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COMMENT

VOLUNTARY MINOR MENTAL PATIENTS: A REALISTIC BALANCING OF THE COMPETING INTERESTS OF PARENT, CHILD, AND STATE

by Robert M. O'Boyle

THE possibility of committing a minor child to a mental institution is far removed from the concerns of most people. Nevertheless, a significant number of children have been institutionalized[1] in state and private mental hospitals pursuant to state statutory procedures.[2] These minor mental patients are generally regarded as belonging to a class similar to that of voluntary adult mental patients,[3] but use of the term

1. According to the 1970 census, of all institutionalized persons below the age of 21, 42% were in mental institutions, while only 23% were in special facilities for juvenile offenders. 1 PRACTISING LAW INST. MENTAL HEALTH LAW PROJECT, LEGAL RIGHTS OF MENTALLY DISABLED PERSONS 399 (1979) [hereinafter cited as MENTAL HEALTH LAW PROJECT].

2. *See* ALA. CODE §§ 22-52-51 to -55 (1977); ALASKA STAT. §§ 47.30.670-.695 (Supp. 1983); ARIZ. REV. STAT. §§ 36-518 to -519 (1974 & Supp. 1983); ARK. STAT. ANN. § 59-1403 (Supp. 1983); CAL. WELF. & INST. CODE § 6000(b) (West Supp. 1983); COLO. REV. STAT. § 27-10-103 (1982); CONN. GEN. STAT. § 17-187 (1983); DEL. CODE ANN. tit. 16, § 5123 (1983); D.C. CODE ANN. §§ 21-511 to -512 (1981); FLA. STAT. ANN. § 394.465 (West 1983); GA. CODE ANN. § 88-503.1 to .3 (Supp. 1982); HAW. REV. STAT. § 334-60(a) (1976); IDAHO CODE §§ 66-318 to -322 (Supp. 1983); ILL. ANN. STAT. ch. 91 1/2, § 3-500 (Smith-Hurd Supp. 1983-1984); IND. CODE ANN. § 16-14-9.1-2 (Burns Supp. 1983); IOWA CODE ANN. § 229.2 (West Supp. 1983); KAN. STAT. ANN. § 59-2905 (1976); KY. REV. STAT. § 202A.020 (1982); LA. REV. STAT. ANN. § 28:57 (West Supp. 1983); ME. REV. STAT. ANN. tit. 34, § 2290 (1978); MD. HEALTH-GENERAL CODE ANN. § 10-610 (1982); MASS. GEN. LAWS ANN. ch. 123, § 10 (Michie/Law Co-op. 1981); MICH. COMP. LAWS §§ 330.1411, .1415 (1980); MINN. STAT. ANN. § 253A.03 (West 1982); MISS. CODE ANN. § 41-21-103(2)(c) (1981); MO. ANN. STAT. §§ 632.110, .115 (Vernon Supp. 1984); MONT. CODE ANN. § 53-21-112 (1983); NEB. REV. STAT. § 83-1019 (1981); NEV. REV. STAT. § 433A.140(1) (1983); N.H. REV. STAT. ANN. §§ 135-B:9 to :11 (1977 & Supp. 1983); N.J. STAT. ANN. § 30:4-46 (West 1981); N.M. STAT. ANN. § 43-1-16 (1979); N.Y. MENTAL HYG. LAW § 9.13 (McKinney 1978 & Supp. 1983-1984); N.C. GEN. STAT. §§ 122-56.3, .5 (Supp. 1983); N.D. CENT. CODE § 25-03.1-04 (Supp. 1983); OHIO REV. CODE ANN. § 5122.02 (Page Supp. 1983); OKLA. STAT. ANN. tit. 43A, § 184 (West 1979); OR. REV. STAT. § 426.220(1) (1981); PA. STAT. ANN. tit. 50, §§ 4402-4403 (Purdon 1969 & Supp. 1983-1984); S.C. CODE ANN. § 44-17-310 (Law Co-op. Supp. 1982); S.D. CODIFIED LAWS ANN. §§ 27A-8-2 to -4 (1977 & Supp. 1983); TENN. CODE ANN. §§ 33-601 (Supp. 1983); TEX. REV. CIV. STAT. ANN. art. 5547—23 (Vernon 1958); UTAH CODE ANN. § 64-7-29 (1978); VT. STAT. ANN. tit. 18, § 7503 (Supp. 1983); VA. CODE § 37.1-64 to -65 (Supp. 1983); WASH. REV. CODE ANN. § 72.23.070 (1982); W. VA. CODE § 27-4-1 (1980); WIS. STAT. ANN. § 51.10(2) (West Supp. 1983); WYO. STAT. § 25-10-106 (1977).

