

# Indiana Health Law Review

---

Volume XXI

2024

Number 2

---

## NOTES

### **DEFYING THE ODDS: HOW INDIANA SCHOOLS SHOULD IMPLEMENT MULTISYSTEMIC THERAPY TO REDUCE THE RATE OF JUVENILE INCARCERATION FOR CHILDREN WITH OPPOSITIONAL DEFIANT DISORDER**

MADISON STEELE\*

#### I. ABSTRACT

Under Indiana Code Section 20-35-4-1.5, schools have a duty to educate students with a disability.<sup>1</sup> However, due to ineffective disciplinary measures in schools, students with debilitating behavioral health disorders are not receiving the education they are due. This Note will explore why Indiana should adopt legislation like New York's 'Timothy's Law' to allow for insurance coverage of Multisystemic Therapy to be implemented in schools as an alternative to other disciplinary actions for students diagnosed with disruptive behavioral disorders, and in particular, Oppositional Defiant Disorder (ODD). Specifically, this Note will begin with a hypothetical scenario of a young child diagnosed with ODD who did not receive proper treatment of his disorder. This Note will then outline what ODD is, its history, and discuss how it is currently treated. Next, this Note will outline how schools are affected by Oppositional Defiant Disorder and how this directly contributes to juvenile incarceration rates.

This Note will then propose a solution to juvenile incarceration rates of children with ODD by proposing that schools implement multisystemic therapy programs, modeled after a Californian logic model. During this proposal, this Note will discuss what Multisystemic Therapy is and how it would look in a school setting. This Note will further outline the cost of implementing the program and analyze how Indiana legislation currently has passed some legislation that can off-set the cost of the program. Finally, this Note will recommend further legislative changes like New York's "Timothy Law" that will allow for insurance coverage of the therapy.

---

\* J.D. Candidate 2024, Indiana University Robert H. McKinney School of Law. B.A. Law and Justice 2021, Auburn University. The author extends her gratitude to Professor Cynthia Baker and Professor Jonathan Warner for their mentorship and guidance during the note writing process. The author also thanks the editorial staff of the Indiana Health Law Review for their diligence in publishing this note.

1. IND. CODE § 20-35-4-1.5.

*A. John's Story*

John Carter, of Benton County, Indiana, was diagnosed at age eight with Oppositional Defiant Disorder (ODD).<sup>2</sup> Over the past year, during school and at home, John would experience frequent patterns of angry and irritable moods, argumentative and defiant behavior, and vindictiveness. Doctors described Oppositional Defiant Disorder to John's parents as a disruptive behavioral disorder in which children show frequent patterns of defiant acts, which appear typically in the presence of adults and authority figures.

After diagnosis, John's parents were referred to the nearest Children's Hospital that specialized in behavioral health treatment to set up an appointment. The following week, John Carter and his family made the hour and forty-five-minute journey to Indianapolis for their first of many weekly treatment sessions. Traveling to these therapy sessions required John to miss entire days of school and caused John's parents to take off work due to the distance needed to travel for treatment. Missing school often caused John to fall behind in his courses. Over the course of the next five-years, physicians tried several therapies and treatments to address John's behavioral issues including behavioral therapy, therapies targeted towards parent-child interaction, and medication.

Behavioral therapy was targeted towards John's ODD diagnosis because of the impulsive behaviors associated with the disorder. Doctors believed that if John learned how to control these impulses, he would be less likely to act defiantly in the presence of others. However, when John's behavioral issues persisted, doctors adjusted his therapy to be modeled around parent-child interactions. This therapy involved the therapist watching from an observation room with a one-way mirror or live video feed. During this therapy, John and his mother would interact with each other in a playroom while his mother was wearing an earpiece. Through the earpiece, the therapist would provide real-time coaching on skills to manage John's behavior.

One afternoon, while the Carter Family was in this interaction therapy, John was instructed by his mother to pick up the toys around the playroom. John refused and after several failed attempts to redirect his behavior, John's mother was instructed to leave the room by the therapist. His mother entered the observation room with the therapist and watched as John continued to play with the toys scattered around the room. When John realized his mother would not be returning to the room, his behavioral issues worsened and he began to make a larger mess in the playroom, scattering toys and tipping over furniture. The therapist instructed John's mother to wait in the observation room, under the suspicion that if his negative behavior were not acknowledged, he would cease his destructive conduct. Eventually, John threw a chair at the one-way mirror

---

2. John Carter is a fictional subject inspired by the author's personal experience with Oppositional Defiant Disorder and juvenile delinquency. His story is used to discuss the implications of the disorder and the effects that it can have on a child if not properly treated.

where he knew his mother and the therapist were observing. Concerned for his safety and the safety of others, the physician recommended that John be committed to the Children's Psychiatric Ward at the hospital they were at.

Following his in-patient care, John's parents felt that treatment at the Children's Hospital was not effectively addressing John's disorder. While he was making progress in his behavior at home, at school John received more negative marks for his behavior on the days following a trip to his therapy than he did leading up to the appointment. His parents feared that his missing school, and effectively falling behind in his lessons and not understanding the material, was causing him to act out even more. When they discussed alternative treatment with the physicians, they prescribed John medication to reduce the symptoms of his Oppositional Defiance Disorder. The Carter family was advised that they may have to try several medicines to find one that works for John.

John continued to act out in school, resulting in the principal sending him to the local alternative school. There he met two seventeen-year-old boys who lived in his neighborhood. When he returned from his alternative school placement, John's behavior persisted, resulting in several out-of-school placements through suspension. During these suspensions, John would be left home alone while his parents went to work. He would frequently meet up with the older boys in his neighborhood and engage in delinquent behavior such as committing curfew violations, underaged drinking, and illegally shooting fireworks.

One night, John and the two seventeen-year-old boys broke into the home of Carter's sixty-two-year-old neighbor, Susan Vance, while wearing bright orange ski masks. Vance, upon hearing the commotion, walked downstairs and found the boys rummaging through a closet under the staircase. Carter, who was standing nearest to the base of the stairwell, saw Vance approach and pulled out a plastic pistol that was spray-painted black to look more realistic. Believing that the gun in Carter's hand was real, Vance attempted to run upstairs where her phone was charging in her bedroom. Carter caught her by the arm and pulled her towards the other boys. The boys then threatened Vance and ordered her to show them where any cash was hidden. Vance directed the boys toward a vintage, sewing kit box where \$200 cash was hidden inside. The boys took the money and left the home. They were arrested the next day after police found a ski mask, matching the description given by Vance, hanging on a fence post separating Vance and Carter's homes. John Carter was fourteen years old when he was convicted of armed robbery and sentenced to seven years in a juvenile detention center.<sup>3</sup>

Children, like John Carter, who suffer from behavioral disorders, like Oppositional Defiant Disorder, are at an increased risk of being incarcerated in

---

3. Juveniles, of similar age to Carter, have been charged as adults for crimes like those in this example scenario; *see, e.g.*, *McGuire v. Lee*, 239 Ariz. 384 (Ariz. Ct. App. 2016).

