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Focusing on Children's Strengths: Accessing Effective Mental Health Services for Juvenile Justice-Involved Youth Through Collaboration and Understanding Federal Entitlements to Care

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Introduction

Youth involved in the juvenile justice system tend to require more access to mental health services than the general population. Between 65 and 70 percent of youth in the juvenile justice system have mental health disorders, with “at least 20 percent experiencing disorders so severe that their ability to function is significantly impaired.”¹ Many of these youth are entitled to adequate and responsive mental health services through federal programs like Medicaid’s Early Periodic Screening Diagnosis and Treatment Program (EPSDT), the Individuals with Disabilities Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973 (Section 504). Nonetheless, many youth go without critical mental health services. On an individual level, advocates can use these entitlements to secure individualized, appropriate community-based mental health services. On a systems-reform level, as jurisdictions become more attuned to trauma-informed care, they should incorporate into larger reform efforts a “system of care” approach to providing mental health services, using coordinated decision-making among state and local agencies and a team approach to providing mental health services for youth. This article seeks to highlight ways youth advocates can improve mental health outcomes for individual clients by focusing on accessing specialized services through collaboration and enforcing entitlements to care. It also discusses some ways in which court players, specifically probation officers, district attorneys, defense attorneys, and judges can play a critical role in improving access to services.

Despite entitlements to care, by and large, youth-serving systems fail to provide youth with services that address their individualized needs. There is tremendous opportunity for advocates and court players to help remedy this failure. A large part of the problem is that many of the systems that serve youth—child welfare, mental health, juvenile justice—have historically operated from a deficits-centered perspective. Youth and their families are rarely seen as part of the solution and are more often seen as part of the problem. Certainly, the default focus in the child welfare and juvenile justice system is one where the parent and child have failed. Similarly, the mental health system has long focused on deficits, diagnoses, pathologies and problem behaviors.² Services are typically delivered in a “one size fits all” approach, consisting of medication management, and individual or group therapy. These services are not individualized to meet the needs of youth and when a child does not engage with services, he or she is often blamed and labeled as a difficult client who needs a higher level of care in a restrictive setting.

Using Entitlements to Improve Access to Entitlements to Care

Children have federal entitlements to appropriate care under EPSDT, IDEA and Section 504. Often, advocates and system actors are unaware of these entitlements or how to use them to access better services. This section describes the various entitlements and provides guidance on how to use them to access specialized services.

Medicaid and EPSDT

The EPSDT program is the child health component of the Medicaid program and requires states to provide Medicaid-eligible youth and children under age 21 with any “necessary health care, diagnostic services, treatment and other measures... to correct or ameliorate defects and physical and mental illnesses and conditions discovered

through screening.”³ States are required to actively arrange for treatment, either by providing the service themselves or via referral to appropriate agencies, organizations, or individuals. “Necessary” services must be provided regardless of whether they are included in a state’s Medicaid plan.⁴

The determination that a service is medically necessary lies primarily with a youth’s treating physician or other health care provider.⁵ Recent case law has suggested that states can place limits on treatment provider discretion and can review medical necessity on a case-by-case basis, but reaffirmed that the treating physician assumes the primary responsibility for determining a child’s treatment needs.⁶ A federal district court in Illinois recently stated that “once a child has been diagnosed as requiring [mental health services, including home and community-based services] (i.e., the services have been found to be ‘medically necessary’) he or she is entitled under the law to whatever services their doctors have recommended for maximum improvement.”⁷ Given the “sweeping scope” of the EPSDT Program’s entitlement and “[b]y virtue of the statutory framework, “medically necessary” services under [this] program are those recommended by the appropriate healthcare provider.”⁸ Therefore, it is critical for advocates to work closely with a youth’s physician to develop treatment recommendation.

Often, clinicians may assess children and understand their history and needs, but when it comes time to making recommendations, they focus on what is available in the community, rather than what the child actually needs. Defense attorneys and probation officers can secure more individualized and appropriate services for children by encouraging providers to: identify specific behaviors and needs, track other services that have been tried and were insufficient, and link the recommendations to the specific need. The EPSDT entitlement is not limited to services that are available in the community to ameliorate the child’s condition. The EPSDT mandate is unequivocal; if a child needs a service to correct or ameliorate his condition, the state must provide that service, regardless of whether it is currently being provided. Focusing on how the services are necessary to “correct or ameliorate” the condition will allow the provider and advocate to make a stronger case for those services. For example, relying on a PTSD and depression diagnosis to make a recommendation for weekly therapy provides little context for what a particular child needs. While there may be certain therapies or approaches that work for youth with PTSD, a “one size fits all” approach is unlikely to have a longer-term impact for the child. However, looking at specific challenges the child faces, like having aggressive outbursts when confronted with new situations, being unable to go to school because of fear, or waking up at night in a panic and being unable to calm down, allows the clinician to make more targeted recommendations focused on providing the child with the supports he or she needs to develop the skills to enter social situations, go to school, and self soothe at night.

Once the recommendations are in writing, the EPSDT entitlement is triggered and on that basis, an advocate can push to have the services provided. The state Medicaid agency must provide an opportunity for an administrative hearing to challenge a denial of medically necessary services when a request for that service is not acted upon with reasonable promptness.⁹ Not only can advocates play a critical role in improving the recommended services, but they can enforce the entitlement to care. See

Attachment A for more tips on engaging treatment providers to advocate for individualized services.

Medicaid-Funded Individualized Home and Community-Based Services

As will be discussed *infra*, collaboration is an important component to accessing individualized services. There are some challenges to providing Medicaid services through a collaborative team approach. For example, many states do not allow providers to bill for participation in team meetings because the meetings may involve multiple providers billing for the same service for an individual client. However, in recent decades, the Medicaid Program has moved towards favoring community-based treatment over institutionalization. Since 1981, Medicaid has provided states with funding for medical care in the home and community through the 1915(b) waiver program.¹⁰ States have used the waiver to increase and provide services for children with serious medical needs, but most states have not used it as a way to provide intensive mental health services.¹¹ There is great opportunity to leverage more resources to begin providing intensive services in the community.

Additionally, over the past twenty years, the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Children's Mental Health Initiative and the Centers for Medicare and Medicaid Services' (CMS) Psychiatric Residential Treatment Facility Demonstration Project have run several pilot projects aimed at providing intensive coordinated, community-based treatment for children with serious mental health needs, including those at risk of entering a residential psychiatric facility. In May of 2013, the two federal agencies released a joint Informational Bulletin that highlights that these services are both clinically effective and cost effective, discusses various Medicaid waiver program, and provides states with resources to develop a benefits package for at risk youth.¹² The Bulletin points to many successes, including: reduced costs of care to the state, substantially improved school attendance and performance, increases in behavioral and emotional strengths, a 40% decrease in clinical symptoms, more stable living conditions, significant reductions in suicide attempts, and half the amount of contacts with law enforcement for those youth involved in the juvenile justice system.¹³

These pilot projects covered traditional services, like one-on-one individual and family therapy and medication management, but also included other home and community-based services that are provided under Medicaid. These intensive services correlated with the significant improvements in outcomes for youth. Some of the intensive home-based services included in the projects were:

1. *Intensive Care Coordination/ Wraparound Approach*, which includes "assessment and service planning, accessing and arranging for services, coordinating multiple services, including access to crisis services."¹⁴ This approach is team-based and focuses on all life domains, includes clinical interventions, and draws upon formal and informal supports.¹⁵ Wraparound is strengths-based and family-centered.
2. *Intensive In-Home Services*, which are therapeutic interventions delivered in the home and community. The services are typically developed through team

collaboration and include individual and family therapy, skills training and behavioral interventions.¹⁶

3. *Respite Services*, which provide support to primary caregivers who need relief by allowing children with serious mental health needs to temporarily stay in safe, supportive placements on a short-term basis.¹⁷ The goal of respite is to provide stability in the home.
4. *Mobile Crisis Response and Stabilization Services* are critical 24/7 services that focus on defusing and de-escalating situations that could otherwise lead to children being hospitalized or being placed out of the home. In addition to stabilizing the situation, the crisis response staff works with the child and family to identify potential triggers for future escalations and learn strategies to effectively manage future crises that may occur.¹⁸

States have significant flexibility to cover intensive services for youth with significant mental health needs. The Bulletin is an excellent resource for advocates in states and jurisdictions where such comprehensive services are not currently available because it lays out financing options to for states to begin providing services that can improve outcomes for youth while also reducing costs.

Barriers to Accessing Medicaid Services for Juvenile Justice Involved Youth

Youth in the juvenile justice system face unique barriers to getting adequate care. Often, youth with unmet mental health needs can only get mental health services once they have entered the juvenile justice system. Unfortunately, many youth languish in detention without access to appropriate services. Getting services while in detention can ameliorate their condition, but many youth are denied services because federal law prohibits Medicaid payments “with respect to care or services for any individual who is an inmate of a public institution.”¹⁹

Despite several letters and memoranda from the federal Department of Health and Human Services (HHS) urging states to suspend, rather than terminate, Medicaid benefits upon incarceration, many states still terminate Medicaid when youth are detained in a public institution. This can result in long delays in accessing services upon release because these youth must then re-establish eligibility for Medicaid by completing the lengthy application process. States are not required to terminate Medicaid eligibility, and in fact, federal guidance has recommended that “states should establish a process under which an eligible inmate or resident is placed in a suspended status...but the person remains on the state’s rolls as being eligible for Medicaid (assuming the person continues to meet all applicable eligibility requirements).²⁰ Furthermore, a state may not terminate anyone from Medicaid without first determining whether the individual would qualify under another eligibility category.²¹ Advocates in states that still terminate Medicaid for inmates of public institutions can work with their state health departments to address this issue.

The Medicaid “Inmate Exception” applies to anyone who is living in a public institution, but certain circumstances exist where someone would not be considered an inmate. One of these situations is if the individual “is in a public institution for a temporary period pending other arrangements appropriate to his needs.”²² A youth in detention awaiting placement in a foster home or group home may not be considered an

inmate of a public institution and can therefore receive Medicaid services.²³ States often do not allow youth in detention awaiting placement to receive services to which they are entitled. Service providers often refuse to work with youth in detention because they cannot be reimbursed for Medicaid services. According to federal law and guidance from the Centers for Medicare and Medicaid Services, this should not be a barrier for youth awaiting placement in a non-correctional setting. Accessing services while awaiting placement can be critical for ensuring a youth's successful and seamless transition to the new placement. Additionally, youth may remain in detention for months while a placement is sought, and advocates can push for the provision of necessary services while the child remains incarcerated.

Special Education

Special education is governed by the federal Individuals with Disabilities Education Act (IDEA),²⁴ Section 504 of the Rehabilitation Act of 1973, and state law.²⁵ The following sections discuss the entitlements to appropriate care under the federal legal frameworks.

IDEA

Under the Individuals with Disabilities Education Act (IDEA), a child is eligible for special education if: (1) the child has a disability²⁶; and, (2) because of that disability, needs specially-designed instruction to make educational progress²⁷. An eligible child is entitled to receive a free appropriate public education (FAPE)²⁸. FAPE is the benchmark of special education law and must be: provided at no cost to the family; designed to enable the student to make progress; and provided through an individualized education program (IEP)²⁹. By definition, FAPE differs from student to student because each has unique needs³⁰. The student's parents, educators, specialists and the student form a team to determine what services the student needs to receive FAPE. The IEP memorializes the decisions of that team into a written roadmap for the provision of special education and related services³¹. Although IEP teams often recommend the services that they know to be available in the school setting, advocates can use the IEP team as a way to creatively brainstorm about how to best meet the individual needs of a youth.

Related services are not direct special education services, but are additional services required for a child to benefit from special education. For students with mental health needs, their IEP may contain related services such as counseling or social work services. These services are designed to help a child benefit from special education services: if a student's mental health needs impact his or her ability to access special education services, related services should be provided to address this impact. Other types of related services may include, but are not limited to, speech and language services³², audiological services, guidance, transportation, physical and occupational therapy, parent counseling and training, and medical services that are required for diagnostic or evaluation purposes. Like special education services, related services should be individualized to the needs of each youth. Just as in the EPSDT context, focusing on specificity of behaviors and needs leads to better services. Advocates can employ the same strategies when working with special education evaluators and IEP teams.

Determining IDEA Eligibility

Before providing special education and related services, a school district, or Local Educational Authority (LEA)³³, must conduct an initial evaluation to determine if a child requires special education³⁴. The LEA must design an individualized evaluation that can assess all areas of suspected disability³⁵ and determine the educational needs of a child³⁶. The evaluation process seeks to determine whether a child qualifies for special education under IDEA, and, if so, what the child's IEP should contain to allow the child to participate in and progress within the general education curriculum³⁷. As with EPSDT, advocates should look for specific and individualized evaluations, and request specific recommendations to help a student make educational progress. IDEA does not prevent a school from providing a child with special education and related services while an evaluation is pending, as long as the parent and the LEA agree that services should be provided³⁸.

When initial evaluations are complete, an IEP team convenes to determine whether a child qualifies for special education and, if so, what the educational needs of the child are³⁹. A student eligible for IDEA should be reevaluated at least once every three years, but can also be reevaluated more frequently if the child's parent or teacher requests a reevaluation based on the child's academic or functional performance⁴⁰.

Developing the IEP

The IEP team is responsible for creating an IEP that will enable the student to make educational progress. The IEP team must include:

1. the child's parents⁴¹;
2. at least one regular education teacher⁴²;
3. at least one special education teacher⁴³;
4. an LEA representative who is qualified to provide or supervise the provision of specially designed instruction, is knowledgeable about the general education curriculum, and is knowledgeable about the availability of LEA resources⁴⁴;
5. an individual who can interpret the implications of evaluation results⁴⁵;
6. other individuals who have knowledge or special expertise regarding the child, including related services personnel⁴⁶; and
7. when appropriate, the child⁴⁷.

Because the parent can invite individuals who have knowledge or special expertise regarding the child to the IEP team, the IEP team can include a range of community providers and advocates, at the parent's invitation. Consequently, IEP team meetings can be used to coordinate school-based and community-based services for students eligible for special education. Advocates can push for IEP teams to use a strengths-based approach which is already built into the legal requirements for IEP development. When developing the IEP, the team must consider, among other factors:

1. the child's strengths⁴⁸;
2. the parent's concerns about the child's education⁴⁹;
3. the results of the most recent evaluation⁵⁰;
4. the academic, developmental, and functional needs of the child⁵¹;

5. the communication needs of the child, both in terms of interactions with peers and school staff⁵²;
6. the use of positive behavioral interventions and supports, as well as other behavioral strategies, if the child has behavioral issues that impact learning⁵³.