3. Doe v. Public Health Trust, 696 F.2d 901, 903 (11th Cir. 1983).

"voluntary" may be inaccurate in the context of minors institutionalized by a parent or guardian. Under voluntary commitment statutes the parent, not the child, seeks institutionalization of the child for treatment of mental illness.[4] Thereafter, the minor child's confinement continues primarily at the discretion of the parents.[5] Adult voluntary patients, on the other hand, may usually secure their own release upon written application.[6] Similarly, an adult voluntary patient may choose among and reject certain forms of treatment,[7] but the minor mental patient's power to refuse treatments is vested in the parent or guardian.[8] This broad parental control rests upon constitutional deference to family privacy[9] and upon the assumptions that parents act in their children's best interests and that children are incapable of making rational decisions regarding medical treatment.[10]

Concern for the constitutional rights of voluntary minor mental patients is a natural extension of the movements toward recognition of the rights of minors and of mental patients in general. Cases involving the constitutional rights of voluntary minor mental patients that have reached the United States Supreme Court have not presented fact situations amenable to blanket rulings or the pronouncement of broad constitutional principles.[11] Consequently, much uncertainty remains as to the limits on the constitutional rights of voluntary minor mental patients and their parents, and the powers of the state.[12] This Comment explores these areas of uncertainty and suggests the proper limits on the rights and powers of voluntary minor mental patients, their parents, and the state. A discussion of the substantial risks and dangers inherent in the institutionalization of minors evidences the cause for concern regarding the commitment of minors for mental illness. A brief treatment of the foundations of the movements to-

4. Some state statutes provide that adolescents of specified ages may unilaterally seek institutionalization for the treatment of mental illness. *See, e.g.*, CONN. GEN. STAT. § 17-205(f) (1983); ILL. ANN. STAT. ch. 9 1/2, § 3-502 (Smith-Hurd Supp. 1983-1984).

5. Generally, the parent requests that the child be released. Many states, however, have statutes providing that the hospital administrator should also exercise independent judgment and release the child should hospitalization no longer be required. *See, e.g.*, GA. CODE ANN. § 88-503.1 to .3 (Supp. 1982); PA. STAT. ANN. tit. 50, §§ 7201-7207 (Purdon Supp. 1983-1984).

6. Fearing that the adult patient might leave once meaningful treatment had begun, most states adopted statutes providing that voluntary patients could be detained for a statutorily prescribed time after giving notice of their intention to withdraw from the facility. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840, 844 n.19 (1974).

7. An adult involuntary patient even has the right to refuse dangerous drugs such as antipsychotic medication. Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom.* Mills v. Rogers, 457 U.S. 291 (1982).

8. Uncertainty remains, however, concerning the limitations on parental power to supervise the treatment program. *See* Doe v. Public Health Trust, 696 F.2d 901 (11th Cir. 1983) (discussed *infra* notes 181-98).

9. *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205, 230 (1972); Prince v. Massachusetts, 321 U.S. 158, 165 (1944); Pierce v. Society of Sisters, 268 U.S. 510, 518 (1925).

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

11. *See* Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Wisconsin v. Yoder, 406 U.S. 205 (1972); Ginsberg v. New York, 390 U.S. 629 (1968).