their youth.<sup>4</sup> These youths are of younger ages at the time of the first arrest and have an increased risk of recidivism compared to children of similar ages without disruptive behavior disorders.<sup>5</sup> Of committed youth, nationally, 94.9% appeared to have significant symptoms of Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, or substance use disorder.<sup>6</sup>

## II. WHAT IS OPPOSITIONAL DEFIANT DISORDER (ODD)?

Oppositional Defiant Disorder is a disruptive behavioral disorder in which children show frequent patterns of defiant acts.<sup>7</sup> These uncooperative behaviors appear typically in the presence of adults and authority figures.<sup>8</sup> Symptoms of Oppositional Defiant Disorder include a pattern of angry/irritable mood, argumentative and defiant behavior, and vindictiveness lasting at least six months.<sup>9</sup> Children with ODD will often lose their temper; be easily annoyed, are often angry or resentful; will often argue with authority figures; actively defy or refuse to comply with request from authority figures; deliberately annoy others; and have a pattern of being spiteful or vindictive.<sup>10</sup> Like other children with Oppositional Defiant Disorder, the symptoms that John was experiencing can be seen in many children and teens, however children with ODD express these behaviors on a frequent basis and with more hostility than peers of their age.<sup>11</sup>

There is no known cause of Oppositional Defiant Disorder, but some physicians and researchers believe it can be linked to genetics and a child's environment (i.e. lack of supervision, inconsistent or harsh discipline, or abuse or neglect).<sup>12</sup> Without proper treatment, children, like John, will continue to lose their temper, argue with authority figures, and actively defy and refuse to comply with request from authority figures.<sup>13</sup> These continued behaviors can lead to an increased risk for a number of problems including antisocial behavior,

---

4. Marjorie Castillo, *Disruptive Behavior Disorders in Childhood and Criminal Justice System Involvement in Adolescence and Emerging Adulthood: Pilot Results Among Puerto Rican Youth* (2016) (M.A. Psychology Dissertation and Thesis, Hunter College CUNY) (on file with Hunter College CUNY's Theses and Dissertation collection).

5. *Id.*

6. Valerie Slater, *Juvenile Justice*, 56 U. Rich. L. Rev. 107, 122 (2021).

7. *Oppositional Defiance Disorder*, NATIONWIDE CHILD.'S HOSP., <https://www.nationwidechildrens.org/conditions/oppositional-defiant-disorder> [<https://perma.cc/4NPR-8VEM>] (last visited Sept. 5, 2022).

8. *Id.*

9. AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 462 (5<sup>th</sup> ed. 2013).

10. *Id.*

11. *Oppositional Defiance Disorder*, *supra* note 7.

12. *Oppositional Defiant Disorder*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/oppositional-defiant-disorder/symptoms-causes/syc-20375831> [<https://perma.cc/M2U2-8SCV>] (last visited Oct. 16, 2022).

13. AM. PSYCHIATRIC ASS'N, *supra* note 9. These are only a fraction of symptoms experienced by children with Oppositional Defiant Disorder.

impulse-control problems, substance abuse, anxiety, and depression.<sup>14</sup> When Oppositional Defiant Disorder is not properly addressed, children with the disorder will experience frequent conflicts with parents, teachers, supervisors, and peers.<sup>15</sup> These problems lead to impairments in the child's present and future emotional, social, academic and occupational development.

#### *A. History of ODD as a Declared Mental Disorder*

Oppositional Defiant Disorder was first introduced into the second edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).<sup>16</sup> It was not listed as an official disorder until the publication of the third edition of the DSM in 1980.<sup>17</sup> With this designation, there were questions as to the validity of the disorder. Many criticized that ODD was just unruly behavior, and others argued that the disorder was just a mild form of a Conduct Disorder.<sup>18</sup> Revisions were made to the DSM in 1987 and 1994 to answer these questions and distinguish ODD from Conduct Disorder.<sup>19</sup> The 1987 revision clarified that ODD is separate from Conduct Disorder because its symptoms are considered to be less aggressive.<sup>20</sup> The published research at the time even suggested that ODD could be a pre-cursor to conduct disorder in extreme cases.<sup>21</sup> Because of this research, and clarifications, ODD has now become widely accepted as a disorder but there is still confusion about the frequency and severity of the disorder, especially because the symptoms can lead to incomplete diagnosis through comorbid disorders or through differential diagnosis.<sup>22</sup>

For example, attention deficit hyperactivity disorder (ADHD) frequently overlaps with "externalizing disorders" such as ODD.<sup>23</sup> With both disorders, children may resist work or school task that require self-application.<sup>24</sup> In ADHD the children resist work or school task that require self-application due to their inability to keep focus on assignment.<sup>25</sup> However, children with ODD resist work because they resist conforming to others demands.<sup>26</sup> Rates of ODD are found more frequently in children with ADHD, which is theorized to be the

---

14. *Id.* at 464.

15. *Id.* at 465.

16. Dustin A. Pardini, et. al, *Building an Evidence Base for DSM-5 Conceptualizations of Oppositional Defiant Disorder and Conduct Order: Introduction to the Special Section*, 119 NAT'L LIBR. MED. 683-88 (2010), [<https://perma.cc/9BY9-XXEF>].

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

23. DSM-V, *supra* note 9, at 65.

24. *Id.* at 63.

25. *Id.*

26. *Id.*

result of temperamental risk factors.<sup>27</sup> Additionally, children with ODD are at increased risk for diagnosis of anxiety disorders and major depressive disorders.<sup>28</sup> These diagnoses are attributable to the presence of the angry and irritable moods.<sup>29</sup>

With the publication of the DSM-V, the fifth edition of the manual, came several updates to the diagnosis of ODD.<sup>30</sup> Symptoms of the disorder were grouped into three major categories: vindictiveness, angry/irritable moods, and argumentative behavior.<sup>31</sup> These groupings were used to emphasize that the disorder is both behavioral and emotional.<sup>32</sup> Information on the frequency of the symptomatic behaviors was also added to the newest edition of the DSM.<sup>33</sup> This information is useful for physicians tasked with diagnosing the disorder because it allows them to differentiate between poor, but normal, childhood behavior and behavior caused by ODD. The final update with the DSM-V was a new severity category that allows physicians to analyze the disorder across different settings to determine how the disorder is affecting the child's life.<sup>34</sup>

There are three levels of severity that physicians use to diagnose ODD.<sup>35</sup> A mild diagnosis is given when symptoms are confined only to one setting (e.g. at home, at school, at work, or with peers).<sup>36</sup> A diagnoses of moderate Oppositional Defiant Disorder shows that symptoms of the behavior present themselves in at least two settings (e.g. both at home and in school). When a child is diagnosed with a severe case of ODD, they are exhibiting symptoms in three or more settings. John Carter's diagnosis would be appropriate under this severe category.

