively short average length of stay, forty days,[309] Bernalillo County applied 42 C.F.R. § 435.1010(b), the "temporary period" exception, to the MIEP.[310] New Mexico's Human Services Department agreed and allowed the clinic to bill Medicaid for the first sixty days a youth was in a secure setting.[311] After the creation of the clinic, recidivism dropped among youth with identified "mental health problems" from 88% to 33%.[312] The program was working. In 2008, *Youth Today* advocated for other states to adopt Bernalillo County's application of the MIEP in an article titled *Medicaid's Buried Treasure for Juvenile Justice*.[313] By 2015, however, the state of New Mexico prohibited billing Medicaid for services provided to juveniles in secure facilities.[314] The New Mexico Human Services Department issued a Supplement in August 2015 clearly stating that "Short Term Medicaid for Incarcerated Individuals" (STMII) covered only inpatient treatment at a hospital "outside of the inmate's incarcerated facility."[315] Juveniles awaiting disposition were explicitly identified as included in the STMII and the MIEP.[316]

Around the same time, Ohio challenged the application of the MIEP to its juvenile legal system. In 2014, Ohio sought approval for an amendment to its State Plan that would explicitly identify "any individual under age 19 who is residing in a juvenile detention facility and has not yet been adjudicated" as excluded from the definition of "inmate."[317] CMS denied the amendment, noting that there was no difference in the state's application of the MIEP between juveniles and adults.[318] The case ultimately went to the Court of

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309 KIM GODFREY LOVETT, PERFORMANCE-BASED STANDARDS LEARNING INST., WHAT WE KNOW ABOUT LENGTH OF STAY IN SECURE FACILITIES 2 (2022), https://ojp.gov/library/publications/pbs-data-snapshot-what-we-know-about-length-stay-secure-facilities [https://perma.cc/68QY-N2QH].

310 *See* MENDEL, *supra* note 180, at 11.

311 *See id.*; WALSH, *supra* note 307.

312 *See* Kelly, *supra* note 184.

313 *Id.*

314 This occurred shortly after a 2013 audit of Medicaid payments to behavioral health organizations in New Mexico. The audit identified overbilling and possible fraud, and it included several recommendations moving forward. PUB. CONSULTING GRP. & N.M. HUM. SERVS. DEP'T, BEHAVIORAL HEALTH PROVIDER AUDITS 1 (2013), https://www.nmlegis.gov/handouts/LHHS%20070113%20Item%2023%20State%20of%20NM%20Behavioral%20Health%20Provider%20Audits%20%E2%80%93%20Executive%20Summary.pdf [https://perma.cc/4FRC-W59X]. One of the recommendations was to "[r]eview and revamp New Mexico's behavioral health provider billing rules and regulations." *Id.* at 11; NANCY SMITH-LESLIE, N.M. HUM. SERVS. DEP'T, SUPPLEMENT NO. 15-07 (2015), https://www.hca.nm.gov/wp-content/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Short-Term-Medicaid-for-Incarcerated-Individuals-8_14.pdf [https://perma.cc/KVJ3-FPGA].

315 SMITH-LESLIE, *supra* note 314, at 2.

316 *Id.* at 1–2.

317 Notice of Hearing: Reconsideration of Disapproval Ohio Medicaid State Plan Amendment (SPA) 14-002, 79 Fed. Reg. 71786, 71786 (Dec. 3, 2014).

318 Ohio Dep't of Medicaid v. Price, 864 F.3d 469, 473 (6th Cir. 2017).

Appeals for the Sixth Circuit.[319] In July 2017, the Sixth Circuit held that CMS' decision to deny pretrial detainees under the age of nineteen status as non-inmates was not arbitrary and capricious.[320]

New Mexico treated, and Ohio sought to treat, juveniles in a "public institution for a temporary period pending other arrangements appropriate to his needs" as not being inmates.[321] While New Mexico and Ohio focused on youth awaiting adjudication, this Article contends that this exception should apply to all youth in secure facilities. Even following the "Get Tough" Era, the purpose of the juvenile legal system in all states is, at least in part, to provide rehabilitation appropriate for the young person's needs.