The IEP should be designed to enable the child to:

1. advance appropriately towards annual goals⁵⁴;
2. be involved in and progress within the general education curriculum⁵⁵;
3. participate in extracurricular and other nonacademic activities⁵⁶; and
4. be educated and participate with his or her nondisabled peers⁵⁷.

Functional Behavior Assessment and Behavior Intervention Plan

For any child whose behavior interferes with his or her educational progress, a functional behavioral assessment (FBA) should be performed and a behavior intervention plan (BIP) integrated into the IEP.⁵⁸ Although IEP teams sometimes fail to conduct FBAs and complete BIPs until after a disciplinary incident, the U.S. Department of Education guidance states that FBAs and BIPs must be used proactively when appropriate.⁵⁹

An FBA is considered an evaluation under federal law and is therefore subject to all provisions regarding evaluations.⁶⁰ An FBA should focus on identifying the function or purpose behind a child's behavior by considering a wide range of child-specific social, affective and environmental factors such as: motivations; triggers for negative behaviors; prevention strategies; and strengths and weaknesses.⁶¹ A BIP should be designed to eliminate or diminish identified behaviors through targeted interventions, including positive interventions.⁶² If a child needs a BIP to improve learning and socialization, the BIP should be included as part of the IEP and aligned with the IEP goals.⁶³

Transition Goals and Services

By the time the child turns 16, his or her IEP must include transition goals and services to prepare the child for post-school activities, such as post-secondary education, employment or independent living.⁶⁴ Transition services include instruction, related services, community experiences, the development of employment and other post-school living objectives, and the acquisition of daily living skills and functional vocational education.⁶⁵ Transition goals and services are critical to supporting youth as they move towards adulthood and independent living.

Extended School Year

If necessary for a student to receive FAPE, his or her IEP team should recommend Extended School Year (ESY) services.⁶⁶ ESY services are educational services provided to a student beyond the length of the regular school year, for example, during the summer and at no cost to the family.⁶⁷ An LEA cannot limit ESY provision to a particular category of disability;⁶⁸ or unilaterally limit the type, duration of amount of ESY services.⁶⁹ Advocating for these services is critical because school districts often refuse to provide individualized services required by the IEP plan over the summer. ESY services can provide structure and support while children are in summer school or

at home on break and can help to ensure that academic gains made during the school year are maintained.

Related Services

As discussed above, students who are eligible for special education may be eligible to receive a range of related services if necessary to access a special education program. For students with mental health needs, some of the most relevant related services are social work and counseling services, parent counseling and training, and transportation.

Social Work and Counseling Services

Like other necessary related services, mental health services that are related services must be provided at no cost to the parents.⁷⁰ An IEP can include mental health services as a related service as counseling services or social work services.⁷¹ Under the IDEA, counseling services include services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.⁷² Social work services include group or individual counseling for the child and family.⁷³

Parent Counseling and Training

Parent counseling and training consists of services to help parents understand the special needs of their child.⁷⁴ Parent counseling and training can include providing parents with information about child development;⁷⁵ and helping parents acquire skills to support the implementation of the child's IEP.⁷⁶ Parent counseling and training can be particularly important for students with mental health needs since, among other benefits, it can help:

1. ensure consistency between behavioral interventions at school and at home;
2. teach parents how to advocate for their child's needs in a variety of settings;
3. coordinate between school and community service providers; and
4. provide parents with resources to help with their child's needs at home.

Transportation

If necessary for a disabled student to access educational programming or related services, the child's IEP should include provision of transportation services as related services.⁷⁷ For example, if a student needs psychological services as a related service and those are provided through a community-provider, the school must ensure that the student has transportation to the related services provider.

Medication

School and LEA personnel are prohibited from requiring a child to obtain a prescription for a controlled substance as a condition of attending school, receiving an evaluation, or receiving special education and related services.⁷⁸ However, schools should also ensure that they can administer medication to students who need it throughout the school day.⁷⁹

Section 504

Students who have disabilities but do not require special education under IDEA may be eligible for a "504 plan." In the educational context, a "504 plan" is an educational plan

created pursuant to Section 504 of Rehabilitation Act of 1973 (Section 504).⁸⁰ Section 504 prohibits discrimination by recipients of federal dollars, including public schools and private or charter schools that receive federal financial assistance either directly from the federal government or through the state government.⁸¹

Section 504 coverage is significantly broader than IDEA coverage: Section 504 protects an individual who has, has had, or is perceived as having,⁸² a physical or mental impairment which substantially limits one or more major life activities (MLA), such as: caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning,⁸³ or working.⁸⁴ Section 504 protects students whose disability limits their ability to attend, participate in, or receive benefit from school activities, including academic and nonacademic activities.

Like IDEA, Section 504 requires that an LEA evaluate students to determine what services, accommodations and modifications are appropriate.⁸⁵ Section 504 also requires periodic reevaluation.⁸⁶ The §504 Team must include persons knowledgeable about the child, the evaluation data, and the placement options.⁸⁷ Federal regulations do not include specific members for the Section 504 team, unlike the IEP team. However, like the IEP team, the Section 504 team can be used as a mechanism to draw together community and school providers to plan appropriate and integrated services for a child.

Changing the Frame: Moving Towards a More Strengths-Based Juvenile Justice Approach

The juvenile justice system has traditionally been deficit-focused. Youth are viewed and treated in the context of the seriousness of their offenses, the level of risk they present to their communities, and the aspects of life in which they are failing, like school or relationships with others. Inherently focused on the problems in the child's life, the juvenile justice system is "designed to protect public safety by incarcerating youth or closely supervising their behavior (incapacitation), imposing sanctions for their past offenses (deterrence and retribution), and reducing the likelihood of future offenses (*rehabilitation*)."⁸⁸ In recent decades, however, an increasing number of jurisdictions have begun to recognize that this approach does not necessarily improve outcomes for youth, reduce recidivism, or keep communities safer and some jurisdictions have taken steps to shift their juvenile justice systems towards rehabilitation rather than punishment. This section discusses the importance of working with youth and families to identify their strengths and needs and highlights the ways in which system actors need shift their roles. Not only can this help system actors access entitlements for youth, as discussed *supra*, but it can also help make the juvenile justice system more responsive to children's needs.