### *B. Current Medical Based Treatments of ODD*

Early diagnosis by a trained child psychologist or psychiatrist is crucial to treat the disorder and prevent future problems.<sup>37</sup> Popular treatment for Oppositional Defiant Disorder includes cognitive-behavioral therapy, family therapy, and medicines to treat comorbid disorders such as ADHD which exacerbate the symptoms of the disorder.<sup>38</sup>

---

27. *Id.*

28. *Id.* at 462.

29. *Id.*

30. Pardini *et al*, *supra* note 16.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.*

35. DSM-V, *supra* note 9, at 462-63.

36. *Id.*

37. Oppositional Deviance Disorder (ODD) in Children, JOHN HOPKINS MED., <https://www.hopkinsmedicine.org/health/conditions-and-diseases/oppositional-defiant-disorder> [https://perma.cc/Q3NK-6U6U] (last visited Sept. 5, 2022).

38. *Id.*

### 1. Cognitive Behavioral Therapy

Cognitive behavioral therapy is a form of therapy that looks to identify and change potentially self-destructive or unhealthy behaviors.<sup>39</sup> Cognitive behavioral therapy is centered around how one's thoughts and beliefs influence one's actions and moods.<sup>40</sup> It focuses on current problems and how to solve them.<sup>41</sup> The long-term goal is to build thinking and behavioral patterns that helps the patient achieve a better quality of life.<sup>42</sup> This therapy was targeted towards, the hypothetical, John Carter's ODD diagnosis because of the impulsive behaviors associated with the disorder. Doctors believed that if John learned how to control these impulses, he would be less likely to act defiantly in the presence of others.

Cognitive behavioral therapy may be one of the most productive treatments towards ODD available to patients. Some critics of cognitive behavioral therapy believe that because it only addresses current problems and focuses on specific issues, the underlying cause of mental health conditions are not addressed.<sup>43</sup> Cognitive behavioral therapy only focuses on the individual's ability to change themselves through their thoughts, feelings, and behaviors. It does not look at wider problems in the child's environment like their families or peers that may have a significant impact on their health and wellbeing.<sup>44</sup> Other therapies may help bridge this gap between a child's internal issues and their environment. Multisystemic therapy, for example, would do this by targeting the child's school, home, and community environments and the interactions held within those environments.

### 2. Parent-Child Interaction Therapy

Parent-child interaction therapy is a behavioral therapy that is conducted through coaching sessions that navigate parent-child interactions.<sup>45</sup> This therapy involves the therapist watching from an observation room with a one-way mirror or live video feed.<sup>46</sup> During this therapy, a parent and child will interact with each other in a play room while the parent is wearing an earpiece, where the therapist will provide real time coaching on skills to manage a child's

---

39. Ana Gotter & Molly Burford, *Behavioral Therapy*, HEALTHLINE, <https://www.healthline.com/health/behavioral-therapy#who-benefits> [<https://perma.cc/XJ82-A3Q2>] (Mar. 17, 2022).

40. *Id.*

41. *Id.*

42. *Id.*

43. *Pros and Cons of CBT Therapy*, THE CBT CLINIC, <http://www.thecbtclinic.com/pros-cons-of-cbt-therapy> [<https://perma.cc/FZW2-VJBF>] (last visited Mar. 26, 2023).

44. *Id.*

45. *What is Parent-Child Interaction Therapy (PCIT)?*, PCIT INTERNATIONAL, [www.pcit.org/what-is-pcit.html](http://www.pcit.org/what-is-pcit.html) [<https://perma.cc/KKPF4-BHVX>] (last visited Oct. 16, 2022).

46. *Id.*

behavior.<sup>47</sup> Doctors attempted this therapy with John Carter and his parents because some behavioral physicians and researchers believe ODD can be caused by a child's environment (i.e. "lack of supervision, inconsistent or harsh discipline, or abuse or neglect").<sup>48</sup> Parent-Child Interaction Therapy is conducted in two phases.<sup>49</sup> First, the treatment focuses on establishing a warmer relationship between parent and child "through learning and applying skills that allow children to feel calm, secure in their relationships with their parents, and good about themselves."<sup>50</sup> The second phase of this therapy focuses on equipping the parent to manage their child's behaviors while remaining calm, confident, and consistent in their approaches to discipline.<sup>51</sup>

This therapy yields positive results towards reforming a child's interaction with their parents and vice-versa. While this is productive in repairing the home environment, there is no guarantee that the behavioral therapy will translate into other environments of the child's life (such as in school or in the community). An alternative therapy, like Multisystemic Therapy would focus on individual, family, peer, school, and community risk factors that contribute to concerning behaviors. Through focusing on more than one environment of a child's life, children can learn to transfer their learned behaviors into different areas of their day-to-day.

### 3. Medication

Medication is usually only prescribed to children with disruptive behavioral disorders if "psychosocial treatment does not help enough."<sup>52</sup> "These medicines cannot cure disruptive behavioral disorders", but they can be "used to reduce the symptoms and improve [a child's] quality of life."<sup>53</sup> These medicines will work differently in different children and teens because of the way they change how certain chemicals act in the brain.<sup>54</sup> Because of this, parents "may have to try several medicines to find one that works" for each child.<sup>55</sup>

This treatment for ODD is helpful in reducing the symptoms of the disorder and may reduce the impulses to act out. However, the root of the issue is not being addressed. Children's behavioral problems are still present, even though they may not be as visual. Multisystemic therapy would work to reduce delinquent behavior by improving cognitive responses to temperamental

---

47. *Id.*

48. MAYO CLINIC, *supra* note 12.

49. PCIT INTERNATIONAL, *supra* note 45.

50. *Id.*

51. *Id.*

52. *Treating Disruptive Behavior Disorders in Children and Teens*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <https://effectivehealthcare.ahrq.gov/products/disruptive-behavior-disorder/consumer>, [<https://perma.cc/9RYJ-YGUD>] (last visited Oct. 16, 2022).

53. *Id.*

54. *Id.*

55. *Id.*



triggers.

### III. WHY SHOULD INDIANA FOCUS ON TREATING OPPOSITIONAL DEFIANT DISORDER IN SCHOOLS?

When students, like those with Oppositional Defiant Disorder, consistently exhibit disruptive behavior, they are often disciplined by being removed from the classroom through suspension, detention, or other out of school placements like alternative schools.<sup>56</sup> Detrimental discipline policies, such as removing students from school for disruptive behavior, contributes to the school-to-prison pipeline. The more a child is suspended, the less likely they are to complete or even return to school.<sup>57</sup> A child's conduct, if not properly addressed, is likely to become more severe when they are not able to attend school, leading to out of home placements in residential facilities and similar juvenile detention centers.<sup>58</sup> By removing the child from school, via suspension or similar disciplinary measures, the root of the behavioral problems are not being addressed.