D. *CMS Must Stop Categorizing Children as Inmates*

As the youth mental health crisis in this country continues, our most marginalized youth—poor youth of color with mental illnesses—will be most harmed. These youth will continue to be pushed into the juvenile legal system, a system with limited, if any, opportunity for meaningful mental health treatment. While we should continue to decrease the number of youth in secure facilities and improve access to care in the youths' own communities, it is vitally important to increase access to effective mental health treatment in secure facilities.[322] CMS' categorization of children as inmates is inconsistent with the goals of both Medicaid and the juvenile legal system, and it should be changed.

Given the urgent need, CMS should change its categorization of youth as inmates immediately instead of waiting for additional piecemeal reforms. As the litigation with Ohio was pending between 2014 and 2016, CMS issued guidance explicitly prohibiting juvenile legal systems from accessing Medicaid funding for youth in secure facilities.[323] Notably, CMS included that "an important consideration of whether an individual is an 'inmate' is his or her legal ability to exercise personal freedom."[324] This limited-personal-freedom criterion is not included in either the Social Security Act or its implementing regulations. Nothing in either the Social Security Act or the implementing regulations requires the Medicaid Inmate Exception Policy to include juveniles.[325]

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[319] *Id.* at 469.

[320] *See id.* at 472.

[321] MENDEL, *supra* note 180, at 11.

[322] Reform efforts to repeal the MIEP for all should continue given the significant harm caused by the MIEP. *See* Edmonds, *supra* note 30, at 282.

[323] *See* WACHINO, *supra* note 221, at 3.

[324] *Id.*

[325] CMS should change their categorization of youth as inmates. It is important, however, to recognize the impact of *Loper Bright* on deference to agency interpretations. *See* Loper Bright Enters. v. Raimondo, 603 U.S. 369 (2024) (holding that courts may not defer to agencies' interpretations and should use their own judgment to interpret laws, overruling

In fact, as New Mexico and Ohio argued, the regulations themselves exclude individuals in a "public institution for a temporary period pending other arrangements appropriate to his needs."[326] A youth's level of system-involvement is based on a determination of needs; in theory, the system is then supposed to meet those needs. Additionally, youth are only in secure settings for "temporary" periods. The average length of stay in a secure setting is forty days,[327] compared to 2.7 years in adult prisons.[328] While there are outliers, with some youth spending significantly more time in a secure setting, staff in the juvenile legal system should be identifying what arrangements are appropriate to the youth's needs[329] when considering the level of support and supervision that the child needs.[330] Often, youths spend longer in secure facilities than they would if other arrangements that are appropriate to their needs were identified.[331]

Alternately, or in addition, youth involved in the juvenile legal system fall under the educational and vocational training exception.[332] Youth in secure settings have a right to education.[333] Some may argue that providing educational or vocational training is not the primary purpose of the juvenile legal system. Yet, all states identify rehabilitation for youth determined to be "in need" as a primary purpose of these systems. Educational and vocational training are central parts of rehabilitation. To say otherwise—that the primary goal of the

Chevron); Although *Chevron* has been overturned, courts have frequently applied *Skidmore* deference in Medicaid cases. Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944); JANE PERKINS & SARAH SOMERS, NAT'L HEALTH L. PROGRAM, CASE EXPLAINER*: LOPER BRIGHT ENTERPRISES V. RAIMONDO* 5 (2024), https://healthlaw.org/wp-content/uploads/2024/08/Case-Explainer-Loper-Bright.August.pdf [https://perma.cc/YA3C-QGCF]. Furthermore, to be consistent with both the goals of Medicaid and the juvenile legal system, interpreting the definition of inmate to not include juveniles is, arguably, the best reading of the MIEP.

[326] PERKINS & SOMERS, *supra* note 325, at 5.

[327] LOVETT, *supra*, note 309, at 2.