Strengths-Based Practice and Positive Youth Development are two models that challenge the traditional deficits-focused approach within juvenile justice. Strengths-Based Practice means recognizing, acknowledging and building upon a child's strengths to support change in that child's life.⁸⁹ Positive Youth Development emphasizes supporting a child through services that build his or her competence, belonging, and empowerment.⁹⁰ These approaches encourage juvenile justice systems to identify what is working well in young people's lives and to develop and employ individually tailored interventions that build upon those strengths, while also holding

them accountable for their actions. Focusing on strengths allows for collaborative case planning and provides young people with the opportunity to learn how to use their abilities to solve problems.⁹¹ A strengths-based approach can be particularly valuable in juvenile justice settings because it provides a way to meaningfully engage youth and have them identify what they need to improve school performance, family dynamics, and other areas of life. Ultimately, “if a young person does not want what the adults think he/she needs, little will change with his/her family, school, and peer adjustment.”⁹²

While not new to other disciplines, this approach reflects a marked shift for juvenile justice systems. But focusing on strengths and needs can be an incredibly powerful strategy to improve both access to mental health services and responses within the juvenile justice system. As will be discussed in detail later, identifying specific needs can help in crafting better recommendations for services, which can trigger entitlements to care. Identifying strengths and needs can also help adults understand the reasons behind a child’s behavior. For example, youth who have experienced multiple traumatic events “often meet diagnostic criteria for depression; attention-deficit/hyperactivity disorder (ADHD); oppositional defiant disorder (ODD); conduct disorder; anxiety disorders; eating disorders; sleep disorders; communication disorders; separation anxiety disorder; and/or reactive attachment disorder.”⁹³ Children suffering from this type of “complex trauma” may lack healthy coping strategies and may also exhibit aggressive behavior to control their experiences or use drugs and alcohol to avoid experiencing arousal of emotion in response to their trauma.⁹⁴ Behavior that may seem oppositional, aggressive, uncooperative, or antisocial by adults in the juvenile justice system may actually be the child’s necessary coping mechanisms to handle trauma. Without proper treatment, many youth with unmet mental health needs do not have the ability to cope with stressful situations in an appropriate way; as a result their mental health issues may result in engaging in delinquent acts or make following probation conditions difficult.⁹⁵

Unfortunately, youth with unmet mental health needs frequently end up in detention for minor, nonviolent offenses, often because community-based treatments options do not exist.⁹⁶ A National Center for Mental Health and Juvenile Justice study found that of the juvenile justice involved youth with a mental health diagnosis, “only 23.5% had committed a violent offense as the most serious offense, with the majority of youth involved with the juvenile justice system for property offenses and probation or parole violations.”⁹⁷ Some of justice-involved youth have never been diagnosed and as such, are labeled as troublemakers. Others have been diagnosed, but cannot receive appropriate services in the community. Sometimes parents are left with no choice but to call the police when their children act out, in the hopes that the juvenile justice system will provide their child with needed mental health services.⁹⁸ Once in detention, they are more likely to re-offend and move deeper into the juvenile or criminal justice system.⁹⁹ Detention is an inappropriate place for children with unmet mental health needs; in fact, it makes their symptoms worse. Research has shown that the combination of unmet mental health needs and detention lead to higher rates of depression and suicidal ideation.¹⁰⁰ Some studies have found that detained youth have two to four times the suicide rate of children in the community.¹⁰¹ Lack of adequate transition planning and aftercare further deteriorates the condition of youth with unmet mental health needs,

and increases the likelihood of recidivism. Without a plan for and access to appropriate services in the community, youth return to a status quo that cannot meet their needs.¹⁰²

Applying a strengths-based approach can help address the needs of youth with mental health issues who unnecessarily become entangled in the juvenile justice system and who are detained for behavioral issues that could be ameliorated with community-based treatment. Improving training and resources on using strength-based tactics and on basic mental health information for players in the juvenile justice system can help shift the way these youth are treated by a system that often further traumatizes them and worsens their mental health condition. Each system actor can play a critical role in improving access to services and reducing the aspects of juvenile justice system involvement that can exacerbate a youth's condition. The following sections briefly discuss the roles that probation officers, defense attorneys, district attorneys, and judges can play in the moving towards a more responsive juvenile justice system.

Probation Officers

The probation system is typically focused on ensuring compliance with probation conditions and court orders. Despite its rehabilitative goals, the juvenile justice system and probation often tend to mimic the adult system in their focus on law enforcement, consequences and compliance. However, part of the role of probation is to help youth learn to make better decisions to keep from recidivating and to stay safe in the community. Often, this latter role is overshadowed by the need to force compliance, particularly with those youth who may be resistant to cooperate. Research has shown that increasing the level of supervision or social control has little effect on probation outcomes.¹⁰³ Probation officers can play a critical role in ensuring the success of the youth they supervise, but this is often ignored in favor of focusing on ensuring supervision.¹⁰⁴

How probation officers view their role, therefore, can have an important impact on how the juvenile justice system functions. Officers who see themselves as primarily law enforcement will tend to focus on interventions assumed to reduce risk to the larger community. Officers who view their role as helping youth improve their ability to make decisions and to connect youth with services will likely shift their approach towards identifying and assessing strengths, resilience factors, and needs. If an officer recognizes that “[a]ll offenders and families have some resources such as skills, capabilities interests, positive character traits, even perseverance and hope, that can be brought to bear for exiting [the juvenile justice] system,”¹⁰⁵ he or she can begin working with that youth and family to develop a plan that can promote those strengths well beyond their court involvement. In focusing on what the youth can do well, the officer can begin to build trust with the child and begin developing solutions. Realizing that “solutions are not reached through [an] offender’s weaknesses and failures, but through [his or her] strengths and healthy patterns,”¹⁰⁶ the probation officer can begin to increase the child’s willingness to not only comply with probation conditions, but also to actually change behaviors.¹⁰⁷ In doing so, the officer can increase accountability for the child and family in carrying out the solutions they help develop. Additionally, when mental health treatment is successful, public safety is actually enhanced.

Motivational interviewing, which was initially used in the context of helping people with substance abuse issues help change their behavior, is a powerful tool probation

officer can use to help youth under their supervision begin to make healthier decision. This approach “hinges on addressing and resolving ambivalence,¹ which is believed to help move a person toward change.”¹⁰⁸ Motivational interviewing is a collaborative discussion that meets the child where he or she is in their readiness and willingness to change, and helps move the youth towards being ready to change behavior. In using this technique, officers “cooperate with the offender, not the criminal behavior. Probation staff can examine how to impose sanctions and build helpful relationships, and with training, agents can build the skills to supervise for compliance and increase the offender’s readiness for change.”¹⁰⁹

Probation officers can also institute screening for mental health needs early on in their contact with youth. Often, probation plays the role of intake early on in a child’s contact with the juvenile justice system. Adopting a standardized policy that uses a mental health screen on all youth who enter intake (both in the community and in detention) can ensure that children’s needs are identified early and flagged for follow-up and referral.¹¹⁰ Coupled with a strengths-based approach, probation officers can ascertain mental health needs and work with the youth to identify what is already working well. Gathering this information is critical to develop a mental health treatment plan and through collaboration, the officer can share this information with the child’s mental health provider/ evaluator and defense attorney. The probation officer can also use this information to make decisions regarding the child’s delinquency case. Probation often has the authority to completely divert a youth from formal court involvement.¹¹¹ If officers identify mental health needs, they can move youth away from the court and instead connect the youth to community-based services.¹¹²

In many ways, probation officers can frame the way the youth is viewed by the juvenile justice system. If an officer does decide to file a petition, reflecting the child’s strengths and assets will provide the other court players information that can be valuable in their decision-making, like charging, ordering evaluations, and disposition. Probation is typically responsible for submitting status reports on all youth under supervision, both in the community and in placement. Rather than monitoring only compliance and recording the child’s failures, probation officers can include what has been working well and provide updates on smaller goals that may have been met.