#### A. *History of the School to Prison Pipeline*

The “school-to-prison pipeline” represents a national trend where primarily youth of color, children with disabilities, and children with histories of poverty, abuse, or neglect are funneled out of public schools and into the juvenile and criminal legal systems.<sup>59</sup> Prior to the Gun-Free Schools Act of 1994, keeping children out of school as a punishment was rare and fewer than 4% of students were suspended across the United States in 1973.<sup>60</sup> This act, signed into law by President Bill Clinton, encouraged states who received federal funding to implement “zero-tolerance policies” which required educational agencies to, at minimum, implement one-year expulsions upon any student that has brought a weapon to school.<sup>61</sup> Additionally, schools were directed to refer these children to the criminal justice or juvenile delinquency system, or risk losing their federal funding.<sup>62</sup>

The rate of suspension drastically increased as schools began to interpret the term “weapon” broadly; leading to the suspension and expulsion of students

---

56. Amreen Khan, *Multisystemic Therapy Can Help Slow the School-to-Prison Pipeline*, MST SERVICES, <https://www.mstservices.com/school-safety-resources> (last visited Oct. 16, 2022) [<https://perma.cc/DD49-SRAQ>].

57. *Id.*

58. *Id.*

59. *School-to Prison Pipeline*, ACLU, <https://www.aclu.org/issues/juvenile-justice/juvenile-justice-school-prison-pipeline> [<https://perma.cc/4QXB-EJL9>] (last visited Oct. 16, 2022).

60. Libby Nelson & Dara Lind, *The school-to-prison pipeline, explained: Police officers in Classrooms are just the tip of the iceberg*, VOX (Oct. 27, 2015, 11:05 AM), <https://www.vox.com/2015/2/24/8101289/school-discipline-race> [<https://perma.cc/RW9Z-VKNL>].

61. Gun-Free School's Act, 20 U.S.C.A. § 7961

62. *Id.*

who, for example, made handguns with their fingers, or chewed Pop-tarts into the shape of a gun.<sup>63</sup> Around the same time as these zero-tolerance policies were being enacted, schools were also heavily disciplining small offenses to “make [students] feel safer and discourage more serious crimes.”<sup>64</sup> This meant that bad behaviors such as talking back to teachers, skipping class, or being disobedient or disruptive, would lead to more suspensions and out-of-school placements.<sup>65</sup> Children with ODD are likely to exhibit these behaviors, putting them at greater risk of heavy discipline under these strict policies. Students who are suspended are more likely to repeat a grade, or drop out, than students who were not.<sup>66</sup> A Texas study found that students who had been suspended or expelled were twice as likely to drop out compared to students with similar characteristics at similar schools who had not been suspended.<sup>67</sup>

Following the Columbine massacre,<sup>68</sup> school administrators also began relying heavily on School Resource Officers (SROs) being stationed at school. While there is no federal mandate requiring the use of SROs, the National Association of School Resource Officers estimated in 2018 that at least 42% of schools in the United States have at least one SRO present at least one day a week during the academic year.<sup>69</sup> However, the resource officers who were designated for a specific occurrence, to prevent school shootings, were soon being used to manage misdemeanor and civil violations caused by students.<sup>70</sup> These officers patrol the schools, often with little to no training on how to work with youth.<sup>71</sup> This resulted in more school-based arrests, “the majority of which [were] for non-violent offenses, such as disruptive behavior.”<sup>72</sup>

Prior to Governor Eric Holcomb signing House Bill 1093 into law in February of 2022, there were a large number of police officers working inside of Indiana schools without specialty training on how to interact with children.<sup>73</sup>

---

63. Patrik Jonsson, *Ohio boy suspended for pointing finger like a gun. ‘Zero tolerance’ run amok?*, THE CHRISTIAN SCIENCE MONITOR (Mar. 4, 2014) <https://www.csmonitor.com/USA/Education/2014/0304/Ohio-boy-suspended-for-pointing-finger-like-a-gun.-Zero-tolerance-run-amok> [<https://perma.cc/ZCP3-TUHY>].

64. Libby Nelson & Dara Ling, *supra* note 60.

65. *Id.*

66. *Id.*

67. *Id.*

68. The 1999 school shooting and attempted bombing in Columbine, Colorado, that resulted in the death of twelve students and one teacher. See Charles Schaefer, *Columbine Shooting*, HISTORY (June 29, 2023), <https://www.history.com/topics/1990s/columbine-high-school-shootings> [<https://perma.cc/3AQZ-LDTD>].

69. *How Many School Resource Officers are There in the United States?*, NAT’L ASS’N OF SCH. RES. OFFICERS, <https://www.nasro.org/faq/> [<https://perma.cc/4QFN-UA7L>] (last visited Jan. 23, 2024).

70. Libby Nelson & Dara Ling, *supra* note 60.

71. *Id.*

72. ACLU, *supra* note 59.

73. Lee V. Gaines, *New Law Closes Training Loophole for Police in Indiana Schools*, WFYI INDIANAPOLIS, <https://www.wfyi.org/news/articles/holcomb-signs-law-training-loophole-police-indiana-schools> [<https://perma.cc/AN2G-PNR9>] (last visited, Mar. 1, 2023).

Previous legislation required that any officer who identified themselves as an SRO was required to undergo an forty-hour SRO training from the National Association of School Resource Officers.<sup>74</sup> This training taught officers basic understandings “on adolescent brain development, how to interact with students with disabilities,” how to understand racial biases, and other subjects to improve officer-student interactions.<sup>75</sup> A loophole existed in previous legislation — according to Chase Lyday, director of the Indiana School Resource Officer Association — that police who worked inside of schools could avoid the required training by not identifying themselves as SROs.<sup>76</sup> Lyday reported that the state did not track how many officers in school had received the basic SRO training, so there was no way to determine if police in schools were properly trained.<sup>77</sup> During the 2018–2019 academic year, 1,217 arrests occurred in schools across the state of Indiana.<sup>78</sup> This total accounted for 1% of all students enrolled in public schools across the state. According to the 2020 Indiana Probation Report, created in accordance with Indiana Code Section 31-31-10-1 et seq., a total of 6,412 individuals ranging from ages six-to-eighteen were declared juvenile delinquents.<sup>79</sup>

House Bill 1093 was designed to eliminate this loophole. The bill amends several sections of the Indiana Code concerning education and the responsibilities of school resource officers.<sup>80</sup> The bill defines an SRO as “a law enforcement officer who has completed the [required] training . . . , [and] is assigned to one (1) or more school corporations or charter schools during school hours.”<sup>81</sup> Through this new definition, the previous loophole has been eliminated because officers do not have to identify themselves as SROs in order to require the training, they need only to be assigned to a school corporation during school hours. The law also specifies that officers must receive the required forty-hours of training within one-hundred-eighty days from the date the officer is assigned as an SRO.<sup>82</sup> The law, as amended, opens “law enforcement agencies to potential legal action” when an SRO is found to have not completed the training, or violated the duties of their role.<sup>83</sup>

---

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. Stephanie Wang & Dylan Peers McCoy, *Why Are School Police Twice as Likely to Arrest Black Students in Indiana Than White Students?*, CHALKBEAT INDIANA, <https://in.chalkbeat.org/2020/6/24/21301860/indiana-black-students-arrested-2-5-rate-of-white-peers> [https://perma.cc/7HLU-FGMD] (last visited, Oct. 16, 2022).

