NOTE

"I've Done Nothing Wrong": Decarceration of Status Offenses and Transinstitutionalization in Washington State

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Until 2019, Washington State incarcerated more youth for non-criminal status offenses, like truancy or running away from home, than any other state. In that year, Washington outlawed incarceration for status offenses while at the same time expanding the options for parents and guardians to admit their children to inpatient mental health treatment without their consent.

This Note asks whether these recent legislative changes will lead to a rise in inappropriate inpatient and residential treatment admissions, a form of transinstitutionalization. It argues that transinstitutionalization can be a harmful unintended consequence of decarceration, and extracts two lessons from the history of legislative change in Washington State for policymakers and advocates seeking to prevent unnecessary transinstitutionalization.

First, physical safety concerns are a significant stumbling block for advocates seeking to increase community-based alternatives to incarceration and institutionalization. Advocates must explicitly address stakeholder physical safety concerns by demonstrating that community-based treatment can increase young people's long-term physical safety while effectively mitigating short-term safety risks. Litigation and pooling funding offer two strategies to expand the availability of high-quality community-based programming.

Second, empowering parents to unilaterally initiate inpatient mental health treatment deprives children of important procedural safeguards against inappropriate inpatient and residential treatment. Policymakers should build up procedural safeguards within the parent-initiated treatment process in order to limit inpatient treatment to cases in which a young person truly cannot remain at home safely.

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INTRODUCTION

In early 2019, a *Seattle Times* headline began, "Washington handles runaway foster kids with handcuffs, shackles and jail."[1] The article described the experiences of a 14-year-old girl who had been arrested and detained in King County's juvenile detention facility four times in one year for running away from a foster placement.[2] This didn't make any sense to her: "I've done nothing wrong," she said.[3] Each time she was released, the girl would leave her foster placement to return to her street family, the group of people she lived with in a homeless encampment.[4] Advocates, service providers, and officials all agreed

1. Nina Shapiro, *Washington Handles Runaway Foster Kids with Handcuffs, Shackles and Jail. Is There a Better Way?*, SEATTLE TIMES (Feb. 17, 2019), https://www.seattletimes.com/seattle-news/when-a-14-year-old-foster-kid-runs-away-is-jail-the-answer/.

2. *Id.*

3. *Id.*

4. *Id.*

that they wanted to help keep her safe, but they disagreed about how to do so.[5] Some viewed detention as providing her with a chance to get medical treatment and connect with supportive services, but others saw it as inflicting further trauma and increasing her distrust of the system.[6]

A few months later, the Washington State legislature outlawed this type of detention. A new law prohibited juvenile courts from detaining youth in most circumstances for non-criminal "status offenses"—that is, misbehavior that would not be a crime if committed by an adult, such as truancy or running away from home.[7] Citing the harms associated with juvenile incarceration, Washington joined a majority of the states in rejecting incarceration as the primary state response to status offenses.[8]

That may not be the end of the story. Past efforts to deinstitutionalize have sometimes led to a rise in other forms of institutionalization, a phenomenon known as transinstitutionalization.[9] In earlier decades, decarceration of status offenses has been followed by an increase in inappropriate admissions for inpatient mental health treatment. As juvenile incarceration rates decrease to historic lows, decarceration could once again lead to the overuse of inpatient and residential treatment, trading one form of institutional harm for another. But what factors influence the likelihood of unnecessary transinstitutionalization, and how should lawmakers prevent it?

To answer these questions, Part II of this Note outlines the historical and present-day intersections between the juvenile legal system and the juvenile mental health system. Part III examines the State of Washington's response to young people who commit status offenses, concentrating on recent legislative changes that outlawed incarceration for status offenses while expanding the authority of parents to commit their children to inpatient and residential treatment. An analysis of Washington's legislative history and advocacy reveals that concerns for young people's physical safety undergird stakeholder decisions about incarceration, institutionalization, and community-based services. It also underscores the procedural vulnerability of young people within the mental health system when parents are empowered to commit their children to inpatient treatment without their consent. Part IV discusses two policy solutions prompted by this case study: (1) addressing the physical safety needs of children through high-

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5. *See id.*

6. *See id.*

7. FINAL B. REP. E2SSB 5290, at 4 (Wash. 2019), https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/Senate/5290-S2.E%20SBR%20FBR%2019.pdf?q=20200529143122.

8. E2SSB 5290, 66th Leg., 2019 Reg. Sess. § 1 (Wash. 2019); *see* OFF. JUV. JUST. AND DELINQ. PREVENTION, STATE USE OF THE VALID COURT ORDER EXCEPTION (2016), https://ojjdp.ojp.gov/state-use-valid-court-order-exception [hereinafter STATE USE OF THE VCO EXCEPTION].

9. *See* Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1447 (2005) [hereinafter Weithorn, *Second-Order Change*].

quality community-based services and (2) increasing procedural safeguards within family-initiated treatment to prevent inappropriate inpatient admissions.

Amidst historic levels of decarceration within the juvenile legal system, decarceration without significant investment in supporting kids to be safe at home risks greater levels of involuntary institutionalization. In order to prevent unintended and unnecessary transinstitutionalization, policymakers and advocates must demonstrate that high-quality community-based treatment can increase young people's long-term physical safety while mitigating short-term safety risks. In the past, judges and parents have sought to use incarceration or institutionalization because they believed those were the only options to keep kids safe. In order to avoid the mistakes of the past, this belief must change.

I. YOUTH TRANSINSTITUTIONALIZATION IN HISTORICAL AND MODERN CONTEXT

This Note focuses on young people whose behaviors could be classified as status offenses. A status offense is an act that is criminalized only because of a young person's age.[10] Primary examples of status offenses are: truancy, running away from home, repeatedly disobeying parental authority, violating curfew, and underage drinking.[11] Serious misbehavior, like repeated status offenses, can be an indication of underlying mental health needs, trauma, or other unmet needs for the young person and their family.[12] While the state response to young people struggling with such behaviors has evolved over the last century, it has almost always included the heavy use of incarceration and institutionalization.[13] The prevailing rationale for those forms of confinement has usually been concern for the safety and welfare of the young people themselves.[14] This Note argues that addressing those same physical safety concerns through community-based treatment is a critical—and overlooked—aspect of the current policy conversation.

A. The juvenile legal system

The incarceration and institutionalization of young people out of concern for their own welfare has a long history in the United States. At the end of the nine-

10. Mahsa Jafarian & Vidhya Ananthakrishnan, *Just Kids: When Misbehaving Is a Crime*, VERA INSTITUTE (Aug. 2017), https://www.vera.org/when-misbehaving-is-a-crime.

11. FINAL B. REP. E2SSB 5290, at 4 (Wash. 2019).

12. Jafarian & Ananthakrishnan, *supra* note 10.

13. This Note uses the term "incarceration" to refer to secure confinement in a juvenile detention facility and the term "institutionalization" to refer to mental health treatment taking place in a secure or semi-secure inpatient unit or residential treatment center. This Note also uses the term "confinement" to refer to both incarceration and institutionalization.

14. Weithorn, *Second-Order Change*, *supra* note 9, at 1333.

teenth century, progressive reformers founded juvenile courts in order to promote rehabilitation and to divert children from the adult criminal legal system.[15] The new system had a broad reach: its jurisdiction included youth accused of criminal offenses, youth accused of committing non-criminal status offenses, and youth who were abused or neglected.[16] In the early days of the juvenile court, regulation of status offenses had a strong moral valence, policing young people, especially girls, for "immorality" or sexual activity.[17] The legal doctrine of *parens patriae*, or parent of the nation, justified state intervention into the traditionally private realms of domestic family life and youthful misbehavior and consolidated multiple forms of state intervention in one place.[18]

The early juvenile court philosophy emphasized the individualized treatment needs of each child, instead of the specific circumstances which had prompted court intervention.[19] As such, a child neglected by their parents might receive a similar disposition, or sentence, to one who had committed a criminal offense.[20] In the eyes of reformers, the juvenile court was more like a social welfare agency than a criminal court.[21] Proceedings were informal and lacked most of the procedural safeguards found in the criminal system, including lawyers, juries, and rules of evidence.[22] Sometimes judges would impose indeterminate sentences with no set end date.[23]

In the second half of the twentieth century, however, juvenile courts began to look more like adult courts, with increased procedural due process rights and increasingly harsh sentences, which disproportionately impacted youth of color.[24] After youth crime rates began to drop dramatically in the 1990s, youth incarceration rates began to fall sharply, too.[25] Since its peak in the year 2000, the rate of young people incarcerated in juvenile facilities has fallen by over sixty percent, to a one-day count of 43,580 in 2017.[26]

Today, youth with psychiatric disabilities are overrepresented in the juvenile

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15. BARRY C. FELD, THE EVOLUTION OF THE JUVENILE COURT: RACE, POLITICS, AND THE CRIMINALIZING OF JUVENILE JUSTICE 3, 19 (2017). These reforms were based on upper- and middle-class parenting values which emphasized the "innocence and vulnerability" of children. *See id.* at 19, 22. Through the juvenile court system, reformers sought to impose those values onto poor and immigrant families. *Id.* at 19.

16. *Id.* at 9.

17. *See id.* at 32.

18. *Id.* at 24; Weithorn, *Second-Order Change*, *supra* note 9, at 1402, 1441-42.

19. Weithorn, *Second-Order Change*, *supra* note 9, at 1442.

20. *See id.*

21. *See* FELD, *supra* note 15, at 35.

22. *Id.* at 33.

23. *Id.* at 35.

24. *Id.* at 12-13, 58-61.

25. *See* Wendy Sawyer, *Youth Confinement: The Whole Pie 2019*, PRISON POL'Y INITIATIVE (Dec. 19, 2019), https://www.prisonpolicy.org/reports/youth2019.html.

26. *Id.*

legal system. Nearly seventy percent of system-involved youth have a "diagnosable mental health disorder," and almost thirty percent "require immediate and significant treatment."[27] In addition, youth involved in the juvenile legal system have experienced much higher rates of trauma than other youth. Upwards of ninety percent of system-involved youth have experienced at least one form of trauma, and one study showed a mean of 14.6 traumatic events per youth.[28] The disproportionate involvement of youth with psychiatric disabilities in the juvenile legal system demonstrates the potential for overlap with another system—the juvenile mental health system.

B. The juvenile mental health system

In the early twentieth century, rather than placing youth in psychiatric hospitals, the government tended to institutionalize youth through the juvenile legal and child welfare systems.[29] But from the 1960s through the 1980s—coinciding with deinstitutionalization from those same systems[30]—inpatient admission rates increased for children.[31] This included a huge rise in rates of admission to private residential treatment centers beginning in the 1970s—indeed, by 1997, around three-quarters of all youth psychiatric admissions were to private facilities.[32]

Today, various types of facilities serve youth for inpatient or residential treatment. Inpatient psychiatric units at hospitals are usually designed for short-term evaluation and stabilization of youth in crisis. For instance, the average stay at Seattle Children's Hospital's Psychiatry and Behavioral Medicine Unit is eight days.[33] Inpatient psychiatric hospitals serve youth diagnosed with severe psychiatric disorders for longer commitments. In Washington, for example, the average length of stay in the Children's Long-Term Inpatient Program (CLIP) is nine months.[34]

Private residential treatment centers (RTCs) also provide juvenile mental

27. MENTAL HEALTH JUV. JUST. COLLABORATIVE FOR CHANGE, BETTER SOLUTIONS FOR YOUTH WITH MENTAL HEALTH NEEDS IN THE JUVENILE JUSTICE SYSTEM 2 (2013), https://ncyoj.policyresearchinc.org/img/resources/Better_Solutions_for_Youth_with_Mental_Health_Needs_in_the_Juvenile_Justice_System-501172.pdf.