District Attorneys

District attorneys play an important role in determining how a youth moves through the juvenile justice system. In most jurisdictions, they have sole discretion over charging decisions and are provided with little guidance on how and whether to charge.¹¹³ The National Prosecutors Association released prosecution standards that serve as a guideline for making charging decisions for juvenile, but they differ little from adult standards, apart from a reference to age and maturity.¹¹⁴ District attorneys can develop guidelines that look beyond the seriousness of the alleged offense, prior offenses, admission of guilt and acceptance of responsibility, the dangerousness of the threat posed to others, and making decisions with respect to similarly situated individuals.¹¹⁵

District attorneys have the opportunity to connect youth and families to community-based services. Like probation officers, district attorneys have discretion in

¹It is believed that ambivalence, or feeling two ways about a behavior, often plays a role in psychological difficulties

diverting youth from the juvenile justice system. While some jurisdictions have policies that prevent prosecutors from diverting felony cases, it is important to remember that the district attorneys often have great discretion in whether to charge a youth with a felony.¹¹⁶ Shifting the language that is used in assessing whether to charge or whether to assign a felony or misdemeanor label can make a significant difference in prosecutorial practice and move the system towards engaging youth and meeting their needs. For example,

[c]riteria that emphasize “dangerousness” may also increase the prosecutor’s tendency to rely on traditional law enforcement responses to adolescent offending and detract from evidence based, positive youth responses that are more likely to improve public safety by facilitating the youth’s successful maturation. Instead, these criteria should force prosecutors to consider the youth’s ability to reintegrate into society with appropriate interventions and encourage prosecutors to identify and rely on community-based responses that have been shown to correct the behavior of even serious, violent offenders.¹¹⁷

De-emphasizing the label of dangerousness reflects acknowledgment that youth can change their behaviors with proper services and supports and gives them the opportunity to take responsibility for their actions. If youth are screened at intake and are identified as having unmet mental health needs, prosecutors should take that into account in making their charging decisions. Given their age and the trauma that many justice-involved youth have faced, understanding that both diagnosed and undiagnosed youth may appear to have no remorse or accept guilt would allow prosecutors to make decisions in a way that is informed by developmental research.

Prosecutors can also play an integral role in changing the way youth are treated in the community and in schools, in particular.¹¹⁸ Many youth with disabilities and mental health needs are funneled into the juvenile justice system for offenses that could more effectively be handled within the school setting. Prosecutors can decline to file on cases that involve low level offenses, like disorderly conduct, school fights, and petty thefts, and can work with judges and school resource officers and officials to develop more appropriate responses within the school. Connecting the youth and family to advocacy agencies or supports who can help assess the child for special education and/ or advocate in special education team meetings would allow the youth to be accountable while also getting his or her needs met.

Judges

Once youth are in the juvenile justice system, judges make the critical decisions that determine whether a child will be in the community or in detention. Their role in connecting youth to services cannot be overstated. Judges can play a critical role in ordering evaluations and assessments that they focus on the child’s strengths and resilience factors and identifying supports that would be necessary to remain safely in the community. As discussed *supra*, evaluations can help trigger entitlements to care and necessary services.

Judges are also in the position to ask questions that may not be asked by other players. For example, if a judge understands that complex trauma or certain mental health disorders can make children appear defiant and uncooperative, he or she can ask questions to understand youths’ needs and order services that address them.

Rather than just punishing a child for running away from a placement, the judge can ask the youth why they chose to leave. Judges can also use their time with the youth in the court to highlight the things the child is doing well. For example, a child with a history of chronic truancy may be unresponsive to a judge's criticism that the child missed many days of school. However, if the judge asks questions to try to understand any underlying fears or triggers keeping the child from going to school, the court might uncover areas for therapeutic intervention.

Judges often use detention as a consequence for violating probation conditions. Along with the rest of the juvenile justice system actors, they need training on how detention impacts youth with mental health needs and what other community-based interventions can keep youth safe. Judges are in the position to move the system away from one being focused solely on consequences and punishment. They can move the court's guiding purpose towards giving "all young people the opportunity to become successful, self-sufficient, and critical-thinking assets to their communities," in addition to ensuring public safety.¹¹⁹

Judges can also rely on information provided by the family and community in making decisions. For youth who live in a home-like setting, engaging family members and caregivers is critical, as they can provide the judge and other court players with insight on what is happening in the child's life. They can also help identify supports that are needed for the youth. A recent study by Justice for Families found that when asked how judges could assign better options for youth, a vast majority of surveyed families expressed a need for job opportunities, educational opportunities, mentorship opportunities, mental health programs, and community-based services that keep children in the home.¹²⁰ Connecting youth to community-based services and supports will have longer lasting benefit to youth and the community, as it allows young people to learn the skills they need to become productive adults.

Defense Attorneys

Defense attorneys are children's primary advocates in the juvenile justice system. Despite often having crippling caseloads, they are charged with zealously advocating for their clients. Zealous advocacy includes, among other things, understanding clients' strengths and needs; communicating effectively with clients; identifying supports and programs in the community; understanding mental health and special education law; knowing the network of schools and placements that may or may not be appropriate for their clients; engaging family without compromising attorney-client privilege.¹²¹ Given their high caseloads, defense attorneys often do not have time to fulfill all these roles. Engaging family and community supports can be critical in helping to identify strengths and needs and develop case plans. As discussed *infra*, collaboration through informal or formal multidisciplinary teams is also a powerful way to push for services. In some jurisdictions, defense attorneys may have social workers or investigators who can gather critical information to allow the attorneys to advocate for their clients. Including social workers in these offices and providing "holistic advocacy" can lower recidivism, improve outcomes, save costs on incarceration, and improve system efficiency.¹²²

Defense attorneys can also play a significant role in ensuring their clients have meaningful and appropriate court-ordered evaluations. Evaluations trigger powerful entitlements to care, which will be discussed in the following sections. But they also play

an important role in providing families and advocates with a tool to better understand the child's underlying needs and to be able to seek and coordinate services. It is important that the attorneys play an active role in the evaluations, both while the clinician is gathering information to make the evaluation, but also once it is presented to court. By asking questions of the evaluator and advocating that recommendations are tied to behaviors and outcomes, the attorney can create a stronger evaluation that can trigger entitlements to individualized services. If possible, Public Defender offices should try to obtain funding so they can find their own experts to evaluate youth. Unlike with court-ordered evaluations, they can then ensure that their input is included in the final evaluations. If the evaluation is inadequate, defense attorneys should object and request an independent evaluation. Comprehensive evaluations are an invaluable tool in accessing services, so effort expended on obtaining appropriate evaluations may make the defender's work more efficient later in the case.

Beyond court-ordered evaluations, defense attorneys can play a critical role in enforcing their clients' entitlements to appropriate mental health services by working with community-based mental health providers and by helping clients engage with those services.

Collaboration: A Critical Component of Mental Health Advocacy

As part of a strengths-based approach, effective collaboration can be one of the cornerstones for challenging the historically deficits-focused system approaches and for obtaining appropriate, individualized services for children and youth. Many states, jurisdictions and localities have started employing collaborative decision-making that involves child welfare involved youth and their families. Several models exist, including Team Decision-making Meetings, Family Group Conferences, and Family Team Conferences, among others, all of which employ a strengths-based, family-centered approach where family input is valued.¹²³ Though more prevalent in child welfare, these team-based decision-making meetings are an ideal setting in which to collaborate to advocate for better mental health services and can be incorporated into juvenile justice case planning. It is critical to engage all advocates for the youth, including social workers, attorneys, therapists, school personnel and any other supports in the community.