79. PROBATION DEPARTMENT OF THE JUVENILE COURT, 2020 INDIANA PROBATION REPORT: SUMMARY AND STATISTICS, 25, <https://www.in.gov/courts/iocs/files/rpts-ij-s-2020-probation.pdf> [https://perma.cc/64YS-KUW9] (last visited June 17, 2024).

80. H.B. 1093 (In. 2022).

81. *Id.*

82. *Id.*; the training requirement may be extended to up to a year if the assigned school has a student population of less than one thousand.

83. Lee V. Gains, *supra* note 73.

This amended law is a critical step towards reforming how schools, and SROs, manage juvenile misconduct; however, children are still at risk of juvenile detention with these changes. When a school permits an SRO to arrest a student, they are turning the student over to the juvenile justice system, making it easier for a student to gain a juvenile record.<sup>84</sup> For districts with disciplinary alternative schools, children who are removed from their regular schools are often sent to alternative schools that are not regulated by educational accountability standards, like curriculum requirements and minimum classroom hours.<sup>85</sup> This means that children already struggling from out-of-school placements are returning to the classroom unprepared.<sup>86</sup> Students in districts without alternative schools, or students who are funneled through alternative schools into the juvenile justice system, are often denied procedural protection in court.<sup>87</sup> Up to 80% of court-involved children do not have lawyers.<sup>88</sup>

Children put on probation within the juvenile justice system may end up in out-of-home placements for minor probation violations like missing school or disobeying teachers.<sup>89</sup> In 2022, Indiana was still incarcerating juveniles at a rate that is around 40% higher than the national average.<sup>90</sup> Around 55% of Indiana children and teens who were detained in 2022, prior to a court decision, were accused of misdemeanors like theft or possession of marijuana.<sup>91</sup> About 5% of the youth in Indiana who were detained prior to trial, in 2022, were accused of offenses that are only illegal because of their age, such as running away or missing school.<sup>92</sup> Students who end up in out-of-home placements like juvenile detention facilities are provided with few, if any, educational services.<sup>93</sup> These delays make it harder for the impacted children to finish school, leading to higher chances of delinquency and recidivism as an adult.

### *B. Juvenile Incarceration and Its Long-Term Effects*

During a recent study conducted by The Marshall Project, Keri Blakinger and Maurice Chammah interviewed over a dozen cases of death row prisoners who previously spent time in juvenile detention centers.<sup>94</sup> Throughout the study,

---

84. Libby Nelson & Dara Ling, *supra* note 60.

85. ACLU, *supra* note 59.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. Dylan Peers McCoy & Katrina Pross, *Why Indiana Locks Up More Children and Teens than New York*, WFYI (Nov. 16, 2022), <https://www.wfyi.org/news/articles/indiana-detains-commits-at-a-rate-40-above-the-national-average> [<https://perma.cc/3J7K-FPH6>].

91. *Id.*

92. *Id.*

93. ACLU, *supra* note 59.

94. Keri Blakinger & Maurice Chammah, *They Went to Prison as Kids. Now They're on Death Row: Fight clubs, solitary confinement and neglect make juveniles angrier and more*

The Marshall Project noted the history of policing and detaining youth and how it often leads to angrier and more violent behavior than when the juveniles entered the facilities.<sup>95</sup> As early as 1830, the United States implemented the first “reform school” which aimed to “rehabilitate troubled city kids through communion with nature.”<sup>96</sup> These “schools” eventually evolved to work farms where children were violently abused.<sup>97</sup> In the 20<sup>th</sup> century, states began sending “juvenile delinquents” to youth prisons.<sup>98</sup> In states, like Texas, kids were reporting abuses that could only be described as “exotic torture.”<sup>99</sup>

In the class action suit of *Ruiz v. Estelle*, eight inmates sued Texas Department of Corrections alleging that present conditions of their incarceration (including overcrowding, lack of access to health care, and abusive security practices) were a violation of their constitutional rights under the Eighth Amendment.<sup>100</sup> The United States District Court for the Southern District of Texas found that the conditions of the Texas Department of Corrections prisons constituted cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution.<sup>101</sup> After *Ruiz* a nationwide trend began to move away from incarceration and into moving “delinquent children” into group homes that emphasized treatment.<sup>102</sup> Soon after the movement came into effect, the war on drugs began.<sup>103</sup> This created fear, across the country, of teenage “super predators” which led to an influx of juvenile incarceration.<sup>104</sup> Researchers found that incarceration, both in juveniles and adults, leads to increased recidivism rates.<sup>105</sup> Researchers found that people incarcerated during their youth were less likely to finish high school and more likely to be incarcerated as adults.<sup>106</sup>

Juan Ramirez, another inmate on death row, tried to escape gang involvement as a teenager but was eventually sent to a juvenile detention center “dominated by gang violence.”<sup>107</sup> Michele Deitch, a professor at the University of Texas, wrote a defense affidavit on behalf of Mr. Ramirez.<sup>108</sup> In the affidavit, she noted that “the punitive treatment of youth confirms their self-identity as

---

*violent*, THE MARSHALL PROJECT (Feb. 1, 2022), <https://www.themarshallproject.org/2022/02/01/they-went-to-prison-as-kids-now-they-re-on-death-row> [https://perma.cc/U3MT-R6N9].

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *See generally*, *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980).

101. *Id.*

102. Plakinger & Chammah, *supra* note 94.

103. *Id.*

104. *Id.*

105. *Id.*

106. McCoy & Pross, *supra* note 90.

107. Blakinger & Chammah, *supra* note 94.

108. *Id.*

criminals and increases their anger, trauma, and reliance on physical force.”<sup>109</sup>

In Indiana, VirSarah Davis’s son was “held in juvenile detention so many times, the reasons blur together in her memory,” starting with the first detention at only ten-years-old.<sup>110</sup> Following the initial detainment, Davis’s son was in-and-out of detention for the next eight years.<sup>111</sup> She noted that every time he came home, he became less like himself and acted more like he was still in detention.<sup>112</sup> Executive Director of the Children’s Policy and Law Initiative of Indiana noted that “the justice system imposes its own trauma. . . [a]nytime you take a child into a locked situation, you’re going to be imposing, potentially, more harm.”<sup>113</sup>

Juvenile incarceration facilities are continuing to fail to address the root causes of the problems that led to incarceration in the first place. It is important that children receive adequate care and support to prevent both the initial incarceration, and to reduce the rate of recidivism for those who have already become victims of mass incarceration. There is robust evidence that Multisystemic Therapy reduces the likelihood of incarceration and recidivism for juveniles more than other treatments.<sup>114</sup>

#### IV. MULTI-SYSTEMIC THERAPY AS AN ALTERNATIVE TO DISCIPLINARY ACTION

In the Indiana Behavioral Health Commission’s September 2022 report, the commission reported that members unanimously agreed that the intersection between criminal incarceration and individuals with behavioral health issues is a priority area that needs to be addressed.<sup>115</sup> Their report found that 37% of people in state and federal prisons, and 44% of people in jail have been diagnosed with a mental illness.<sup>116</sup>

Multisystemic Therapy (MST) is an intensive family and community-based treatment for at-risked youth.<sup>117</sup> The goal of MST is to decrease criminal behavior in juveniles and reduce “out-of-home” placements.<sup>118</sup> MST treatments

---

109. *Id.*

110. McCoy & Pross, *supra* note 90.

111. *Id.*

112. *Id.*

113. *Id.*

114. *Multisystemic Therapy (MST) for Juvenile Offenders*, COUNTY HEALTH RANKINGS, <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/multisystemic-therapy-mst-for-juvenile-offenders> [https://perma.cc/Q7S3-XJHM] (last visited Mar. 23, 2023).