28. Yael Cannon & Andrew Hsi, *Disrupting the Path from Childhood Trauma to Juvenile Justice: An Upstream Health and Justice Approach*, 43 FORDHAM URB. L.J. 425, 448-50 (2016).

29. Weithorn, *Second-Order Change*, *supra* note 9, at 1448-49, 1465.

30. *Id.* at 1450-51, 1454-56.

31. *Id.* at 1470. During the same time period, historic levels of deinstitutionalization took place in adult mental health facilities. *Id. See also* Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 9 (2012).

32. Weithorn, *Second-Order Change*, *supra* note 9, at 1384-85.

33. *What to Expect on the Psychiatry and Behavioral Medicine Unit*, SEATTLE CHILDREN'S, https://www. seattlechildrens.org/clinics/psychiatry-behavioral-medicine-unit/what-to-expect/ (last visited June 21, 2020).

34. *Frequently Asked Questions*, CHILDREN'S LONG-TERM INPATIENT PROGRAM, http://clipadministration.org/FAQ/ faq.html (last visited June 21, 2020).

health or substance use treatment.[35] They are not licensed as hospitals and are typically somewhat less restrictive than an inpatient setting, although they can range from a hospital-like setting to a facility more akin to a group home.[36] In most RTCs, access to the outside world is partially or fully limited.[37] Well-resourced families can seek placements for their children directly into RTCs.[38] Low-income youth, on the other hand, are usually placed into RTCs through a state agency, like the juvenile legal or child welfare system, at taxpayer expense.[39] Residential treatment placements are generally not legally scrutinized in the same way as inpatient psychiatric admissions, even though placement in an RTC can implicate a child's liberty interest in much the same way as treatment in a hospital setting.[40]

Community-based treatment programs also serve young people with mental health and behavioral challenges. Indeed, evidence consistently suggests that the most effective interventions "address children's needs within their natural environments of home, school, and community"—the exact opposite of incarceration or institutionalization.[41] High-quality community-based treatment options have some common themes: a focus on strengths of the youth and their family, coordination between multiple systems impacting the youth, and the goal of enabling the child to be successful at home.[42] Models include wraparound programs, which provide care coordination for youth involved in multiple systems, therapeutic foster care, which places youth with specially trained foster parents, and multisystemic therapy and functional family therapy, both of which provide intensive therapeutic treatment for youth and their families in the community.[43]

But to many families and system stakeholders, inpatient and residential treatment programs often seem like the only viable option to provide treatment for youth struggling with serious misbehavior. This is partly due to a pervasive lack of community-based treatment programs. Nationwide, there are long waiting lists for community-based services.[44] And the prevalence of expensive RTCs and other forms of institutional care drains state resources that could be spent on community-based services instead.[45] Nearly 25% of child mental health spending nationally goes to residential care, even though only eight percent of children

35. *See* OFF. OF JUV. JUST. AND DELINQ. PREVENTION, RESIDENTIAL TREATMENT CENTERS 1 (2011), https://www.ojjdp.gov/mpg/litreviews/Residential_Treatment_Centers.pdf.

36. *Id.*; Yael Z. Cannon, *There's No Place Like Home: Realizing the Vision of Community-Based Mental Health Treatment for Children*, 61 DEPAUL L. REV. 1049, 1056 (2012).

37. Cannon, *supra* note 36, at 1058-60.

38. *Id.* at 1056.

39. *Id.* at 1056-57.

40. *See id.* at 1060.

41. Weithorn, *Second-Order Change*, *supra* note 9, at 1487.

42. *See id.* at 1493.

43. Cannon, *supra* note 36, at 1114-25.

44. Weithorn, *Second-Order Change*, *supra* note 9, at 1363; Cannon, *supra* note 36, at 1104.

45. Cannon, *supra* note 36, at 1057.

treated in the mental health system receive residential treatment.[46]

In addition to long waiting lists and inadequate funding, individualized community-based treatment plans present other challenges for institutional providers agencies.[47] Regarding the challenges of community-based mental health programming and the high rates of RTC placement in the District of Columbia, a local system administrator commented, "The issue is lazy bureaucracy. . . . It's much more difficult to design a detailed wraparound plan than it is just to stick a youth in a facility."[48]

Parents, families, and institutional caregivers for state-dependent youth also play a powerful role in seeking out inpatient mental health treatment for their children. In the adult system, many parent-activists have opposed deinstitutionalization, arguing for the importance of institutional placements for their children.[49] Parents of children with behavioral challenges may feel that they cannot adequately manage a child's behaviors at home or that a child's presence in the home is detrimental to family well-being.[50]

The legal system recognizes parental authority to seek out treatment for minors. In *Parham v. J.R.*, the U.S. Supreme Court held that a parent's interest in the welfare of their child, along with the admitting criteria of a psychiatric institution, was a sufficient safeguard for a minor's procedural due process rights even if the youth did not consent to the institutional commitment.[51] While the Court noted that a child "has a substantial liberty interest in not being confined unnecessarily for medical treatment,"[52] it ultimately based its decision on the "broad parental authority over minor children" and the assumption that the "natural bonds of affection lead parents to act in the best interests of their children."[53] In partial concurrence and partial dissent, Justice Brennan rejected the idea that "[c]hildren incarcerated because their parents wish them confined . . . are really voluntary patients."[54] He contrasted the minimal procedural safeguards affirmed by the majority with the "full and fair adversary hearings" that adults facing involuntary commitment receive.[55] However, the majority ultimately relied upon

46. *Id.*

47. *Id.* at 1105.

48. *Id.* (quoting Jason Cherkis, *Outsourcing Troubled Kids*, WASH. CITY PAPER (Jan. 7, 2011), https://washingtoncitypaper.com/article/221371/outsourcing-troubled-dc-kids/).

49. Bagenstos, *supra* note 31, at 19; *see also* Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RSRV. L. REV. 657, 693-94 (2016) (noting the challenges that parents face in finding appropriate services for adult children with psychiatric disabilities who do not meet criteria for involuntary treatment).

50. Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 701 (1993).

51. Parham v. J.R., 442 U.S. 584, 602-07 (1979).

52. *Id.* at 600.

53. *Id.* at 602.

54. *Id.* at 630 (Brennan, J., concurring in part and dissenting in part).

55. *Id.* at 627 (Brennan, J., concurring in part and dissenting in part).

the assumption that parents act in the best interest in their children to justify minimal procedural due process for children in this context.

The *Parham* decision also affirmed the same procedural due process standard for instances in which a state social worker seeks inpatient admission for a state-dependent child.[56] The dissent sharply criticized this reasoning: "[S]tate officials acting *in loco parentis* cannot be equated with parents."[57]

Parham's rationale has put state-dependent youth at even greater risk of inappropriate institutionalization. A disproportionate number of youth in inpatient and residential treatment are state-dependent: one study from the 1990s found that half of the youth institutionalized in three states were referred through the child welfare system.[58] Moreover, inpatient hospitalization stays are longer for state-dependent youth than for other youth, and a lack of available foster home placements may incentivize social workers to use inpatient treatment as a placement when other options are scarce.[59]

C. Systems overlap: Status offenses and involuntary mental health treatment

Historically, the juvenile court served as a single pathway that could lead to institutionalization, regardless of the cause. But as the juvenile legal, child welfare, and mental health systems became more separate over the course of the twentieth century, deinstitutionalization from one system could lead to transinstitutionalization.[60] And because of the lack of coordination between systems, a struggling young person's "entry point" often determines what services are available to them, rather than their underlying needs triggering an individualized response.[61] Race and socio-economic status may influence this entry point, with children of color and poor children more likely to enter through the juvenile legal system than white and middle-class youth.[62] And since effective community-

56. *See id.* at 618.

57. *Id.* at 638 (Brennan, J., concurring in part and dissenting in part).

58. Bernard P. Perlmutter & Carolyn S. Salisbury, *"Please Let Me Be Heard": The Right of a Florida Foster Child to Due Process Prior to Being Committed to a Long-Term, Locked Psychiatric Institution*, 25 NOVA L. REV. 725, 733 (2001) (quoting GARY B. MELTON ET AL., NO PLACE TO GO: THE CIVIL COMMITMENT OF MINORS 15-16 (1998)). Because of profound racial disparities in child welfare system involvement, the over-institutionalization of state-dependent youth may disproportionately impact youth of color. *See* CHILDREN'S BUREAU, RACIAL DISPROPORTIONALITY AND DISPARITY IN CHILD WELFARE 2-3 (Nov. 2016), https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf.

59. Perlmutter & Salisbury, *supra* note 58, at 733; *see also id.* at 735 (quoting Sally Kestin, *No Place Else to Go: Florida Has Never Measured the Effectiveness of Treatment Centers for Troubled Children*, SUN-SENTINEL, Nov. 8, 1999, at 18A) ("In Florida, some children have been sent to locked treatment centers simply because the state has no place else to put them.").

60. Weithorn, *Second-Order Change*, *supra* note 9, at 1447.

61. *Id.* at 1360-61; *see also* Cannon, *supra* note 36, at 1052 (describing youth-serving public agencies as "operat[ing] in silos").

62. Susan P. Leviton, *Children of Color with Mental Health Problems: Stuck in All the*

based interventions are often unavailable or inadequate,[63] deinstitutionalization within one system can lead to transinstitutionalization.[64]

The decarceration of status offenses and the subsequent increase in inpatient mental health admissions in the 1980s and 1990s is one example of this phenomenon.[65] Prior to 1974, youth charged with a non-criminal status offense were "twice as likely . . . to be placed in secure detention" compared to youth charged with a criminal offense.[66] Responding to concerns about the negative impacts of incarceration on status offenders housed alongside serious criminal offenders, the 1974 Juvenile Justice and Delinquency Prevention Act (JJDPA) tied federal funding for state juvenile justice programs to states' deinstitutionalization of status offenders.[67] By 1988, states had reduced their rates of status offense detention by 95 percent since the "base year" at which each state joined the program.[68]

However, a 1980 amendment created the valid court order (VCO) exception: a child could be detained for violating a court order, and if a judge ordered a child to go to school or stop running away, a youth's noncompliance could be grounds for detention.[69] Prosecutors and judges pushed for the VCO exception in order to protect runaway youth, especially those at-risk of homelessness, and to convey the need to respect the court's authority.[70]

Over the years, many states eliminated their use of this exception in order to continue to decarcerate status offenders. But by 2016 over 20 states still used it, for a total of 5,085 VCO exceptions that year.[71] On a single day in 2019, 1,424 youth were detained for status offenses nationwide.[72] And status offenses still

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Wrong Places, 2 U. MD. L. J. RACE RELIGION GENDER & CLASS 13, 27 (2002). Even within the provision of mental health services, youth of color may be more likely to be involuntarily institutionalized than whites. *See* AM. PSYCH. ASS'N, ADDRESSING THE MENTAL HEALTH NEEDS OF RACIAL AND ETHNIC MINORITY YOUTH: A GUIDE FOR PRACTITIONERS 4 (2017), https://www.apa.org/pi/families/resources/mental-health-needs.pdf; *see also* Roberto Cancio et al., ALL. NAT'L PSYCH. ASS'NS. FOR RACIAL & ETHNIC EQUITY, THE COLOR OF JUSTICE: THE LANDSCAPE OF TRAUMATIC JUSTICE: YOUTH OF COLOR IN CONFLICT WITH THE LAW 18 (2019) [hereinafter COLOR OF JUSTICE].