In state juvenile justice statutes, there appear to be relatively few formal structures for multidisciplinary team decision-making. Some states have team decision-making processes for youth who are at risk-of-out of home placement. Others, like California, allow for the development of MDT once a ward of the court is identified as being seriously emotionally disturbed, having a serious mental disorder, or having a developmental disability.¹²⁴ In California, the MDT includes "qualified persons who are collectively able to evaluate the minor's full range of treatment needs and may include representatives from local probation, mental health, regional centers, regional resource development projects, child welfare, education, community-based youth services, and other agencies or service providers."¹²⁵ The MDT must also include at least one licensed mental health professional.¹²⁶ These MDTs do allow parents, guardians or primary caretakers to participate in developing a treatment plan.¹²⁷ The statute specifies that the team "will identify the mental health or other treatment services, including in-home and community-based services that are available and appropriate for the minor"

and highlights wraparound as a possible service.¹²⁸ The team develops a recommended disposition and written treatment plan for the youth, which is incorporated or appended to the probation social study presented to the court.¹²⁹

As another example, in West Virginia, a multidisciplinary treatment team is tasked with creating an after-care plan for youth who are to be released from any institution or facility to which the youth was committed.¹³⁰ Prior to the youth's release the youth's treatment team is required to distribute copies of the after-care plan to the youth's parents or guardian; the youth's lawyer; the youth's probation officer or community mental health center professional; the prosecuting attorney; and the principal of the school the youth is to attend.¹³¹ The after-care plan is to include a plan for the education, treatment, and counseling of the youth upon the youth's discharge.¹³² It is important to note that even if provisions for MDTs do not appear in a state's statute, there may be local policies or ordinances that provide authority to create these teams.

Advocates in jurisdictions that have no provisions for MDTs can still work to create informal team decision meetings. For example, as described *supra*, they can use special education IEP teams as a vehicle for seeking individualized related services paid for by the school district. Informal MDTs can also be created in the community with supports, providers, and relatives. In general, advocates should be aware that when teams involve probation or other law enforcement agencies, unless specifically prohibited, information shared through the team can potentially be used against the child in future proceedings. They should familiarize themselves with federal and state laws governing the sharing of sensitive information.

Conclusion

The juvenile justice system does not have to be one focused primarily on punishment and consequences to ensure public safety. Detention and residential placement often do not make the public safer, as youth return to the same, unchanged community without having learned critical skills and without support systems in place. To provide longer lasting impact, it is important to shift the focus towards understanding the complex history and needs of youth with mental illness and providing them with the skills to becoming productive adults who can contribute to their communities. Allowing youth to develop coping and problem-solving skills through strengths-based practice will benefit them and their community long after they leave the court's jurisdiction.

Collaboration and understanding of federal entitlements to care are critical to securing appropriate mental health services. Ideally, advocates can participate in teams to identify the treatment needs of their system-involved clients and develop responsive, individual-focused services. Even in the absence of formal teams, advocates can still partner with individual physicians and clinicians to trigger entitlements to care. Using Medicaid and special education entitlements, they can push for services that go beyond the bare minimum and can access services for their clients that are appropriate and not just available in their communities.

ATTACHMENT A: Tips for Advocates: Accessing *Appropriate* Rather Than *Available* Services

To the extent possible, try to work as a team with the youth and his or her family, clinician/therapist, caregiver, and teachers, as well as anyone else who can serve as a support or resource for the family.

- 1) **Focus on strengths and needs.** What services work well? What can be improved?
 - a. What services are currently being provided, and which are meeting (or not) the youth's needs?
 - b. What does the youth enjoy, care about, and/or do well? How can this information be used to develop more supports?
 - c. What informal resources/supports (e.g., friends, relatives, faith based organizations) do the youth and caregiver already have?

- 2) **Stay goals-oriented.**
 - a. What are the youth's goals? Examples might include:
 - i. To stabilize his or her living situation (or step down to a less restrictive setting).
 - ii. To graduate high school.
 - iii. To get involved in sports or other activities.
 - b. What behaviors are impeding achievement of those goals? Examples:
 - i. Inability to self-soothe, and lashing out.
 - ii. Running away.
 - iii. Engaging in promiscuous or other unsafe behavior.
 - iv. Engaging in self-harm.
 - c. What does the youth and his or her family feel would help address some of these behaviors?

- 3) **Work with the clinician to make recommendations that address the identified needs.**
 - a. Try to get the clinician to link the specific behavior to a needed service. More specificity means better services.
 - b. Describe how the service corrects or ameliorates the specific behavior or condition.
 - c. Focus on what the youth needs, not on what is available in the community.

- 4) **The clinician's written recommendation triggers the EPSDT entitlement.**

If the youth is eligible instead for special education services, the recommendation enables the advocate to build a stronger case for services that should be included in an Individualized Education Plan (IEP).

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2. Banton A, Timmerman S. A Strength-Based Approach to Working with Youth and Families: A Review of Research. 1. http://humanservices.ucdavis.edu/academy/pdf/strength_based.pdf. Published 2011. Accessed August 14, 2014.
3. Social Security Act, 42 USC §1396d(r)(5) (2012); *see also* Centers for Medicare & Medicaid Services, Department of Health and Human Services. *Fed Regist.* 2013; 79(11). To be codified at 42 CFR §441.50.
4. Social Security Act, 42 USC §1396a(a)(43)(C), 1396d(r)(5) (2012).
5. *E.g., Collins v Hamilton*, 349 F3d 371 (7th Cir 2003) (holding that a state's discretion to exclude services that have been deemed medically necessary under EPSDT by a treating provider has been "circumscribed by the express mandate of the statute"); *Pediatric Specialty Care Inc v Arkansas Department of Human Services*, 293 F3d 472 (8th Cir 2002) (reminding state that it has a duty to "arrange for corrective treatments prescribed by physicians"); *Rosie D v Romney*, 410 F Supp 2d 18, 26 (D Mass 2006) (holding that "if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state's Medicaid plan pursuant to the EPSDT mandate"); *Urban v Meconi*, 930 A2d 860, 865 (Del S Ct 2007) (holding that the administrative decision-maker must give "substantial weight to the opinions of treating physicians; ... generally should give less probative weight to the opinion of a physician who has never examined the patient; ... and should not substitute its expertise for the competent medical evidence)."
6. *See Moore v Reese*, 637 F3d 1220, 1255 (11th Cir 2011).
7. *NB v Hamos*, 2014 LEXIS 18232, 15-16 (ND Ill) (motion for class certification).
8. *NB v Hamos*, 2014 LEXIS 18232, 17 (ND Ill) (motion for class certification), (citing *Collins v Hamilton*, 349 F3d 371, 376 n 8 (7th Cir 2003) ("a state's discretion to exclude services deemed 'medically necessary' . . . has been circumscribed by the express mandate of the statute"); *Pediatric Specialty Care Inc v Arkansas Department of Human Services*, 293 F3d 472, 480 (8th Cir 2002) (states must pay for costs of treatment found to ameliorate conditions discovered by EPSDT screenings if such treatments are listed in section 1396d(a)); *Pereira v Kozlowski*, 996 F2d 723, 725-26 (4th Cir.1993) (EPSDT program obligates states "to provide to children under the age of twenty-one all necessary services, including transplants"); *Rosie D v Romney*, 410 F Supp 2d 18, 26 (D Mass 2006) ("The breadth of EPSDT requirements is underscored by the statute's definition of 'medical services'" in § 1396d(a)(13)); *Ekloff v Rogers*, 443 F Supp 2d 1173, 1179-80 (D Ariz 2006) (observing that "[e]very Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service

necessary for EPSDT corrective or ameliorative purposes that is allowable under §1396d(a)" and that "from reading the legislative history and the Congressional Record, it appears that there is a very strong inference to be inclusive rather than exclusive"); Cannon YZ. There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children. *DePaul L. Rev.* 2012; 61: 1049, 1080 ((under EPSDT, "[w]hen doctors find that services are medically necessary, the state must pay for those services and assure that payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area") (emphasis added)).