115. INDIANA BEHAVIORAL HEALTH COMMISSION, FINAL REPORT 27 (2022), <https://www.in.gov/fssa/dmha/files/INBHC-Report.pdf> [https://perma.cc/T5RN-SWLM].

116. *Id.*

117. COUNTY HEALTH RANKINGS, *supra* note 114.

118. CALIFORNIA EVIDENCE-BASED CLEARINGHOUSE FOR CHILD WELFARE, MULTISYSTEMIC THERAPY PROGRAM GUIDE (2009), <https://www.cebc4cw.org/program/multisystemic-therapy/detailed> [https://perma.cc/XDL4-XZPA].

include several key features like: (a) integration of treatment approaches aimed to address risk factors across family, peer, school, and community contexts; (b) promotion of behavior changes in children's natural environment and to empower caregivers; and (c) implementing assurance mechanisms that focus on maintaining treatment fidelity and which overcome barriers of the intended behavior change.<sup>119</sup> This treatment, unlike other mental health treatments that focuses on one core issue, works to both reshape behavioral responses as well as rebuilding relationships within a child's environment.<sup>120</sup> The program targets all influences of a child's ecology.

The California Evidence-Based Clearinghouse for Child Welfare created a Multisystemic Therapy Program Guide outlining the program, required training, and implementation. The program's key components include improving family functioning, and intervention into peer, school, and community ecology.<sup>121</sup> These interventions improve family functioning; decreases association with negative peers; improves school behavior, attendance, and performance; improves family connections with informal supports, community resources, and formal systems; and increases prosocial attitudes and skills within the individual which reduces other individually based problems for children.<sup>122</sup> Each therapist carries a maximum caseload of six families and each case length would range from three-to-five months.<sup>123</sup>

The expected beneficial outcomes of the program include a reduced rate of incarceration and recidivism for at-risk youth.<sup>124</sup> Other potential benefits include reduced delinquent behaviors, reduced risk of substance abuse disorders, improved family and community interactions, improved mental health, and reduced foster care use.<sup>125</sup>

#### A. What Would Multisystemic Therapy Look Like in Schools?

According to California's program guide, service intensity would vary slightly with the needs of the student in the program.<sup>126</sup> Early in the treatment, the therapist may meet with the student several times per week, but as treatment progresses the intensity tapers.<sup>127</sup> The recommended duration of the multisystemic therapy is typically between three-to-five months.<sup>128</sup> During this

---

119. *Id.*

120. *Id.*

121. Scott Henggeler et. al, *Multisystemic Therapy Logic Model*, EVIDENCE-BASED PREVENTION & INTERVENTION SUPPORT CTR. AT PENN ST. UNIV., <https://www.episcenter.psu.edu/sites/default/files/202006/MST%20Logic%20Model%20rev%202015.pdf> [<https://perma.cc/6TY4-863P>] (last revised Feb. 2015).

122. *Id.*

123. CALIFORNIA EVIDENCE BASED CLEARINGHOUSE FOR CHILD WELFARE, *supra* note 118.

124. COUNTY HEALTH RANKINGS, *supra* note 114.

125. *Id.*

126. Henggeler et. al, *supra* note 121.

127. CALIFORNIA EVIDENCE BASED CLEARINGHOUSE FOR CHILD WELFARE, *supra* note 118.

128. *Id.*

time a MST therapist will meet with the caregiver, family, and/or youth, as well as others in the child's life. Services are delivered in home, school, and community, at times convenient for the family.<sup>129</sup> Specific strategies and techniques will then be selected and tailored after careful assessment of the factors driving the problem behavior.<sup>130</sup> Interventions are then closely monitored for effectiveness and modified as needed.<sup>131</sup> MST would include a homework component, which may be assigned in relation to parent management training, treatment for anger management, treatment for caregiver or youth substance abuse, or for family communication training.<sup>132</sup> MST therapists will then target decreasing risk factors that increase the likelihood of negative outcomes, such as drug use, delinquency, school dropouts, violent behavior, and incarceration.<sup>133</sup> They will also target increasing protective factors that exert positive influence, such as engagement in prosocial activities in school and community, commitment to schooling, problem-solving skills, and more that buffer against negative outcomes.<sup>134</sup>

During this time, a child should be given their own individualized education plan (IEP) to be used as the therapy is being implemented. IEPs serve as a “map that lays out the program of special education instruction, supports, and services kids need to make progress and thrive in school.”<sup>135</sup> These individualized educations should give students extra help and support in the classroom while they are completing the multisystemic therapy program. These plans will be effective in insuring that these children continue to learn alongside their peers in regular classroom settings, as much as possible, while still getting the accommodation needed to be successful in the curriculum.

However, the implementation of IEPs should not be seen as a permanent solution for children with behavioral health issues, like Oppositional Defiant Disorder. While IEPs typically contain several educational objectives that make it easier for a child to understand the curriculum,<sup>136</sup> they do not target solutions to the cognitive, behavioral, and social struggles children with disruptive behavioral issues face. These children with Behavioral Health Disorders need programs like multisystemic therapy to address these cognitive, behavioral, and social issues so that youths are better prepared to function within and to keep up with the pace of the general classroom setting as well as the curriculum they are expected to follow. IEPs will not follow children into post-secondary education or the workforce, but the behavioral coping skills they develop within the multisystemic therapy will follow them beyond the classroom.

---

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. COUNTY HEALTH RANKINGS, *supra* note 114.

135. Gail Belsky, *What is an IEP?*, UNDERSTOOD, <https://www.understood.org/en/articles/what-is-an-iep> [<https://perma.cc/64ER-389L>] (last visited Mar. 23, 2023).

136. *Id.*



Supervisors over the program should be required to be, at minimum, Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies.<sup>137</sup> At least 66% of therapists must have a master's degree in counseling or social work.<sup>138</sup> To meet the demands of the program, it is important to utilize Indiana Code Section 20-20-18.5-1, which created a grant provides funding for training for school counselors in kindergarten to grade twelve schools to obtain a mental health counselor license under Indiana Code Section 25-23.6-8.5.<sup>139</sup> This grant would fund a school counselor to receive the master's degree needed to supervise the program.