63. Weithorn, *Second-Order Change*, *supra* note 9, at 1362-63; Cannon, *supra* note 36, at 1104.

64. *Id.* at 1447.

65. *Id.* at 1460.

66. *Id.* at 1455.

67. *Id.* at 1454.

68. *Id.* at 1456.

69. *Id.* at 1458.

70. Patricia J. Arthur & Regina Waugh, *Status Offenses and the Juvenile Justice and Delinquency Prevention Act: The Exception that Swallowed the Rule*, 7 SEATTLE J. SOC. JUST. 555, 560 (2009).

71. *See* STATE USE OF THE VCO EXCEPTION, *supra* note 8. This is the most recent federal data available.

72. OFF. JUV. JUST. AND DELINQ. PREVENTION, EASY ACCESS TO THE CENSUS OF JUVENILES IN RESIDENTIAL PLACEMENT (2021), https://www.ojjdp.gov/ojstatbb/ezacjrp/asp/State_Offense.asp; *see also* OFF. JUV. JUST. AND DELINQ. PREVENTION, EASY ACCESS TO THE CENSUS OF JUVENILES IN RESIDENTIAL PLACEMENT: METHODS (2021),

comprise a large part of juvenile court dockets. There were approximately 90,500 status offense cases processed in juvenile court systems across the country in 2019, which constituted over one-tenth of all formally processed cases in that year.[73]

Some youth committing status offenses have been institutionalized under a different label—in other words, transinstitutionalized. Admission rates to psychiatric inpatient facilities and residential treatment programs, initiated by parents or juvenile courts, rose during the 1980s and 1990s, just as rates of status offense incarceration fell as a result of the JJDPA.[74] Many of these youth were hospitalized as a result of status offense behaviors, like running away or disobeying parents at home, even when inpatient commitment may not have been medically necessary.[75] Some status offenders have also been incarcerated for minor criminal offenses instead.[76] And some youth previously incarcerated as a result of status offense behaviors may also become more likely to live on the streets.[77]

The status offense system is "highly gendered."[78] In 2019, girls made up roughly 44% of status offense cases but only 28% of delinquency cases (cases in which children are prosecuted for criminal offenses), and the majority of youth in court for running away from home were girls.[79] This trend is in line with the

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https://www.ojjdp.gov/ojstatbb/ezacjrp/asp/methods.asp (describing the census as based on a single reference date, typically the fourth Wednesday in October).

73. SARAH HOCKENBERRY & CHARLES PUZZANCHERA, NAT'L CTR. FOR JUV. JUST., JUVENILE COURT STATISTICS 2019, at vii, 64 (2021), https://www.ojjdp.gov/ojstatbb/njcda/pdf/jcs2019.pdf. These figures could be undercounts. Jafarian & Ananthakrishnan, *supra* note 10 (noting that specialized court systems may handle many such cases and many status offenses are probation violations for existing dispositions). In a recent, well-publicized example of detention for a probation violation, a Michigan judge incarcerated a 15-year-old girl for failing to complete her online coursework after her school began remote learning due to the COVID-19 pandemic. She was confined in a treatment facility for over two months before her release. Jodi S. Cohen, *A Teenager Didn't Do Her Online Schoolwork. So a Judge Sent Her to Juvenile Detention*, PROPUBLICA (July 14, 2020), https://www.propublica.org/article/a-teenager-didnt-do-her-online-schoolwork-so-a-judge-sent-her-to-juvenile-detention; George Hunter, *Oakland Co. Girl Jailed for not Doing Homework Released from Probation*, DETROIT NEWS (Aug. 11, 2020), https://www.detroitnews.com/story/news/local/oakland-county/2020/08/11/oakland-county-girl-jailed-homework-probation/3342770001/.

74. Weithorn, *Second-Order Change*, *supra* note 9, at 1459-60.

75. Ira M. Schwartz, Marilyn Jackson-Beeck & Roger Anderson, *The* "*Hidden" System of Juvenile Control*, 30 CRIME & DELINQ. 371, 377-78 (1984). The authors provided numerous examples of potentially inappropriate admissions, including a girl who was hospitalized for 37 days after running away from home. Her parents reported that she was "out of control at home, engaged in socially inappropriate behavior, was using drugs, and was in acute danger to herself." *Id.* at 378. She had not received family counseling or outpatient therapy prior to admission, and peer review found "no evidence of serious delinquent behavior." *Id.*

76. Weithorn, *Second-Order Change*, *supra* note 9, at 1458-59.

77. *See id.* at 1461.

78. Cynthia Godsoe, *Contempt, Status, and the Criminalization of Non-Conforming Girls*, 35 CARDOZO L. REV. 1091, 1102 (2014).

79. HOCKENBERRY & PUZZANCHERA, *supra* note 73, at 13, 69.

juvenile court system's concerns about "immoral or wayward" girls dating back to the beginning of the twentieth century.[80] And concern for the safety of girls, particularly girls who have run away from home or are experiencing homelessness, also animates the twenty-first century debate about status offenses.[81] For example, as states have outlawed bringing prostitution charges against minors, increasing numbers of children who have been sexually exploited for profit have been brought into juvenile court on status offense charges instead, sometimes in order to connect them with social services or in an attempt to keep them safe.[82]

The unique features of the juvenile legal system may further entrench the overlap between these forms of institutionalization. The juvenile court system has broad jurisdiction over non-criminal matters, including status offenses, and has always maintained at least a nominal commitment to providing treatment and rehabilitation instead of punishment. Indeed, the juvenile court's commitment to treatment, rehabilitation, and support is what enables system actors to justify incarceration to protect children from the risks of their own behavior or the dangers of the streets.[83] As one commentator has observed, "the use of the status offense system often increases after a well-publicized tragedy involving a troubled girl."[84] That is exactly what happened in Washington State.[85] And children often lack procedural safeguards because of the legal system's assumption that the court is acting in a child's best interests and that parents are acting in their children's best interests.

However, neither incarceration nor institutionalization is generally in a child's best interest. Even short periods of incarceration are damaging to children.[86] Incarceration negatively impacts school performance, high school graduation rates, and future employment prospects.[87] Incarceration may also worsen mental illness and create its own trauma.[88] Institutionalization also has substantial risks, especially when it is medically unnecessary. Institutionalization de-

80. Godsoe, *supra* note 78, at 1094-95.

81. *Id.* at 1107. Cynthia Godsoe critiques the "protectionist rationale" espoused by most actors in the system, arguing that the status offense system fails to offer adequate services to girls and instead functions as a form of social control. *See id.* at 1107-09.

82. *Id.* at 1111-12.

83. *See id.* at 1107.

84. *Id.*

85. *See infra* Part III.

86. Sue Burrell, *The 48-Hour Rule and Overdetention in California Juvenile Proceedings*, 20 U.C. DAVIS J. JUV. L. & POL'Y, Winter 2016, at 1, 8.

87. *Id.* at 8-9.

88. *Id.* at 9; *see also* U.S. DEP'T OF JUST., BUREAU OF JUSTICE STATISTICS, SEXUAL VICTIMIZATION REPORTED BY YOUTH IN JUVENILE FACILITIES, 2018, at 1 (2019), https://www.bjs.gov/content/pub/pdf/svryjf18_sum.pdf ("In 2018, an estimated 7.1% of youth in juvenile correctional facilities reported being sexually victimized during the prior 12 months . . . ."); Benjamin C. Hatten, Note, *Carceral Trauma and Disability Law*, 72 STAN. L. REV. 995, 1000 (2020) ("[N]early every person incarcerated for a significant period of time encounters events during their confinement that create a serious risk of trauma.").

prives a person of agency and can create "[f]eelings of powerlessness and helplessness."[89] As the Supreme Court has noted, social isolation and deprivation from everyday activities are inherently stigmatizing.[90] And the lack of adequate regulation of residential treatment centers can lead to abuse and neglect within those facilities.[91] Ultimately, both incarceration and institutionalization take a child away from their family and their community, destabilizing the family unit and disrupting a child's support system in the community.[92] And for youth experiencing homelessness, incarceration and institutionalization can disrupt their access to services, healthcare, and their emotional support systems.

To be sure, providing support and services to young people with complex emotional needs is challenging and sometimes far from straightforward. But more than two decades of empirical research indicates that the most successful interventions for young people struggling with status offense behaviors are those that take place at home and in the community.[93] Providing those community-based alternatives to confinement, then, is generally the intervention that is in a child's best interests, not confinement.

A sea change is taking place in the juvenile legal system. As juvenile crime rates dropped and evidence of the harmful effects of incarceration piled up, policymakers took notice.[94] Rates of incarceration in juvenile facilities have fallen by 60% in the last two decades.[95] And case rates in the juvenile court system have dropped by over 50% since 2005.[96] Tens of thousands of young people are no longer in juvenile detention or being processed in juvenile courts, but many still need services. For youth who commit status offenses, decarceration may lead, yet again, to an increase in the use of inpatient and residential treatment. Recent legislative changes in Washington State show us that concerns over young people's physical safety cast a long shadow over how stakeholders view

89. Lois A. Weithorn, Note, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773, 796 (1988) [hereinafter Weithorn, *Mental Hospitalization*]; *see also* Perlmutter & Salisbury, *supra* note 58, at 735.

90. Olmstead v. L.C., 527 U.S. 581, 600 (1999).

91. *See, e.g.*, Curtis Gilbert & Lauren Dake, *'Youth Were Abused Here'*, APM REPORTS (Sept. 28, 2020), https://www.apmreports.org/story/2020/09/28/for-profit-sequel-facilities-children-abused; Annie Waldman, *Kids Get Hurt at Residential Schools While States Look on*, PROPUBLICA (Dec. 15, 2015, 5:15 PM EST), https://www.propublica.org/article/kids-get-hurt-at-residential-schools-while-states-look-on.

92. *See* Weithorn, *Second-Order Change*, *supra* note 9, at 1435. Removal from the community can have particularly damaging impacts on youth of color. *See* COLOR OF JUSTICE, *supra* note 62, at 41 ("Out-of-home placement and secure confinement can be equivalent to the kiss of psychological death for [youth of color] for whom connection to family and community serve as the cultural foundation of development, emotional well-being, and healing.").

93. *See* Weithorn, *Second-Order Change*, *supra* note 9, at 1487-1500; *see also infra* Part IV.A.1.

94. Sawyer, *supra* note 25.

95. *Id.*

96. HOCKENBERRY & PUZZANCHERA, *supra* note 73, at 6, 65.

alternatives to incarceration, and that if advocates for community-based alternatives do not explicitly address these concerns, parents and lawmakers may simply turn elsewhere to lock kids up.