9. Social Security Act, 42 USC §1396(a)(3) (2012).
10. Social Security Act, 42 USC §1396n(c) (2012).
11. Bazelon Ctr for Mental Health Law. Teaming Up: Using the IDEA and Medicaid To Secure Comprehensive Mental Health Services for Children and Youth. 4. <http://www.bazelon.org/LinkClick.aspx?fileticket=sytvuAC9rUw%3D&tabid=104>. Published August 2003. Accessed August 14, 2014.
12. Mann C, Hyde PS. Joint CMCS and SAMHSA Information Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. 1. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>. Published May 7, 2013. Accessed August 14, 2014.
13. *Id.* at 2.
14. *Id.* at 3.
15. *Id.*
16. *Id.* at 4.
17. *Id.* at 5.
18. *Id.*
19. Social Security Act, 42 USC §1396d(a)(27)(A) (2012).
20. Stanton G. Letter to State Medicaid Directors and CMS Associate Regional Administrators for Medicaid: Ending Chronic Homelessness. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Community-Living/Downloads/Ending-Chronic-Homelessness-SMD-Letter.pdf>. Published May 25, 2004. Accessed August 14, 2014.
21. 42 CFR §435.930(b) (2013) (stating that a state must "continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible").
22. 42 CFR §435.1010(b) (2013).
23. See Burrell S, Bussiere A. The Inmate Exception and Its Impact on Health Care Services for Children in Out-of-Home Care in California. 14. http://www.ylc.org/publication_info?id=jj_bb2002. Published November 2002. Accessed August 14, 2014.
24. Pub L No. 108-446, 2647 Stat. 118.; *see also* Office of Special Education and Rehabilitative Services, Department of Education. *Fed Regist.* 2013; 78(230). To be codified at 34 CFR §300.1.
25. Note that there are areas of special education law that are left to state discretion, which are outside the scope of this article. Advocates should familiarize themselves

with state law as states may have more protective standards for youth in special education.

26. Individuals with Disabilities Education Act, 20 USC §1401(3)(A) (2012); 34 CFR §300.8(c) (qualifying disabilities under the IDEA include autism, deaf-blindness, deafness, emotional disturbance, hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech or language impairment, traumatic brain injury, or visual impairment including blindness). A child does not need to be classified by his or her disability to receive special education and related services. Individuals with Disabilities Education Act, 20 USC §1412 (a)(3)(B) (2012). Students who require mental health services may be likely to be eligible for IDEA services under emotional disturbance or other health impairment (OHI). Emotional disturbance means exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational progress:
An inability to learn that cannot be explained by intellectual, sensory or health factors;
An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
Inappropriate types of behavior or feelings under normal circumstances;
A general pervasive mood of unhappiness or depression;
A tendency to develop physical symptoms or fears associated with personal or school problems.
34 CFR §300.8(c)(4).
OHI means limited strength, vitality, or alertness due to chronic or acute health problems such as lead poisoning, asthma, or attention deficit disorder which adversely affects educational progress. 34 CFR §300.8(c)(9). Students with post-traumatic stress disorder may be eligible for IDEA services under OHI. However, full evaluations in all areas of suspected disability are necessary to determine a students' individual disability correctly.
27. Individuals with Disabilities Education Act, 20 USC §1401(3) (2012).
28. Individuals with Disabilities Education Act, 20 USC §1401(9) (2012).
29. *Id.* An appropriate education does not mean the best education possible. See *Board of Education v Rowley*, 458 US 176, 200-01 (explaining the duty to provide an appropriate education as services sufficient to provide some meaningful educational benefit to the eligible child).
30. One of the purposes of IDEA is to “ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment and independent living.” Individuals with Disabilities Education Act, 20 USC §1400(d)(1)(A) (2012).
31. The LEA is responsible for ensuring that personnel necessary to implement a child's IEP are appropriate and adequately prepared to do so. Individuals with Disabilities Education Act, 20 USC §1413(a)(3) (2012).
32. Note that speech and language services can be special education services if the child has a language-based or speech disability. If child has another disability, but

- still needs speech and language services to benefit from special education, then they are provided as related services.
33. Individuals with Disabilities Education Act, 20 USC §1401(19) (2012); i.e., a school district.
 34. Individuals with Disabilities Education Act, 20 USC §1414(a)(1)(A) (2012). Initial evaluation can also be conducted by the State Educational Agency, or other state agency. *Id.*
 35. Common areas of evaluation are: psychological, academic achievement, speech and language, psychiatric, social-emotional, behavioral, social work, and trauma/sexual assault. Neuropsychological evaluations may be used to diagnose or describe the impact of the following conditions: traumatic brain injury, developmental learning disabilities, attention deficit disorders, psychiatric or neuropsychiatric disorders, seizure disorders, medical illnesses or treatments, effects of toxic chemicals (such as lead exposure), strokes, and dementing conditions.
 36. *Id.*; Individuals with Disabilities Education Act, 20 USC §1414 (a)(1)(C) (2012); Individuals with Disabilities Education Act, 20 USC §1414 (b)(3)(B) (2012). Unless infeasible, evaluations must be conducted in the language most likely to yield accurate information. Individuals with Disabilities Education Act, 20 USC §1414 (b)(3)(A)(ii) (2012); *see also* Individuals with Disabilities Education Act, 20 USC §1412 (a)(6)(B) (2012) (unless clearly infeasible, evaluations should be administered in the child's native language or mode of communication); Individuals with Disabilities Education Act, 20 USC §1401 (20) (2012) (native language means the language normally used by the individual or the language normally used by the parents of a child).
 37. Individuals with Disabilities Education Act, 20 USC §1414 (b)(2)(A) (2012).
 38. US Department of Education. Questions and Answers on Individualized Education Programs, Evaluations, and Reevaluations. Question A-2. http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/3. Published September 2011. Accessed August 14, 2014. Although the LEA may not agree to provide the services, when necessary, advocates should argue for additional supports and interventions while evaluations are pending.
 39. Individuals with Disabilities Education Act, 20 USC §1414(b)(4)(A) (2012).
 40. Individuals with Disabilities Education Act, 20 USC §1414(a)(2) (2012).
 41. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(B)(i) (2012). The LEA must try to schedule the IEP team meeting at a time and place that is convenient for the parent. 34 CFR §300.322; *see, e.g., Doug C v State of Hawaii Department of Education*, 720 F.3d 1038 (9th Cir 2013). IEP team members can attend IEP team meetings through alternative means of meeting participation such as video conferences, conference calls, and home visits. Individuals with Disabilities Education Act, 20 USC §1414(f) (2012).
 42. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(B)(ii) (2012).
 43. Individuals with Disabilities Education Act, 20 U.S.C. §1414(d)(1)(B)(iii) (2012).
 44. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(B)(iv) (2012). *See also* US Department of Education. Questions and Answers on Individualized Education Programs, Evaluations, and Reevaluations. Question C-1.