Further, it would be beneficial if the supervisor understood juvenile justice and child welfare systems.<sup>140</sup> They must have some experience in managing severe family crises that involve safety risks to the family.<sup>141</sup> Clinical teams for the MST program would include a staff of two to four therapists and a supervisor.<sup>142</sup> All staff within the program would complete a standard five-day orientation. After which the team would participate in weekly consultation with an expert on the program, quarterly booster training, ongoing organizational assistance, and quality assurance support through the monitoring of treatment adherence.<sup>143</sup>

The targeted population for MST is delinquent or antisocial youth between the ages of twelve-to-seventeen-years-old who are at imminent risk of out-of-home placement due to criminal offenses; those who experience physical aggression at home, at school, or in the community; and those who express verbal aggression, or verbal threats of harm to others.<sup>144</sup> The Indiana Code defines a delinquent child who needs care, treatment, or rehabilitation as

a child who, before becoming eighteen years of age, . . . commits a delinquent act; and 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.<sup>145</sup>

A child could be considered delinquent and in need of care for a number of reasons including, but not limited to, violations of compulsory school

---

137. CALIFORNIA EVIDENCE BASED CLEARINGHOUSE FOR CHILD WELFARE, *supra* note 118.

138. *Id.*

139. IND. CODE § 20-20-18.5-1 (2015).

140. CALIFORNIA EVIDENCE BASED CLEARINGHOUSE FOR CHILD WELFARE, *supra* note 118.

141. *Id.*

142. *Id.*

143. *Id.*

144. *Multisystemic Therapy*, THE FAMILY PARTNERSHIP, <https://www.thefamilypartnership.org/services/mental-health-therapies/multisystemic-therapy/> [https://perma.cc/UG22-BUPS] (last visited Mar. 24, 2023).

145. IND. CODE § 31-37-2-1 (2022).

attendance,<sup>146</sup> leaving home, or a designated location without reasonable cause or parental approval,<sup>147</sup> being out past curfew,<sup>148</sup> or disobeying a parent, guardian, or custodian (such as a teacher or school administrator).<sup>149</sup> These “delinquent acts” can be minor and are often over policed, leading to out-of-home and out-of-school placements to punish the child for committing these acts.

Multisystemic therapy can be used to target a broad range of behavioral health issues, many of which are diagnosed comorbidly with Oppositional Defiant Disorder.<sup>150</sup> These disruptive, impulse-control, and conduct disorders work well in a multisystemic therapy setting because the treatment works to address the distress in the individual and others within his or her immediate social context (i.e. family, peer group, school administration).<sup>151</sup> These disorders tend to be more common in males than in females, although the degree of predominance between genders may vary across disorders and within a disorder at different ages.<sup>152</sup> Children with Oppositional Defiant Disorder are at risk for eventually developing other disorders, including anxiety and depressive disorders which can further lead to increased risks of developing substance-use disorder.<sup>153</sup> This raises their risk of being incarcerated for crimes associated with substance use and possession of illegal substances (e.g., driving under the influence, or charges of possession). Addressing this disorder as soon as possible reduces the risk of other disorders developing and further reduces the risk of incarceration.

One roadblock of the MST program is that it excludes youth living independently or without a primary caregiver; those who are actively suicidal, homicidal, or suffering from psychosis; and those who have severe difficulties with social communication and interaction, such as those with autism.<sup>154</sup> This is mainly because the program’s focus is to improve behavioral responses to a child’s environment. This program focuses on the child’s environment in school, home, and community. It is crucial that they can communicate effectively with a caregiver who can provide them with adequate support during this therapy. While other programs may be available to those who do not qualify as participants in the multisystemic therapy program, this issue is beyond the scope of this Note.

---

146. IND. CODE § 31-37-2-3 (2022).

147. IND. CODE § 31-37-2-2 (2022).

148. IND. CODE § 31-37-2-5 (2022).

149. IND. CODE § 31-37-2-4 (2022).

150. DSM-V, *supra* note 9 at 465.

151. CALIFORNIA EVIDENCE BASED CLEARINGHOUSE FOR CHILD WELFARE, *supra* note 118.

152. DSM-V, *supra* note 9 at 461.

153. *Id.*

154. CALIFORNIA EVIDENCE BASED CLEARINGHOUSE FOR CHILD WELFARE, *supra* note 118.

### *B. Legislative Changes to Support Therapy Implementation*

Under the Federal Patient Protection and Affordable Care Act, group and individual health insurance providers must provide essential health benefits in accordance with federal and state laws. “Essential health benefits” must include: “ambulatory patient services; emergency services; hospitalization; maternity and newborn care; *mental health and substance use disorder services including behavioral health treatment*; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.”<sup>155</sup> Thirty-four states have licensed multisystemic therapy providers, and some states, including Indiana, fund these programs through Medicaid state plans.<sup>156</sup>

In Indiana, outpatient coverage for mental health treatment is available to the following provider types, who are enrolled within the Managed Care Entities (MCE) network: Outpatient mental health treatments, community mental health centers (CMHCs), psychologist, psychiatrist, health service providers in psychology, certified social workers, certified clinical social workers, psychiatric nurse, independent practice school psychologists, advanced practice nurses (credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center), and persons holding a master’s degree in social work, marital and family therapy, or mental health counseling, under 405 IAC Section 5-20-8.<sup>157</sup>

Currently, the Indiana Department of Insurance may review insurance plans for parity compliance only to the extent that an insurance plan chooses to include any coverage of behavioral health care.<sup>158</sup> However, it lacks any enforcement ability to investigate violations that may occur in practice.<sup>159</sup> By implementing legislation like Timothy’s Law, the Indiana Department of Insurance would be given the authority to investigate parity violations.<sup>160</sup>

#### *1. Timothy’s Law*

On December 22, 2006, New York state enact “Timothy’s Law” which expanded coverage requirements to include comparable coverage for adults and children with “biologically based mental illness or serious emotional disturbance disorders” as provided for treatment for physical illness.<sup>161</sup> Biologically based mental illness is defined by the law as “a mental, nervous, or

---

155. Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18022(b)(1)(A)-(J). (Emphasis added)

156. COUNTY HEALTH RANKINGS, *supra* note 114.

157. Outpatient Mental Health Services, 405 Ind. Admin. Code 5-20-8 (2016).

158. INDIANA BEHAVIORAL HEALTH COMMISSION, *supra* note 115.

159. *Id.*

160. *Id.*

161. Timothy’s Law, 2006 N.Y. ALS 748, 2005 N.Y. S.N. 8482 (2006).

emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome that substantially limits the functioning of the person with the illness.”<sup>162</sup> The law further defines a person with emotional disturbance disorders as someone with a diagnosed disorders such as Attention Deficit Disorder, Disruptive Behavioral Disorders, or Pervasive Development Disorders, who have had suicidal or self-destructive behaviors, significant psychotic symptoms, or behavior that places the patient at substantial risk of removal from the household.<sup>163</sup> The intent of Timothy’s Law was to strengthen and enhance the protections established by federal law, as well as to ensure that mental health coverage is provided by insurance companies and health maintenance organizations in comparable terms to other healthcare services.<sup>164</sup> Oppositional Defiant Disorder would fall under coverage of this law because it is an emotional disturbance disorder and is a biologically based mental illness that substantially limits the functioning of the person with the illness as improper treatment of the disorder can lead to impairments in the child’s present and future emotional, social, academic and occupational development.