II. CASE STUDY: WASHINGTON STATE

The evolution of Washington State's policies provides a useful case study to analyze the potential for transinstitutionalization following the decarceration of status offenses. Until 2019, Washington detained more youth for status offenses than any other state.[97] In 2016, Washington used the VCO exception 1,723 times, more than twice the next highest state's total and comprising one third of the nationwide total.[98] Then, in 2019, Washington prohibited the use of the VCO exception and outlawed incarceration for status offenses.[99] In the very same year, the legislature also expanded the ability of parents to commit children to inpatient treatment without their consent.[100] The debates about both of these measures illustrate current discourse about how to protect the physical safety of youth committing status offenses in an era of increasing juvenile decarceration. This case study also highlights various factors that could determine whether significant transinstitutionalization occurs, including state budget politics around expanding community-based services and the role of private RTCs.

A. The past: The Becca bill

After two decades of deinstitutionalization of status offenses in line with nationwide trends, Washington gained national attention in 1995 for its passage of the Becca Bill, which increased the power of juvenile courts to incarcerate status offenders.[101] By this time, parent-advocates and law enforcement officials across the country were expressing frustration with the lack of alternatives to detention available for runaway youth.[102] The Becca Bill was named for Rebecca Hedman,

97. Melissa Santos, *'It's an Issue of Liberty': WA Will Stop Jailing Kids Who Run Away or Skip School*, CROSSCUT (May 9, 2019), https://crosscut.com/2019/05/its-issue-liberty-wa-will-stop-jailing-kids-who-run-away-or-skip-school [hereinafter Santos, *'It's an Issue of Liberty'*].

98. STATE USE OF THE VCO EXCEPTION, *supra* note 8. The next highest state total was Arkansas, at 832 uses. *Id.*

99. FINAL B. REP. E2SSB 5290, *supra* note 7, at 3-4.

100. FINAL B. REP. E2SHB 1874, at 2-3 (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/House/1874-S2.E%20HBR%20FBR%2019.pdf?q=20200620212919.

101. Tiffany Zwicker Eggers, Note, *The "Becca Bill" Would Not Have Saved Becca: Washington State's Treatment of Young Female Offenders*, 16 L. & INEQUALITY 219, 230-31 (1998).

102. *See* David J. Steinhart, *Status Offenses*, 6 FUTURE OF CHILDREN 86, 92 (1996).

a 13-year-old girl who was beaten to death while living on the street after repeatedly running away from home.[103] Rebecca's parents and other parent-led lobbying groups campaigned to increase parents' ability to control their children's behavior.[104]

The Becca Bill expanded the reach of the juvenile court to incarcerate status offenders and parents' ability to initiate mental health treatment without their children's consent. Through a court petition initiated by a parent or guardian, such as an At-Risk Youth petition, a court could order a child to reside at home or in an out-of-home placement and comply with other provisions, like school attendance.[105] The Bill provided for five days of detention or semi-secure confinement for a youth who has run away from home or a foster placement, and it created semi-secure facilities called Crisis Residential Centers (CRCs) for this purpose.[106] The Becca Bill also enabled parents to initiate voluntary commitment to inpatient treatment, even without the youth's consent.[107] Moreover, the Becca Bill also encouraged use of the VCO exception to "bootstrap" status offenses into delinquency charges by charging young people with criminal contempt.[108] Through the Bill's inclusion of both incarceration and institutionalization options, legislators empowered both courts and parents confine youth committing status offenses.

Critical commentary at the time reflected skepticism that these provisions, however well-intentioned, would lead to positive outcomes for runaway youth like Rebecca. One commentator speculated that, at best, the five-day detention provision could have enabled Rebecca's parents to reconnect with their daughter, but temporary confinement likely would have increased her mistrust in the systems attempting to protect her.[109] Indeed, a more recent study of youth at risk of commercial sexual exploitation suggests that status offense detention may "exacerbate vulnerability and reduce motivation to return from a runaway episode."[110]

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103. *Id.*

104. *Id.*

105. Alison G. Ivey, Comment, *Washington's Becca Bill: The Costs of Empowering Parents*, 20 SEATTLE U. L. REV. 125, 139-141 (1996).

106. Eggers, *supra* note 101, at 231; Melissa Santos, *Washington No. 1 for Jailing Noncriminal Kids, Spurred by Law Named for Tacoma Runaway*, NEWS TRIBUNE (last updated Jan. 31, 2016 6:57 PM), https://www.thenewstribune.com/news/politics-government/article27129946.html [hereinafter Santos, *Washington No. 1*].

107. Kelli Schmidt, Note & Comment, *"Who Are You To Say What My Best Interest Is?": Minors' Due Process Rights When Admitted by Parents for Inpatient Mental Health Treatment*, 71 WASH. L. REV. 1187, 1193-94 (1996); Eggers, *supra* note 101, at 231-32.

108. Ivey, *supra* note 105, at 150-52.

109. Ivey, *supra* note 105, at 156.

110. Michael D. Pullmann et al., *Residential Instability, Running Away, and Juvenile Detention Characterizes Commercially Sexually Exploited Youth Involved in Washington State's Child Welfare System*, CHILD ABUSE & NEGLECT 1, 10 (2020).

Over the course of the 1990s and 2000s, Washington courts tasked with interpreting the scope of the Becca Bill weighed children's liberty interests against judicial and parental beliefs about their best interests. In 1996, the Washington Supreme Court ruled that a youth was entitled to a court hearing upon requesting release from an inpatient mental health facility. In that case, *State v. CPC Fairfax Hospital*, a 15-year-old girl, T.B., was committed to an inpatient facility by her parents without her consent.[111] She immediately asked to be released, but the hospital refused.[112] The court held that T.B. had a right to be discharged upon her request, unless the hospital or a parent filed a court petition.[113] Despite deciding the case on statutory grounds, the majority also emphasized the "massive curtailment of liberty" inherent in involuntary commitment[114] and the possible "injurious effect of commitment."[115]

The concurring opinion agreed in the judgment but disagreed with the majority's implicit characterization of T.B.'s parents as "irresponsible guardians" who were too quick to institutionalize their child.[116] The opinion emphasized that T.B. had been "a runaway living on the streets" prior to her hospitalization,[117] although her parents committed her immediately upon her release after serving a seven-day sentence for contempt of court under the VCO exception.[118] In the concurrence's view, the parental right to commitment was a backstop when the court's tools were inadequate to "prevent T.B. from seriously harming herself."[119] The court, through its power to incarcerate, and parents, through their inpatient commitment power, were partners in using short-term confinement to prevent physical harm from coming to runaway teenagers.

In the following years, Washington courts continued to wrestle with where incarceration and institutionalization fit into the court's therapeutic goals. *CPC Fairfax* scrutinized the limits of parental power, but a subsequent line of cases dealt with the power of judges to incarcerate children under their jurisdiction. In *In re Dependency of A.K.* and *In re Interest of Silva*, the state Supreme Court held that in dependency and At-Risk Youth petition cases, a court must find its statutory contempt sanctions inadequate before turning to its inherent contempt powers.[120] In *A.K.*, the majority noted: "Only under the most egregious circumstances should the juvenile court exercise its contempt power to incarcerate a status offender in a secure facility. If such action is necessary, the record should

111. State v. CPC Fairfax Hosp., 918 P.2d 497, 498-500 (Wash. 1996).

112. *Id.* at 500.

113. *Id.* at 503.

114. *Id.* at 504 (quoting Humphrey v. Cady, 405 U.S. 504, 509 (1972)).

115. *Id.* at 504 (quoting In re Harris, 654 P.2d 109, 111 (Wash. 1982)).

116. State v. CPC Fairfax Hosp., 918 P.2d at 505 (Dolliver, J., concurring).

117. *Id*. at 506 (Dolliver, J., concurring).

118. *Id.* (Dolliver, J., concurring).

119. *Id.* (Dolliver, J., concurring).

120. In re Dependency of A.K., 174 P.3d 11, 21 (Wash. 2007); In re Interest of Silva, 206 P.3d 1240, 1247 (Wash. 2009).

demonstrate that all less restrictive alternatives have failed."[121] However, the very alternative that the court contemplated was detention with the opportunity to "purge the contempt" by, for example, writing an essay and promising not to repeat the status offense in the future, which it viewed as "coercive" instead of "punitive."[122]

In each case, Judge Barbara Madsen wrote a strongly worded concurrence questioning the use of detention for runaway behavior, highlighting the fact that "[d]etention should not be used as a substitute for access to basic services, treatment, and care."[123] She also suggested that the system should utilize secure substance use and mental health treatment options before incarceration and mentioned institutionalization as a preferable alternative to incarceration.[124]

When interpreting various provisions of the Becca Bill during this period, the Washington Supreme Court sought to balance youth's liberty interest with judicial or parental interests in short-term confinement to protect a young person's physical safety. The court seemed to suggest that incarceration or institutionalization could be in a child's best interest, but that institutionalization was preferable to incarceration. However, the court was also suspicious of using detention as a policy solution to keep youth off the streets.

B. The present, part 1: SB 5290 and the decarceration of status offenses

By 2019, the political winds had shifted. The Washington legislature narrowly passed Senate Bill 5290, eliminating the use of the VCO exception.[125] By then, many policymakers and youth advocacy groups had become critical of Washington's outlier status regarding status offense incarceration.[126] Even Rebecca Hedman's parents had come to feel that the law wasn't working as they had hoped it would.[127] One problem was that the state had failed to fund the semi-secure Crisis Residential Centers (CRCs) provided for as an alternative to detention in the Becca Bill.[128] By 2014 there were only thirty-four secure CRC beds throughout the state, and even those were only available in five out of Washington's thirty-nine counties.[129] One youth legal advocate called the CRC system "defunct."[130]

In addition to the shortage of CRC beds, the use of the VCO exception varied

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121. A.K., 174 P.3d at 18, 22 (quoting State v. Norlund, 644 P.2d 724 (Wash. 1982)).

122. *See id.* at 18.

123. *Id.* at 23 (Madsen, J., concurring).