[328] *Criminal Justice Budgeting: Shortening Length of Stay*, NAT'L CONF. OF STATE LEGISLATURES, https://www.ncsl.org/civil-and-criminal-justice/criminal-justice-budgeting-shortening-length-of-stay [https://perma.cc/TZB2-CTYF] (June 10, 2021).

[329] *See generally* BILCHIK, *supra* note 52.

[330] *See* statutes cited *supra* note 91.

[331] Fiza Quraishi, *Enhancing Mental Health Advocacy for Girls in the Juvenile Justice System*, NAT'L CTR. FOR YOUTH L. (Jan. 13, 2013), https://youthlaw.org/news/enhancing-mental-health-advocacy-girls-juvenile-justice-system [https://perma.cc/7PE8-2DCG].

[332] The language of the exception states, "public educational or vocational training institution for purposes of securing education or vocational training." 42 C.F.R. § 435.1010 (2025).

[333] EDUC. L. CTR., EDUCATIONAL RIGHTS OF STUDENTS IN THE JUVENILE JUSTICE SYSTEM 1–2 (2023), https://www.elc-pa.org/resource/educational-rights-of-students-in-the-juvenile-justice-system [https://perma.cc/Q75V-NJAF].

juvenile legal system is a punitive one—ignores the historical and current codified goals of the juvenile legal system.[334]

Finally, there are strong policy arguments in support of CMS amending its categorization of children as inmates, both normative and economic. Categorizing children as "inmates" does not align with the history of Medicaid or the purported rehabilitative goal of the juvenile legal system. The juvenile legal system is distinct from the adult criminal legal system. A definition that includes both adults and juveniles ignores the very goal of creating a distinct juvenile system. Despite the evolution of *parens patriae* in the juvenile legal system, the *parens patriae* power remains an important foundation of the system, providing states both the power and the obligation to provide care for youth in need. The advances in adolescent research have given juvenile legal systems, advocates, and system-involved youth and their families a greater understanding of what true care should actually look like—and it is not what is currently provided.

As discussed in Part III, for most system-involved youth, meaningful care cannot be provided without consistency in Medicaid coverage. Failing to provide consistent, evidence-based care leads to worse health outcomes for system-involved youth. This failure also limits the potential to use Medicaid-funded care to reduce recidivism, as was done in New Mexico. Placing children in secure facilities is costly; states spend between $100,000 and $500,000 annually for each youth in a secure facility.[335] To address the urgent mental health crisis, CMS should immediately issue guidance removing children from the definition of inmates in the context of the MIEP instead of waiting for an increase in Medicaid funding through legislation or Section 1115 waivers.

V. CONCLUSION

The juvenile legal system was created with a rehabilitative goal because it was well understood that children are different from adults. Even as the juvenile legal system has become more punitive, the goal of rehabilitation has remained at its core. Yet, study after study reveals that youth involved with the juvenile legal system are not "rehabilitated" and often face worse outcomes than similarly situated youth who are not involved with the system. Because of CMS' categorization of youth as "inmates," and not as youth in need of care, these children are denied access to Medicaid, the largest provider of youth mental health services in the country. Youth with mental illnesses are not receiving the

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[334] For example, in 1839, the Pennsylvania Supreme Court determined that the juvenile facility at issue was "not a prison, but a school," highlighting that the stated goal of the facility was the "reformation" of wayward youth through training and "furnishing them with means to earn a living." *Ex parte* Crouse, 4 Whart. 9, 11 (Pa. 1839).

[335] JUST. POL'Y INST., STICKER SHOCK 2020: THE COST OF YOUTH INCARCERATION 1 (2020), https://justicepolicy.org/wp-content/uploads/2022/02/Sticker_Shock_2020.pdf [https://perma.cc/YT4N-DDDV].

treatment they need while in secure settings in the juvenile legal system. Allowing system-involved youth continuous access to Medicaid-funded services would increase access to evidence-based care and improve outcomes for system-involved youth.