Under the law, the superintendent of insurance will monitor the implementation of the coverage required under the law and take any action as necessary to ensure that insurers’ contracts or policies do not contain unreasonable definitions of mental or emotional disorders or ailments in their policies.<sup>165</sup> The superintendent will also work with the office of mental health and perform a study on the effectiveness of the mental health parity which would include a comprehensive analysis of the costs associated with coverage pursuant to the act, a record of the number of policy holders which have elected to purchase other mental health coverage, and a comparison of the type and number of illnesses for which coverage has been provided during the study period, which would occur over a two-year-span.<sup>166</sup>

Indiana currently allows MST services to be funded through Medicaid reimbursement by using therapy CPT codes, and, in eligible cases, Indiana Department of Child Services funding can be used to cover the cost of treatment.<sup>167</sup> By implementing legislation similar to Timothy’s Law, parity treatment of Oppositional Defiant Disorder and other Behavioral Health Disorders through programs like multisystemic therapy would also be covered under an individual’s private insurance plan. This means that multisystemic therapist working within the school could bill the individual student’s insurance company to cover the cost of the therapy versus the funding coming from an education fund, or through increased taxpayer dollars.

---

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.* at § 7 (a-b).

167. *FAQ: Indiana Statewide Implementation of MST*, IN.GOV, <https://www.in.gov/children/files/Indiana-MST-FAQ.pdf> [<https://perma.cc/ZX3F-BGEX>] (last visited Feb. 7, 2024).

### C. Considerations

The average cost for Multisystemic Therapy is \$6,000 per juvenile participant, which is substantially less than the cost of incarceration, group home placement, or residential treatment.<sup>168</sup> Having the cost of the program covered under insurance would further reduce the burden on individuals and taxpayers. The cost to imprison a child in the state of Indiana can reach to over \$96,000 per year in taxpayer dollars, as opposed to the less than \$10,000 average cost to educate the child in public school.<sup>169</sup> For children who become recidivist after their time in juvenile detention, the cost of detention for adults in the state averages over \$19,000 per year.<sup>170</sup> Making the investment, even into costly programs such as multisystemic therapy, to properly address disruptive behavior disorders, like oppositional defiance disorder, prior to the initial out of home placement, will reduce the rate of incarceration, and thus greatly reduce the cost of housing detained individuals throughout the state.

Another roadblock of the program is the apprehension towards programs that may promote “social-emotional learning.” Social-emotional learning was previously seen as a crucial program in schools, and many districts were developing practices to support social and emotional development throughout various parts of the school day.<sup>171</sup> Implementing these practices reportedly made improvements in student behavior and outcomes.<sup>172</sup> However, because of the debate over critical race theory in schools, social-emotional learning has also fallen under attack by critics.<sup>173</sup>

Social-emotional learning is a process in which children develop life skills, such as communication, problem solving, and managing stress to help them be successful learners and communicators inside and outside of the classroom.<sup>174</sup> Multisystemic therapy may fall under the category of social-emotional learning because it targets behavioral and emotional responses to a child’s environment, much like social-emotional learning.

Despite critical debate over the use of social-emotional learning, programs

---

168. Jessica Ann Garascia, Note, *The Price We Are Willing to Pay for Punitive Justice in the Juvenile Detention System: Mentally Ill Delinquents and Their Disproportionate Share of the Burden*, 80 IND. L.J. 489, 509–10 (2005).

169. *Youth Incarceration in Indiana*, NO KIDS IN PRISON CAMPAIGN, <https://www.nokidsinprison.org/explore/indiana/?section=race-interactive> [https://perma.cc/QHY9-GZ26] (last visited Oct. 10, 2022).

170. *How Much Does It Cost to Keep an Offender in Prison?*, IN.GOV, <https://faqs.in.gov/hc/en-us/articles/115005238288-How-much-does-it-cost-to-keep-an-offender-in-prison-> [https://perma.cc/YMS2-C374] (last visited, Oct. 16, 2022).

171. Emily Tate Sullivan, *Demystifying Social-Emotional Learning, and the Controversy Surrounding It*, EDSURGE (Sept. 30, 2022), <https://www.edsurge.com/news/2022-09-30-demystifying-social-emotional-learning-and-the-controversy-surrounding-it> [https://perma.cc/24QG-42AQ].

172. *Id.*

173. *Id.*

174. *Id.*

like multisystemic therapy are beneficial in developing essential life skills to be productive members of society. Research shows that having strong social-emotional competency will lead to both short-term and long-term successes.<sup>175</sup> Students who undergo social-emotional learning are more likely to graduate from high school or college, be more career ready, and develop healthier and more positive relationships.<sup>176</sup>

## V. RECOMMENDATIONS AND CONCLUSION

Schools can be an ideal outlet for students needing mental health support as they spend more time interacting at school than at home. At school, children can receive support from teachers, counselors, coaches, and other staff.<sup>177</sup> However, school staff are stretched thin, and many families are unable to cover the cost of treatment on their own. In the Indiana Behavioral Health Commission's September 2022 report, access to behavioral healthcare has been identified as a key challenge across the state.<sup>178</sup> This challenge is typically driven by affordability and insurance coverage. Supplemental programs are crucial in making sure that children needing this support receive it.<sup>179</sup>

Multisystemic Therapy can be the model supplemental program as MST therapists work within the school and community to help youth struggling with mental health and behavioral issues.<sup>180</sup> These therapists also provide school faculty and staff with tools to address troubling situations with students who have disruptive behavior disorders.<sup>181</sup> When schools are able to develop mental health support, the entire community benefits. Children who have the resources to address mental and behavioral challenges early are more likely to gain skills to be successful in school and life. Through this, the threat of later harm or crime is significantly reduced.<sup>182</sup> A twenty-one year follow up evaluation of MST showed a reduced rate of recidivism and less frequent offenses among its patients as compared to individual therapy participants, in programs like cognitive behavioral therapy.<sup>183</sup> It is recommended that Indiana pass legislation like New York's Timothy's Law to create parity expansion through insurances, which will allow for coverage of Multisystemic Therapy to be used as an alternative to disciplinary measures for children with Oppositional Defiant Disorder.

---

175. *Id.*

176. *Id.*

177. Khan, *supra* note 56.

178. INDIANA BEHAVIORAL HEALTH COMMISSION, *supra* note 115, at 39.

179. Khan, *supra* note 56.

180. *School Safety: Addressing school shootings, student mental health, and other related factors*, MST SERVICES, <https://www.mstservices.com/school-safety-resources> [<https://perma.cc/PD67-RRQJ>] (last visited Oct. 16, 2022).

181. *Id.*

182. *Id.*

183. INDIANA BEHAVIORAL HEALTH COMMISSION, *supra* note 115.