124. *Id.*

125. FINAL B. REP. E2SSB 5290, *supra* note 7, at 4.

126. Santos, *Washington No. 1*, *supra* note 106.

127. *Id.*

128. *Id.*

129. *Id.*

130. Telephone Interview with George Yeannakis, Special Counsel, TeamChild (May 29, 2020) [hereinafter Yeannakis Interview].

widely between counties.[131] For instance, rural Grays Harbor utilized the VCO exception more than King County (which includes Seattle, the state's largest city) in 2016, even though King County has more than twenty-five times the number of youth than Grays Harbor.[132] The majority of Grays Harbor status offense admissions were for truancy, while in King County the majority of youth were incarcerated on dependency violations, which occur when a foster child runs away from their placement.[133]

Despite those criticisms, the opponents of 5290 argued that detention was an essential tool to protect youth. In an editorial written on behalf of the Superior Court Judges' Association, Judge Blaine Gibson wrote that, while detention for status offenses should be a "last resort . . . sometimes, when faced with the choice of either releasing a child back to their rapists, traffickers and abductors, or keeping that child in custody, detention is the only reasonable choice."[134] Judge Gibson also pointed to the short duration of each detention: 1.5 days on average in 2015.[135] In a similar vein, Senate Republican Minority Leader Mark Schoesler recalled "parents' frustration" before the passage of the Becca Bill when their children ran away from home, and thought that detention should remain an option for runaway youth without a safe place to stay.[136]

Supporters of 5290, on the other hand, argued that detention failed to keep youth safe. The director of the King County Department of Public Defense wrote that "[j]ail endangers children. The only thing a child learns by going to jail is that they belong in jail,"[137] a claim supported by the fact that status-offending youth are placed in the same facility as youth on delinquency charges.[138] Supporters also argued that many status offenders, especially girls, are survivors of trauma and violence and that they need supportive services, not confinement.[139] Rather than protecting girls, detention "criminaliz[es] youth for the trauma they

131. Santos, *Washington No. 1*, *supra* note 106.

132. AMANDA B. GILMAN & RACHAEL SANFORD, WASH. ST. CNTR. FOR CT. RES., WASHINGTON STATE JUVENILE DETENTION 2016 ANNUAL REPORT 11 (2017), https://www.courts.wa.gov/subsite/wsccr/docs/2016Detention AnnualReport.pdf (finding 168 non-offender admissions in Grays Harbor in 2016 and 139 in King County); Santos, *Washington No. 1*, *supra* note 106.

133. GILMAN & SANFORD, *supra* note 132, at 11.

134. Blaine Gibson, Opinion, *Sometimes detention is the only choice to keep a child safe*, SEATTLE TIMES (Mar 7, 2019 1:50 PM), https://www.seattletimes.com/opinion/sometimes-detention-is-the-only-choice-to-keep-a-child-safe/.

135. *Id.*

136. Santos, *'It's an Issue of Liberty'*, *supra* note 97.

137. Anita Khandelwal, *Jailing Runaways Does Not Keep Them Safe*, SEATTLE TIMES (Mar. 17, 2019 12:01 PM), https://www.seattletimes.com/opinion/jailing-runaways-does-not-keep-them-safe/.

138. *See* Santos, *Washington No. 1*, *supra* note 106.

139. Telephone Interview with Ann Muno, Executive Director, Justice for Girls Coalition of Washington State (June 19, 2020) [hereinafter Muno Interview].

have experienced"[140] while "fail[ing] to address underlying causes of status-offending behaviors."[141]

Both supporters and opponents of the Becca Bill emphasized the need for other solutions beyond detention. The Superior Court Judges' Association specifically advocated for funding secure therapeutic alternatives, like CRCs.[142] State Representative Noel Frame, a Democrat and one of the sponsors of the legislation, commented that detention had become "not a tool, but a crutch" for judges, which had prevented attempts to find alternative solutions.[143] These statements indicate that, more than twenty years after its passage, the Becca Bill still set the terms of the debate. Opponents of 5290 were reluctant to let go of a detention tool intended to protect youth. And both sides argued that it was their position that was necessary to keep youth safe.

In the end, the vote on 5290 was close.[144] Ultimately, to ensure the Bill's passage, supporters lengthened the timeline for implementation in order to develop other services to address status offense behaviors.[145] Incarceration for status offenses would soon become a thing of the past in Washington.

C. The present, part two: HB 1874, HB 2883, and the expansion of parent-initiated treatment

Notably absent from the legislative debate about 5290 was any mention of another option to confine youth: inpatient mental health treatment. There has been a long movement in Washington to augment parents' ability to commit their children into inpatient treatment. This effort culminated in two recent legislative changes that expanded the parent-initiated treatment process in Washington.

In 1985, a state law gave children thirteen and older the right to initiate treatment without their parents' consent in order to expand adolescent access to healthcare services.[146] The same law also had the unintended consequence of limiting parents' ability to seek treatment without their child's consent and preventing providers from communicating treatment information to parents.[147] A 1998 bill, initiated in response to the state Supreme Court ruling in *CPC Fairfax*,

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140. Ann Muno, Opinion, *Stop Locking Up Teen Girls For Nonviolent Offenses*, SEATTLE TIMES (Feb. 7, 2019 1:50 PM), https://www.seattletimes.com/opinion/stop-locking-up-teen-girls-for-nonviolent-offenses/.

141. Khandelwal, *supra* note 137.

142. Gibson, *supra* note 134.

143. Santos, *'It's an Issue of Liberty'*, *supra* note 97.

144. *Id.*

145. *See id.* (noting that the bill's provisions do not fully phase in until 2023).

146. Tori Marlan, *A Change In Washington Law Helps Parents Address Mental-Health Needs Of Their Teenage Children, But Barriers Remain*, SEATTLE TIMES (Feb. 16, 2020 6:00 AM), https://www.seattletimes.com/seattle-news/homeless/a-change-in-washington-law-helps-parents-address-mental-health-needs-of-their-teenage-children-but-barriers-remain/.

147. *Id.*

created Patient-Initiated Treatment (PIT), a process by which parents could seek inpatient treatment on their child's behalf when an admitting professional determined that the treatment was "medically necessary."[148] This provided an option for parents to seek treatment without their child's consent, even if the child did not meet the stricter standards to qualify for involuntary treatment.[149] However, PIT was not utilized: there were only two documented inpatient admissions using the system between 1998 and 2011.[150]

In describing the problems with PIT, parents specifically highlighted their fears about their children's safety when they were on the run and their desire to avoid a juvenile court response. For instance, Karen Kelly described feeling powerless when she was unable to seek mental health or substance use treatment for her daughter, who was running away and using methamphetamine.[151] At one point, Kelly took her daughter out of state to seek a secure residential treatment program.[152] Peggy Dolane, one of the primary parent-advocates for raising increasing options for parent-initiated inpatient treatment, wanted to avoid the juvenile court process to seek treatment for her children because she did not want them to be incarcerated for status offenses. She stated, "I have African American kids, and I didn't want to use jail to enforce what they needed."[153]

Parent-advocates tried to change the law eleven times, without success, between 1989 and 2009.[154] In 2018, the Washington State Legislature tasked a Workgroup with exploring problems with the current PIT system and proposing solutions.[155] The Workgroup recommended that the Legislature fix the access issues within the PIT system, instead of raising the age of consent, to preserve

148. FINAL B. REP. SSB 6208, 2 (Wash. 1998), http://lawfilesext.leg.wa.gov/biennium/1997-98/Pdf/Bill%20Reports/Senate/6208-S.FBR.pdf?q=20200614133211. The statutory definition of "medical necessity" for inpatient care is: "a requested service which is reasonably calculated to: (a) Diagnose, correct, cure, or alleviate a mental disorder or substance use disorder; or (b) prevent the progression of a substance use disorder that endangers life or causes suffering and pain, or results in illness or infirmity or threatens to cause or aggravate a handicap, or causes physical deformity or malfunction, and there is no adequate less restrictive alternative available." E2SHB 1874, 66th Leg., 2019 Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session %20Laws/House/1874-S2.SL.pdf?q=20200614142842.

149. *See* REVISED CODE OF WASH. § 71.05.153 (stating Washington's standard for emergency custody as an "imminent likelihood of serious harm" or "in imminent danger because of being gravely disabled").

150. KATHY BREWER & PEGGY DOLANE, WASH. BEHAVIORAL HEALTHCARE CONF., FAMILY INITIATED TREATMENT AND ENGAGING FAMILIES IN THE TREATMENT OF YOUTH 9 (2019), http://www.thewashingtoncouncil.org/wp-content/uploads/2019/06/T305.pdf.

151. Marlan, *supra* note 146.

152. *Id.*

153. *Id.*

154. *Id*.

155. AMANDA HUBER, PARENT INITIATED TREATMENT STAKEHOLDER ADVISORY WORKGROUP: REPORT TO CHILDREN'S MENTAL HEALTH WORKGROUP 3, 5 (2018), https://www.hca.wa.gov/assets/PIT-progress-report-20181201.pdf.

adolescent access to services while also empowering parents.[156]

These recommendations resulted in the passage of House Bill 1874 in 2019. While HB 1874 kept the age of consent intact, it expanded the definition of "parent" to include stepparents and kinship caregivers and renamed the process Family-Initiated Treatment (FIT).[157] The bill also gave parents the ability to initiate medically necessary outpatient treatment without their child's consent and empowered providers to use their discretion in disclosing treatment and evaluation records with parents.[158] In 2020, the Legislature passed House Bill 2883, which expanded the definition of "inpatient treatment" to include residential treatment facilities, including private RTCs.[159] Neither of these bills met significant opposition in the Legislature.[160]

Supporters applauded these changes to FIT as a step to treat "the family . . . [n]ot just the individual."[161] But some expressed skepticism about whether adolescents will open up to their care providers if their disclosures might be shared with their parents, and whether involuntary outpatient treatment would be effective if the young person was unwilling to cooperate.[162] And most parties agreed that more education is necessary to make sure that providers, parents, and youth all understand their options under the new laws.[163]

While the Becca Bill expanded the authority of both courts and parents to seek incarceration or institutionalization for youth committing status offenses, these recent legislative changes have moved in two different directions. Washington has significantly limited the court's power to incarcerate while expanding parents' ability to seek mental health treatment, including secure inpatient treatment. One explanation for this is the strength of the decarceration movement,

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156. *Id.* at 4.

157. FINAL B. REP. E2SHB 1874, 2-3 (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/House/1874-S2.E%20HBR%20FBR%2019.pdf?q=20200620212919.

158. *Id*.

159. FINAL B. REP. SHB 2883, 3 (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/House/2883-S%20HBR%20FBR%2020.pdf?q=20200620213230.

160. FINAL B. REP. E2SHB 1874, *supra* note 157, at 5; FINAL B. REP. SHB 2883, *supra* note 159, at 3.

161. Emily McCarty, *'It Affects the Entire Family': Washington Parents Now Work Alongside Teens in Mental Health Recovery*, CROSSCUT (Jan. 8, 2020), https://crosscut.com/2020/01/it-affects-entire-family-washington-parents-now-work-alongside-teens-mental-health-recovery [hereinafter McCarty, *'It Affects the Entire Family'*].

162. *See* Deborah Wang, *Should Parents Be Able to Weigh in on teens' Mental Health Treatment?*, KUOW (Jan. 30, 2019 3:51 PM), https://www.kuow.org/stories/should-parents-be-allowed-to-weigh-in-on-teens-mental-health-treatment; Telephone Interview with Liz Trautman, Director of Public Policy & Advocacy, Mockingbird Society (June 2, 2020) [hereinafter Trautman Interview].

163. McCarty, *'It Affects the Entire Family'*, *supra* note 161.

particularly within the juvenile court system.[164] Some stakeholders, like Peggy Dolane, support empowering parents but not increasing the authority of the juvenile court to incarcerate. This echoes the deinstitutionalization movement in the 1960s and 1970s, in which parents pressed for the shuttering of particularly harmful institutions while fighting to maintain their own power to institutionalize.[165]

D. The future: The possibility of transinstitutionalization in Washington

There is no indication that legislators consciously sought to shift confinement of youth committing status offenses from juvenile detention to inpatient mental health treatment.[166] But these legislative developments do indicate the presence of some political will to disempower the juvenile court system and to empower parents. It remains to be seen whether these changes will lead to transinstitutionalization, as occurred in the 1980s and 1990s after the decarceration of status offenses nationwide. Will youth who formerly would have been incarcerated for a status offense appear in greater numbers in inpatient treatment, and, if so, will some of those hospitalizations be inappropriate? This will partly depend on whether the state adequately funds community-based treatment programs and whether the changes to the FIT process lead to an increase in the number of psychiatric beds available for minors in Washington.