- http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/3. Published September 2011. Accessed August 14, 2014. (“If a public agency representative is excused from attending an IEP Team meeting, consistent with 34 CFR §300.321(e), the public agency remains responsible for implementing the child’s IEP and may not use the excusal as a reason for delaying the implementation of the child’s IEP.”).
45. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(B)(v) (2012).
 46. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(B)(vi) (2012). This provision provides the parent with the authority to invite individuals to join the IEP team if the parent can assert that those individuals have special knowledge regarding the child.
 47. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(B)(vii) (2012). The child must be invited to every IEP team meeting following his or her fifteenth birthday. Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(A)(i)(VIII) (2012) (requiring an IEP to include transition services beginning no later than the first IEP that will be in effect when the child is 16); 34 CFR §300.321(b)(1) (requiring the LEA to invite a child to attend his or her PPT meeting if the team will discuss transition services)
 48. Individuals with Disabilities Education Act, 20 USC §1414(d)(3)(A)(i) (2012).
 49. Individuals with Disabilities Education Act, 20 USC §1414(d)(3)(A)(ii) (2012).
 50. Individuals with Disabilities Education Act, 20 USC §1414(d)(3)(A)(iii) (2012); Individuals with Disabilities Education Act, 20 USC §1412 (a)(6)(B). IDEA says that the IEP should be based on more than one evaluation or assessment.
 51. Individuals with Disabilities Education Act, 20 USC §1414(d)(3)(A)(iv) (2012).
 52. Individuals with Disabilities Education Act, 20 USC §1414(d)(3)(B)(iv) (2012).
 53. Individuals with Disabilities Education Act, 20 USC §1414(d)(3)(B)(i) (2012).
 54. Individuals with Disabilities Education Act, 20 USC §1414 (d)(1)(A)(i)(IV)(aa) (2012).
 55. Individuals with Disabilities Education Act, 20 USC §1414 (d)(1)(A)(i)(IV)(bb) (2012).
 56. *Id.*
 57. Individuals with Disabilities Education Act, 20 USC §1414 (d)(1)(A)(i)(IV)(cc) (2012).
 58. 34 CFR §300.324(a)(2)(i); see also US Department of Education. Questions and Answers on Discipline Procedures. Question E-3. http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/7. Published June 2009. Accessed August 14, 2014.
 59. *Id.* at Question E-1.
 60. *Id.* at Question E-5. Parental consent is usually required for an FBA, unless it is merely based on information collected on all children. *Id.* If a parent disagrees with the results of an FBA, the parent can obtain an independent educational evaluation at public expense. *Id.*; 34 CFR §300.502.
 61. *Id.* at Question E-2.
 62. *Id.* at Question E-3.
 63. *Id.*
 64. Transition planning is required for any special education student, even if his or her skill levels relative to training, education and employment are age appropriate. US

- Department of Education. Questions and Answers on Individualized Education Programs, Evaluations, and Reevaluations. Question F-1. http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/3. Published September 2011. Accessed August 14, 2014; Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(A)(i)(VIII) (2012); Individuals with Disabilities Education Act, 20 U.S.C. § 1414(d)(1)(A)(i)(VIII)(bb) (2012); Individuals with Disabilities Education Act, 20 USC §1414(d)(1)(A)(i)(VIII)(aa) (2012). If appropriate, community access skills should be included as part of independent living skills within transition planning. US Department of Education. Questions and Answers on Individualized Education Programs, Evaluations, and Reevaluations. Question F-2. http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/3. Published September 2011. Accessed August 14, 2014.
65. Individuals with Disabilities Education Act, 20 USC §1401 (34) (2012). IEP teams should consider the child's need for transportation to access transition services as well as travel training as part of transition planning. See section *infra* on transportation. See also US Department of Education. Questions and Answers on Transportation. Question A-2. http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/12. Published November 2009. Accessed August 14, 2014.
66. 34 CFR §300.106(a)(2).
67. 34 CFR §300.106(b).
68. 34 CFR §300.106(a)(3)(i).
69. 34 CFR §300.106 (a)(3)(ii).
70. 34 CFR §§300.101, 300.17. See also US Department of Education. Questions and Answers on Individualized Education Programs, Evaluations, and Reevaluations. Question E-2. http://idea.ed.gov/object/fileDownload/model/QaCorner/field/PdfFile/primary_key/3. Published September 2011. Accessed August 14, 2014.
71. Note, however, that the school is not responsible for paying for mental health services that are medical treatment by a physician except as needed for diagnostic and evaluation purposes. 34 CFR §300.34(c)(5).
72. 34 CFR §300.34(c)(2).
73. 34 CFR §300.34(c)(14)(ii).
74. 34 CFR §300.34(8)(i).
75. 34 CFR §300.34(8)(ii).
76. 34 CFR §300.34(8)(iii).
77. 34 CFR §300.34; 34 CFR §§300.107; 34 CFR §300.117. Among other types of required transportation, transportation includes travel to and from school, and travel around school buildings. A child's IEP can also provide for travel training, if necessary. Travel training is instruction that enables children with disabilities to develop an awareness of the environment in which they live and to learn the skills necessary to move effectively and safely from place to place within that environment. 34 CFR §300.39(a)(2)(ii); 34 CFR §300.39(b)(4).
78. Individuals with Disabilities Education Act, 20 USC §1412 (a)(24) (2012).
79. Rehabilitation Act of 1973, 29 USC §794 (2012).
80. *Id.*

81. 34 CFR §104.31. The analysis of whether an individual is disabled is the same under Section 504 as it is under the Americans with Disabilities Act (ADA), Rehabilitation Act of 1973, 29 USC §705(9)(B) (2012).
82. An impairment that is episodic or in remission is a disability if it would substantially limit an MLA when active. Americans with Disabilities Amendment Act of 2008, 42 USC §12102(4)(D) (2012). Note that a student is not eligible for FAPE or accommodations under the categories of being previously disabled or being perceived as disabled. The anti-discrimination provisions of Section 504 still apply to these students (i.e., there can be no restriction on their participation in the full range of services provided by the LEA to non-disabled students). See Frequently Asked Questions About Section 504 and the Education of Children with Disabilities. US Department of Education. <http://www2.ed.gov/about/offices/list/ocr/504faq.html>. Updated December 19, 2013. Accessed August 15, 2014. Section 504 does not usually cover students who have temporary disabilities. Whether a temporary disability is substantial enough to constitute a disability for purposes of Section 504 is determined by the extent to which the disability limits an MLA and the expected duration of the disability. A disability is not a qualifying disability if it is expected to endure for 6 months or less. Frequently Asked Questions About Section 504 and the Education of Children with Disabilities. US Department of Education. <http://www2.ed.gov/about/offices/list/ocr/504faq.html>. Updated December 19, 2013. Accessed August 15, 2014.
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84. The ADA Amendments, effective January 1, 2009, provided that the definition of disability should be “construed in favor of broad coverage of individuals.” Pub L 110-325 §3(4)(A), codified at Americans with Disabilities Amendments Act of 2008, 42 USC §12101 (2012).
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