First, will community-based support and treatment for youth be adequately funded? In 2020, the Legislature passed House Bill 2873, which mandates that the state offer Family Reconciliation Services, supportive services for a family experiencing conflict, upon request.[167] However, this is only a modest step towards increasing community-based services. Overall, Washington youth advocates are not optimistic that future budgets will fund robust options for community-based treatment. Front-end preventative services are often vulnerable to budget cuts.[168] One advocate for 5290 feared a "backlash" against the decarceration of status offenses without community-based solutions that meet kids' needs.[169]

One bright spot is that the decarceration of status offenses may have increased the ability of runaway youth to access existing community services.

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164. Sawyer, *supra* note 25 (noting the significant decline in rates of juvenile incarceration since 2000).

165. *See* Bagenstos, *supra* note 31, at 16-18.

166. *See* Muno Interview, *supra* note 139; Telephone Interview with Karen Pillar, Managing Attorney, TeamChild (June 15, 2020) [hereinafter Pillar Interview].

167. Previously DCYF was not required to offer such services upon request, although some such services were available. FINAL B. REP. SHB 2873 1-2 (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/House/2873-S%20HBR%20FBR%2020.pdf?q=20200621065719.

168. Trautman Interview, *supra* note 162.

169. Muno Interview, *supra* note 139.

Washington law mandates that homelessness services organizations report the whereabouts of a runaway youth to their parent, law enforcement, or the child welfare system.[170] In the past, this may have disincentivized youth on the run from going to shelters or seeking out other services.[171] With the fear of arrest and detention for status offenses reduced, young people may be less worried about the institutional consequences of connecting with service providers.

Second, will the recent expansion of the FIT process actually result in a greater use of inpatient treatment? There are a few reasons to be skeptical that these legislative changes will lead to significant shifts in the system. For one, there have been no major changes to the "medically necessary" standard for admission or the independent healthcare authority review.[172] This standard has traditionally been difficult to meet for the young people that judges and families might be most eager to confine for their safety: youth on the run.[173] On the other hand, the expansion of the definition of "parent" could empower social workers and kinship caregivers to pursue FIT, and there has already been more education within the child welfare system about how and when to use the process.[174]

Moreover, inpatient psychiatric beds for minors are already scarce in Washington.[175] Indeed, some parents continue to find Washington's inpatient treatment programs inadequate to meet demand.[176] This lack of beds may disincentivize evaluating clinicians from deeming a youth eligible for FIT admission.[177] While FIT may have somewhat expanded possibilities for entry into the mental health system, it did not change the capacity within the system.[178]

HB 2883's addition of RTCs to the FIT framework, however, could impact system capacity. Nationwide, the private RTC industry greatly expanded in the last three decades of the twentieth century.[179] But unlike other states, Washington

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170. WASH. REV. CODE § 13.32A.082.

171. *See* Shapiro, *supra* note 1 (noting that youth on the run might avoid shelters because they fear getting arrested).

172. Trautman Interview, *supra* note 162.

173. Telephone Interview with Norene Roberts, Former Commercially Sexually Exploited Children's Liaison, Wash. State Dep't of Child., Youth & Fams. (June 12, 2020) [hereinafter Roberts Interview].

174. *Id.*

175. Hannah Furfaro, *33 Days Without Sunlight: Why Hundreds of Washington Kids Are Living in Windowless Emergency Rooms*, SEATTLE TIMES (Feb. 20, 2022), https://www.seattletimes.com/seattle-news/mental-health/33-days-without-sunlight-why-hundreds-of-washington-kids-in-mental-health-crisis-are-living-inside-windowless-emergency-departments/.

176. *See* Emily McCarty, *Lack of Behavioral Health Care in WA Forces Families Apart*, CROSSCUT (June 2, 2020, 10:35 AM), https://crosscut.com/2020/06/lack-behavioral-health-care-wa-forces-families-apart; *see also* Emily McCarty, *Kids Desperate for Inpatient Psych Care Have Few Options in WA*, CROSSCUT (July 27, 2020, 2:00 PM), https://crosscut.com/2020/07/kids-desperate-inpatient-psych-care-have-few-options-wa.

177. Trautman Interview, *supra* note 162.

178. *Id.*

179. Weithorn, *Second-Order Change*, *supra* note 9, at 1384-86.

has not had significant growth in that industry. In fact, Disability Rights Washington (DRW) recently exposed the state's practice of placing foster youth in private treatment centers in other states.[180] After a DRW report revealed "abusive physical restraints" and a high degree of segregation from society in one such facility, Clarinda Academy,[181] the state agreed to stop placing kids there.[182]

Before HB 2883, qualifying facilities were primarily inpatient, hospital-like settings.[183] The new inclusion of RTCs in FIT could incentivize private entities to build private facilities like Clarinda Academy in-state.[184] But other advocates are skeptical that new secure facilities will be built. If the current trend towards decarceration leads to positive outcomes for children and families, those outcomes may persuade lawmakers to invest in community-based options instead of institutional facilities.[185] And budget cuts could stymie efforts to build more physically secure treatment facilities.[186]

If neither community-based treatment options nor rates of inpatient treatment increase, there could be other negative consequences. More status offending youth may end up unstably housed. Rates of youth living on the street rose after the nationwide deinstitutionalization of status offenses.[187] This may have already begun in Washington. In the summer of 2019, even before the implementation of 5290, Washington's child welfare agency stopped requesting that the juvenile court issue run warrants for state-dependent youth when they left placement.[188] There is anecdotal evidence that run episodes began to increase in length,[189] which could expose some youth to greater risks.[190] And without greater capacity within the mental health system, some status offenders may be arrested and incarcerated on delinquency charges instead.[191]

III. BEYOND WASHINGTON: MEETING PHYSICAL SAFETY NEEDS THROUGH

180. DISABILITY RIGHTS WASH., WASHINGTON'S OUT-OF-STATE YOUTH PLEAD: LET US COME HOME 3-4 (2018), https://assets.documentcloud.org/documents/5004875/DRW-Final-Report-Clarinda-2018.pdf.

181. *Id.* at 6-7.

182. Joseph O'Sullivan, *Report: Washington Foster Kids Sent to Iowa Were Abused in Facility Run 'Like a Correctional Institution'*, SEATTLE TIMES (Oct. 17, 2018), https://www.seattletimes.com/seattle-news/report-washington-foster-kids-sent-to-iowa-were-abused-in-facility-run-like-a-correctional-institution/.

183. Pillar Interview, *supra* note 166.

184. *Id.*

185. Trautman Interview, *supra* note 162.

186. *Id.*

187. Weithorn, *Second-Order Change*, *supra* note 9, at 1461.

188. Roberts Interview, *supra* note 173.

189. *Id.*

190. Weithorn, *Second-Order Change*, *supra* note 9, at 1378-79.

191. *See id.* at 1458-59 (noting that, in some circumstances, law enforcement and court personnel can treat what could be a status offense as a delinquency case, like charging a runaway child with trespassing, enabling juvenile detention as a result).

COMMUNITY-BASED SERVICES AND IMPROVING MENTAL HEALTH PROCEDURAL SAFEGUARDS

Whether significant transinstitutionalization occurs in Washington because of the decarceration of status offenses will depend on what kinds of community-based services are provided and what types of incentives exist to move kids into—or keep kids out of—inpatient and residential treatment. But regardless of exactly what happens in Washington going forward, the case study already offers two important lessons for policymakers. First, addressing stakeholders' physical safety concerns is paramount for building the necessary buy-in to build and utilize community-based services as alternatives to incarceration and institutionalization. Second, empowering parents to initiate inpatient treatment requires strong procedural protections to prevent inappropriate admissions.

These lessons suggest two avenues for policy reform to avoid unnecessary transinstitutionalization. First, policymakers must explicitly address physical safety concerns by creating, funding, and educating stakeholders about community-based services that can meet young people's physical safety needs at home. Through community-based services that specifically address status offense behaviors, advocates can demonstrate to stakeholders that community-based treatment increases young people's long-term physical safety while mitigating short-term safety concerns. Advocates can also incentivize providing high-quality community-based services through litigation and integrating funding sources across systems, generating buy-in through shared stakeholder commitment to safety. Second, increasing procedural safeguards for youth in parent-initiated inpatient treatment can further guard against unnecessary institutionalization.[192]

A. Reducing transinstitutionalization by addressing physical safety concerns

Recognizing the role that concern for children's physical safety plays in justifying incarceration and institutionalization, this Note recommends a strategic shift that policymakers, advocates, and scholars have long overlooked: focusing on meeting children's physical safety needs by expanding community-based treatment and educating key stakeholders—including parents and judges—that community-based services can keep kids safe while avoiding the harms of confinement.

1. Stakeholder education about mitigating physical safety risks through

192. The scholarly literature on community-based care often emphasizes the failures of youth-serving *systems* to incentivize community-based services, without analyzing the role of parents in seeking out inpatient and residential treatment. *See, e.g.*, Weithorn, *Second-Order Change*, *supra* note 9, at 1389. As this Note demonstrates, foregrounding parents as stakeholders sheds light on important policy considerations, including stakeholder education about meeting physical safety needs through community-based care and the need for procedural safeguards specific to family-initiated treatment programs.

community-based treatment

The Washington case study offers one explanation for why investment in quality community-based services has been inadequate despite the consensus about their effectiveness: When it comes to physical safety, stakeholders remain unconvinced.[193] Washington's history with status offenses demonstrates how physical safety dominates the conversation about how to help children struggling with status offense behaviors. Of course, parents and policymakers alike worry about how to keep kids safe. But even if Washington were to rectify the scarcity of community-based mental health services tomorrow, key stakeholders like parents and judges would likely continue to seek out inpatient treatment and even incarceration in an effort to protect children. As such, decarcerating youth without changing the mindset that kids with risky behaviors need to be "put away" could make transinstitutionalization more likely.[194] In the legislative debate about 5290, the perceived need for some kind of confinement for youth living on the street echoed the origins of the Becca Bill and set the terms of the debate.[195] The Washington case study shows that policymakers must address stakeholder concerns about physical safety head-on.

Shifting the culture around confinement requires both the right mix of community-based treatment options and effective stakeholder education about how to create long-term physical safety for youth. Offering community-based interventions that focus specifically on reducing high-risk status offense behaviors is critical.[196] For instance, recent research has highlighted specific interventions that decrease run behaviors. Determining the causes of run behavior for an individual young person, including running *to* something (a "pull" factor) and running *from* something (a "push" factor), and creating a prevention plan specific to those circumstances can lead to a significant decrease in run episodes.[197] Safety planning around running away can also include harm reduction strategies, like

193. *See, e.g.*, Weithorn, *Second-Order Change*, *supra* note 9, at 1487; Cannon, *supra* note 36, at 1109-10. Weithorn and Cannon both argue that greater coordination between youth-serving systems would incentivize stakeholders to craft community-based treatment plans for young people. But the role of physical safety concerns in encouraging the continued use of inpatient and residential treatment, which the Washington case study underscores, has not been explored in the scholarly literature. Indeed, multisystemic coordination alone would not change the mindset that safety concerns must be dealt with through institutionalization.

194. *See* Muno Interview, *supra* note 139.

195. *See* Yeannakis Interview, *supra* note 130.

196. These types of interventions are similar to the "harm reduction" model for substance use, which emphasizes decreasing the harm associated with a risky behavior, rather than mandating abstinence. *See, e.g.*, U.S. DEP'T OF HEALTH & HUM. SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., HARM REDUCTION, https://www.samhsa.gov/find-help/harm-reduction#:~:text=What%20is%20Harm%20Reduction%3F,the%20individual%20and%20community%20levels.

197. Pullmann et al., *supra* note 110, at 9-10; *see also* Hewitt B. Clark et al., *A Functional Approach to Reducing Runaway Behavior and Stabilizing Placements for Adolescents in Foster Care*, 18 RSCH. SOC. WORK PRAC. 429, 436-37 (2008).

working with a young person to develop strategies to increase their physical safety while on the run. Increasing access to these types of interventions would provide parents and other care providers with tools to increase safety while a young person is in their care. Offering community-based crisis response programs can also increase young people's ability to remain at home safely, including mobile crisis services and in-home stabilization services.[198] The state of Connecticut, for example, followed its prohibition on incarceration for status offenses with legislative reform that provided ready access to safety-oriented diversion services, including 24-hour crisis intervention and respite care.[199]

Advocates and policymakers should also directly address stakeholder safety concerns about the need for confinement by discussing the physical safety tradeoffs of incarceration or institutionalization compared to community-based treatment. While placing a youth in a locked facility can sometimes provide short-term physical safety, successful community-based treatment of a young person's underlying behavioral and mental health needs can also address her medium- and long-term physical safety risks.[200] Incarcerating a teenage girl for running away might increase her physical safety for a few days by preventing some high-risk behaviors during the period of confinement. In exchange, however, she may leave detention with more trauma, increased distrust of the system and decreased motivation to return the next time she runs away, leading to longer periods of running away and greater safety risks.[201] A stay in a psychiatric unit or residential treatment center may cause the same long-term result, especially if the stay is involuntary and perceived by the young person to be inappropriate.[202] Highlighting the ways in which high-quality community-based treatment can mitigate

198. *See* CTR. FOR HEALTH CARE STRATEGIES, MAKING MEDICAID WORK FOR CHILDREN IN CHILD WELFARE: EXAMPLES FROM THE FIELD 9 (2013), http://www.chcs.org/media/Making_Medicaid_Work.pdf. Mobile crisis teams can quickly respond to mental and behavioral health crises in the community, which can help to prevent children from being hospitalized. *Id.* Through in-home services, teams of providers provide treatment, behavioral support, and resources to children and their families at home. *Id.*

199. SARA MOGULESCU & GASPAR CARO, VERA INST. OF JUST., MAKING COURT THE LAST RESORT: A NEW FOCUS FOR SUPPORTING FAMILIES IN CRISIS 9-11 (2008), https://www.njjn.org/uploads/digital-library/Making_Court_the_Last_Resort_A_New_Focus_for_Supporting_Families_in_Crisis-ModelsforChange-12.08.2008.pdf.

200. *See* Weithorn, *Second-Order Change*, *supra* note 9, at 1489-90.

201. *See* Pullmann et al., *supra* note 110, at 10 (noting that status offense detention might decrease a young person's desire to return from running away).

202. Michelle Andrews, *Washington State Law on Behavioral Care Balances Parental Rights, Teens' Autonomy*, KAISER HEALTH NEWS (Oct. 24, 2019), https://khn.org/news/washington-state-law-on-behavioral-care-balances-parental-rights-teens-autonomy/?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=78489172&_hsenc=p2ANqtz-9FzeYJ7nR_E03TAuM4B jWDNe2tpr9B08ZL42P5uRYkmOclg41a0PhbbM_rVCcZ91MLffIsxsffztHZ1tfbvEeAND_6w&_hsmi=78489172 (quoting Jennifer Mathis, Director of Policy and Legal Advocacy at the Bazelon Center for Mental Health Law in Washington, D.C.: "I'm not sure the solution is more compelled treatment . . . . With younger people, that is their first experience with [mental health] services, and if it's a bad one, that defines their experience for

short-term safety risks while avoiding the long-term safety concerns associated with incarceration and institutionalization can help to address stakeholder concerns about young people's physical safety.

2. Increasing the availability of high-quality community-based treatment

If advocates generate greater stakeholder buy-in for community-based services by emphasizing physical safety, they still need effective strategies to increase the availability of high-quality community-based services. When young people in need of services lack access to treatment options, they may continue to engage in risky status offense behaviors.[203] Expanding adequate community-based services can alleviate waiting lists and help support young people more quickly.[204]

Litigation offers one strategy to incentivize states to create home- and community-based services that can enable youth to remain at home safely. In order to receive federal Medicaid funding for children's healthcare, states must provide early and periodic screening, diagnostic, and treatment services, including mental health assessment and treatment.[205] In addition to the statutory entitlement under Medicaid, the U.S. Supreme Court's 1999 decision in *Olmstead* held that unnecessary institutionalization constitutes unconstitutional discrimination under the Americans with Disabilities Act (ADA).[206] Under *Olmstead*, the state's integration duty applies not only to the state's own facilities, but also to the state's administration of services and its funding structure.[207] Together, Medicaid and *Olmstead* litigation can be used to push for a positive mandate for high-quality community-based services to prevent institutionalization and promote youth safety.[208]

Advocates have already found some success using impact litigation on behalf of institutionalized children.[209] Washington provides one such example. In 2010, Disability Rights Washington and several other organizations filed a class action suit against Washington's Department of Social and Health Services (DSHS) on behalf of Medicaid-eligible Washington children.[210] They alleged

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the rest of their lives"); *see also* Cannon, *supra* note 36, at 1058-59; Weithorn, *Mental Hospitalization*, *supra* note 89, at 797.

203. *See* Jafarian & Ananthakrishnan, *supra* note 10.

204. *See* Weithorn, *Second-Order Change*, *supra* note 9, at 1363 (noting "excessively long waiting lists" for community-based services); Cannon, *supra* note 36, at 1104-05 (same).

205. Cannon, *supra* note 36, at 1079.

206. Olmstead v. L. C. by Zimring, 527 U.S. 581, 607 (1999).

207. Bagenstos, *supra* note 31, at 31-32.

208. *Id.* at 33-34. *Olmstead* litigation may also offer advocates a tool to challenge budget cuts to community-based services for increasing risk of institutionalization. *Id.* at 36.

209. *See, e.g.*, Cannon, *supra* note 36, at 1099; *see also* Weithorn, *Second-Order Change*, *supra* note 9, at 1433-34 (arguing that so far, the promise of the ADA and the Individuals with Disabilities Education Act has been yet unrealized).

210. Settlement Agreement and Proposed Order at 3, T.R. v. Dreyfus, No. C09-1677-

that DSHS had failed to provide "intensive home and community-based mental health services" to Medicaid recipients in violation of Medicaid's statutory requirements, the ADA, and the Rehabilitation Act.[211] The complaint laid out the complex histories of the named plaintiffs, which it summarized as "cycling in and out of hospitals, juvenile detention centers, long-term psychiatric institutions, and foster care placements that may be hundreds of miles away from their homes and families."[212] The plaintiffs argued that the state had failed to provide outpatient treatment options "that would allow [the plaintiffs] to remain safely at home" and had instead resorted to multiple forms of confinement, including both incarceration and institutionalization, to deal with youth with behavioral challenges.[213]

In 2012, the parties reached a landmark settlement agreement to transform mental health care provision for children in Washington.[214] The ultimate outcome was the Wraparound with Intensive Services (WISe) program, which provides multisystemic care coordination for mental health services for Medicaid-eligible youth, including a single provider coordinating care, in-home and community-based direct services, and mobile crisis services.[215] By 2018, WISe had been implemented statewide.[216] As of 2019, the state had met its benchmark for enrollment in services and its assessment tool measured substantial progress from participants.[217] WISe is an example of systems change moving the needle towards an evidence-based, multisystemic response emphasizing community-based and family-based services that enable youth to remain at home safely.[218]

TSZ (W.D. Wash., Aug. 30, 2013), https://www.disabilityrightswa.org/wp-content/uploads/2017/12/Settlement-Agreement-and-Order-signed-8.30.2013_0.pdf [hereinafter Settlement Agreement].

211. First Amended Complaint at 2, T.R. v. Dreyfus, No. 09-cv-01677-TSZ (W.D. Wash., Oct. 27, 2011), https://www.clearinghouse.net/chDocs/public/PB-WA-0007-0005.pdf.

212. *Id.* at 3.

213. *Id.*

214. Austin Jenkins, *Landmark Agreement To Improve Mental Health For Kids In Wash.*, NPR (Mar. 7, 2012, 3:00 AM), https://www.npr.org/templates/story/story.php?storyId=148183711&ft=3&f=148183711.

215. Settlement Agreement, *supra* note 210, at A-1-5. In September 2021, the case was dismissed after parties agreed that the State had "substantially complied" with the settlement agreement. Joint Stipulation and Order to Dismiss at 3, T.R. v. Birch & Strange, No. 09-cv-1677-TSZ (W.D. Wash., Sept 2, 2021).

216. WISE WORKFORCE COLLABORATIVE, https://wisewc.com/ (last visited June 21, 2021).

217. T.R. Status Report at 7-8, 31, T.R. v. Birch & Strange, No. 09-cv-01677-TSZ (W.D. Wash., Dec. 30, 2019), https://www.hca.wa.gov/assets/program/wise-implementatiom-status-report-2019.pdf.

218. *See* SHEILA PIRES ET AL., CTR. FOR HEALTH CARE STRATEGIES, IDENTIFYING OPPORTUNITIES TO IMPROVE CHILDREN'S BEHAVIORAL HEALTH CARE: AN ANALYSIS OF MEDICAID UTILIZATION AND EXPENDITURES 15 (2013), https://www.chcs.org/media/Identifying-Opportunities-to-Improve-Childrens-Behavioral-Health-Care2.pdf.

Beyond litigation, changing funding arrangements can provide another powerful institutional incentive to decrease out-of-home placements and increase the use of community-based treatment. Institutional care is expensive, costing hundreds of dollars per child per day of treatment.[219] But because funding is siloed between different child-serving systems, agencies are not incentivized to provide community-based interventions before a behavioral health crisis occurs.[220] Pooling costs between agencies can encourage stakeholders to work collaboratively to decrease incarceration and institutional placements. Better coordination could also help providers recognize and reckon with transinstitutionalization if agencies prioritize diverting youth from RTCs and inpatient admissions the same way that systems are beginning to prioritize diverting youth from the juvenile legal system.[221]

Wraparound Milwaukee offers one example of how a blended funding model incentivizes the use of community-based mental health treatment instead of institutionalization. The program, first established in 1995, enrolls all youth with severe emotional disturbances across multiple systems in Milwaukee County and is a single payer for their services.[222] Since the program's inception, Milwaukee has seen steep declines in the use of residential treatment centers, inpatient psychiatric treatment, and incarceration.[223] Wraparound Milwaukee uses multiple methods to pool funding, including Medicaid billing on a per-client basis, crisis billing of the mental health system, and drawing funds budgeted for institutional care from the child welfare and juvenile legal systems.[224] As the program reports, this funding structure incentivizes "win-win" situations for all systems involved, since reducing out-of-home placements saves money all around.[225] Pooling funding helps agencies to internalize the costs of institutional

219. *See* Cannon, *supra* note 36 at 1057.

220. Weithorn, *Second-Order Change*, *supra* note 9, at 1483-84.

221. *See* Cannon, *supra* note 36, at 1111.

222. BRUCE KAMRANDT, COSTS AND COST-EFFECTIVENESS IN WRAPAROUND PROGRAMS 54, https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/Costs-and-Cost-Effectiveness-in-Wraparound-Programs-Wisconsin.pdf.

223. BETH A. STROUL ET AL., NATIONAL TECHNICAL ASSISTANCE CENTER FOR CHILDREN'S MENTAL HEALTH, RETURN ON INVESTMENT IN SYSTEMS OF CARE FOR CHILDREN WITH BEHAVIORAL HEALTH CHALLENGES 16 (2014), https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/Return-on-Investment-in-Systems-of-Care-for-Children-with-Behavioral-Health-Challenges.pdf. Wisconsin rarely incarcerates youth for status offense behaviors. *See* STATE USE OF THE VCO EXCEPTION, *supra* note 8 (stating that Wisconsin had five uses of the VCO exception in 2016).

224. KAMRANDT, *supra* note 223, at 6-7; CTR. FOR HEALTH CARE STRATEGIES, INC., CASE RATE SCAN FOR MANAGED CARE ENTITIES 10 (2012), https://www.chcs.org/media/Case_Rate_Scan_for_CMEs.pdf. New Jersey similarly finances its children's system of care with blended funding from multiple youth-serving systems in a single "pot." Center for Health Care Strategies, CASEY FAMILY PROGRAMS, *How Can Medicaid Support the Treatment Costs for Youth in Residential Programs?*, (Aug. 10, 2020), https://www.casey.org/residential-reimbursement/#:~:text=Residential%20treatment%20programs%20are%20funded,not%20Title%20IV%2DE%20eligible.

225. KAMRANDT, *supra* note 223, at 8.

placements and incentivizes community-based services.[226]

Maintaining quality data across systems would also help policymakers to grapple more explicitly with the possibility of transinstitutionalization and make data-driven decisions about what is necessary to keep young people safe. In Washington, for instance, the 2020 family-initiated treatment expansion mandated that the Washington State Health Care Authority implement a data collection and tracking system.[227] This is a good first step, but in and of itself will not provide information about transinstitutionalization since it only tracks information about family-initiated treatment from within the healthcare system. More collaboration across systems could yield better data. While it is relatively straightforward to track juvenile incarceration data, and even congregate care placements for foster youth, the same is not true for inpatient psychiatric treatment and especially RTCs. Centralizing enrollment and funding for these programs, as in a program like Wraparound Milwaukee, could help ensure better data. Better data could also provide policymakers with information about whether services are adequate to meet youth's physical safety needs or whether youth are falling through the cracks.

B. Increasing procedural safeguards in family-initiated treatment

Even with access to a full spectrum of high-quality community-based treatment options, there will still be young people whose safety needs require inpatient or residential treatment. Increasing the procedural safeguards within the

226. Funding can be used to discourage institutionalization in other ways, too. Within the child welfare system, the Family First Prevention Services Act (FFPSA), passed in 2018, shifted some federal funds from adoption and other foster care services to prevention services to enable youth to stay with parents or relatives. *Family First Prevention Services Act*, NAT'L CONF. STATE LEGISLATURES (Apr. 1, 2020), https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx#:~:text=The%20Family%20First%20Prevention%20Services%20Act% 20also%20seeks%20to%20curtail,for%20more%20than%20two%20weeks. Washington State recently received federal approval for its prevention plan, which includes evidence-based services, including functional family therapy and multi-systemic therapy, among others. WASH. STATE DEPT. CHILD., YOUTH & FAMS., FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN 19-22 (2020), https://www.dcyf.wa.gov/sites/default/files/FFPSA-Jul20.pdf. The FFPSA also enacted limitations on federal reimbursements for the use of congregate care, instituting a two-week limitation on reimbursement for placements except for those in qualified residential treatment programs that have licensed clinical staff and regular court oversight over the placements. *Family First Prevention Services Act*, NAT'L CONF. OF STATE LEGISLATURES (Apr. 1, 2020), https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx#:~:text=The%20Family%20First%20Prevention%20Services%20Act% 20also%20seeks%20to%20curtail,for%20more%20than%20two%20weeks. In Washington, for instance, a wraparound program screening is required before a youth can be placed in a qualified program. *4533. Behavioral Rehabilitation Services*, WASH. STATE DEPT. CHILD., YOUTH & FAMS., https://www.dcyf.wa.gov/4500-specific-services/4533-behavior-rehabilitation-services (last visited Mar. 3, 2022).

227. FINAL B. REP. SHB 2883, *supra* note 159, at 5.

mental health treatment system beyond the minimum required in *Parham* would provide a backstop to ensure that institutionalization is limited to those necessary cases.[228] Increased procedural safeguards—such as a mandatory pre-admission hearing—can help to protect against the unintended consequences of decarcerating status offenses and decrease the risk of transinstitutionalization while meeting young people's physical safety needs.[229]

Meaningful access to procedural safeguards is also important. In Washington, for example, state statute allows a youth to petition for release from a family-initiated commitment, but in practice there is no established process for the youth to do so.[230] This deprives youth of the ability to challenge their commitment. Increasing these types of procedural safeguards would help to ensure that institutionalization is used only in situations in which a youth's immediate need for physical safety truly outweighs their liberty interest.

When considering the importance of procedural safeguards in the context of inpatient mental health treatment, policymakers should also be alert to how and why adolescent brain development is deployed as a justification for policy decisions. Developmental psychology research about the immature adolescent brain has been used to mitigate harsh criminal or delinquency penalties by arguing for a young person's diminished culpability.[231] It has also been used to advocate for increasing procedural safeguards in the delinquency system, like mandatory appointment of counsel, on the grounds that children may need to be protected from their own immaturity.[232]

However, this same rationale could also be used to justify disregarding or removing a child's ability to provide informed consent for mental health treatment.[233] The Supreme Court's opinion in *Parham* reflected this logic: "Most

228. *See* Weithorn, *Mental Hospitalization*, *supra* note 89, at 831-35 (recommending increased procedural safeguards and a strengthened substantive threshold for state family-initiated treatment statutes); Dennis E. Cichon, *Developing a Mental Health Code for Minors*, 13 T.M. COOLEY L. REV. 529, 574-85 (1996) (similar).

229. *See* Weithorn, *Mental Hospitalization*, *supra* note 89, at 831-32 ("The cornerstone of a statutory structure protecting minors against inappropriate admissions must be a mechanism for some form of relatively neutral scrutiny."); Cichon, *supra* note 229, at 583-85 (recommending "mandatory reviews" of all admissions).

230. *See* Pillar Interview, *supra* note 166; Trautman Interview, *supra* note 162; WASH. REV. CODE § 71.34.620.

231. FELD, *supra* note 15, at 276.

232. *Id.* at 252-53. *See also* Lois Weithorn, *A Constitutional Jurisprudence of Children's Vulnerability*, 69 HASTINGS L.J. 179, 185-87 (2017) (arguing that children's vulnerabilities have justified a wide variety of outcomes in the Supreme Court's jurisprudence, including both narrowing and broadening minors' constitutional rights in different contexts).

233. *See* BREWER & DOLANE, *supra* note 150, at 15 (noting that one of the gaps in the pre-2019 statute was that it "assumes all children are capable informed consent – and discounts the importance of trauma-informed interventions & adolescent brain development (that the US Supreme Court has recognized)" (sic)).

children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment."[234] Paradoxically, the same research that has led courts and policymakers to *increase* procedural safeguards in the delinquency system could lead them to *decrease* those safeguards in the mental health system.[235] Rigorous scrutiny of the science underlying such arguments may help policymakers to be able to make informed decisions.[236]

Ultimately, policymakers should be skeptical of efforts to deny young people procedural due process on the grounds of their immaturity when the law already empowers parents, courts, and medical providers to provide treatment without a young person's consent if it is truly necessary to keep the child safe. When faced with potential changes to a state inpatient admissions statute, policymakers should primarily analyze any proposed changes to their statutory schemes with reference to empirical evidence regarding the efficacy of inpatient treatment.[237] Indeed, the use of this type of empirical research could also encourage policymakers to weigh long-term child wellbeing outcomes more appropriately alongside short-term care and safety and concerns.

CONCLUSION

Washington has recognized that incarceration is inappropriate for young people who have not committed crimes—in other words, young people who have "done nothing wrong."[238] That is not enough. Decarceration of status offenses can lead to an increase in inappropriate inpatient and residential treatment admissions, trading one set of institutional harms for another. The Washington case study shows that addressing physical safety concerns through community-based

234. Parham v. J.R., 442 U.S. 584, 603 (1979).

235. *See* Emily Buss, *What the Law Should (and Should Not) Learn from Child Development Research*, 38 HOFSTRA L. REV. 13, 43 (2009) (arguing that children's developmental capacities can "point in opposite directions" on the issues of adolescent autonomy rights and juvenile sentencing reductions, even though many legal advocates may seek to expand children's autonomy rights while advocating for less criminal culpability); *see also* Lawrence Steinberg et al., *Are Adolescents Less Mature Than Adults? Minors' Access to Abortion, the Juvenile Death Penalty, and the Alleged APA "Flip-Flop"*, 64 AM. PSYCHOL. 583 (2009).

236. *See* Clare Huntington & Elizabeth S. Scott, *Conceptualizing Legal Childhood in the Twenty-First Century*, 118 MICH. L. REV. 1371, 1435-36 (2020) ("Developmental research has enhanced understanding of maturation in adolescence, allowing for more informed judgments about when rights can promote minors' wellbeing, when paternalistic restrictions inflict harm, and when restrictions actually offer protection to minors and are justified in a system that aims to further child wellbeing.").

237. *See* Weithorn, *Second-Order Change*, *supra* note 9, at 1490-93 (describing the most-endorsed approaches in the empirical literature as those that "*avoid* the child's removal from the home, restriction of that child's liberty, and segregation of the child from the community").

238. *See* Shapiro, *supra* note 1.

treatment is critical to preventing unnecessary transinstitutionalization. Policymakers should advocate for community-based programs that enable young people to remain at home safely to address those concerns. At the same time, lawmakers should increase procedural safeguards within the family-initiated treatment system, with the goal of permitting involuntary interventions only where a young person's immediate physical safety needs cannot be met through community-based care.

As momentum behind the decarceration movement grows, we must avoid the mistakes of the past. Policymakers should not wait for another institutionalization crisis before investing in community-based solutions. Nor should they ignore stakeholder concerns about children's physical safety. Addressing these issues should not prevent the important work of dismantling mass incarceration. Rather, the risk of unnecessary and harmful transinstitutionalization should encourage policymakers to build political consensus around the need for community-based services.