12. *See* Doe v. Public Health Trust, 696 F.2d 901 (11th Cir. 1983).

ward recognition of the rights of mental patients in general and of children's rights helps frame the analysis of Supreme Court cases involving the competing interests of parent, child, and state. The limitations on these interests are then discussed in the context of Supreme Court cases involving the voluntary commitment of minors to mental institutions. Finally, the Comment sets forth a proposed analysis of the Supreme Court decisions in an attempt to remove existing uncertainties and to find a constitutional balance that will more adequately protect the liberty interests of minor children.

I. CONCERNS RAISED BY THE VOLUNTARY COMMITMENT OF MINORS TO MENTAL INSTITUTIONS

A marked increase in the number of minor mental patients has accompanied the widespread adoption of laws allowing parents to commit their children to mental institutions. In 1952 less than 20% of the states had laws allowing parents voluntarily to commit their children to psychiatric inpatient facilities.[13] A movement for the passage of voluntary commitment statutes had already begun, however,[14] and within a few years a majority of states passed legislation that allowed parents to volunteer their children for commitment.[15] The result in one state was a greater than 700% increase in the number of minor mental patients committed to its state hospitals in the five-year period following enactment of the voluntary commitment statute.[16] By 1972, 42% of all institutionalized persons under the age of eighteen were in mental health care facilities.[17] In contrast, only 23% of institutionalized minors were in special facilities for juvenile delinquents.[18] The substantial and increasing population of minor mental patients illustrates the fact that judicial and legislative pronouncements concerning voluntary minor mental patients affect a large proportion of persons in state hospitals. As procedural safeguards concerning the commitment of adult mental patients have become more stringent, the percentage of hospitalized adults has decreased. This trend has been accompanied by a steady increase in the percentage of persons below age twenty-four admitted to mental hospitals, with the most noticeable increase occurring in the age group of fifteen and under.[19]

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13. Weihofen, *Hospitalizing the Mentally Ill*, 50 MICH. L. REV. 837, 855-56 (1952).

14. Institute of Mental Health's Draft Act Governing Hospitalization of the Mentally Ill, Public Health Service Publication No. 51 (1951), *cited in* Weihofen, *supra* note 13, at 859 n.52.

15. Ellis, *supra* note 6, at 844 n.22.

16. *Id.* at 844 (citing CAL. ASSEMBLY SELECT COMM. ON MENTALLY ILL AND HANDICAPPED CHILDREN, REPORT ON SERVICES FOR THE HANDICAPPED AND MENTALLY DISORDERED CHILDREN 146 (1970) [hereinafter cited as REPORT ON SERVICES]). In 1954 the number of minor mental patients, patients below 21 years of age, in California represented 1.3% of the total hospital population. By 1959 minor mental patients constituted 9.2% of the state hospital population. *Id.*

17. 1 MENTAL HEALTH LAW PROJECT, *supra* note 1, at 399.

18. *Id.* Nineteen percent of institutionalized minors were located in centers for dependent and neglected children. *Id.*

19. Harris, *Mental Illness, Due Process and Lawyers*, 55 A.B.A. J. 65, 67 (1969).

Persons committed to mental health care institutions may experience substandard care, lowered self-esteem, and the reinforcement of aberrant behavior by fellow patients. Minors committed during the formative years of their lives may be particularly affected by these factors. Numerous studies indicate that persons committed to institutions, particularly minor children, are susceptible to a lowering in social competence[20] and intelligence.[21] Moreover, the United States Supreme Court has recognized that commitment to an inpatient facility necessarily entails a "massive curtailment of liberty"[22] that is not diminished by the institution's desire to rehabilitate the minor.[23] Indeed, many of the mental health care facilities that house minors are regimented and impersonal and provide simple custodial care rather than treatment designed to rehabilitate the child.[24] Such ineffectual care probably results from a lack of adequate funding and qualified personnel.[25] The inadequate facilities and the severe social and self stigmatization[26] that result from commitment to mental institutions[27] are particularly appalling in light of the possibility that a minor will be wrongfully committed.[28]

In many voluntary commitment situations the problems that the child is experiencing do not constitute a mental illness requiring commitment to an institution. Many psychologists believe that a substantial number of these minors merely exhibit behavior patterns that their parents disapprove of

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20. *See* Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1308 n.40 (E.D. Pa. 1977) ("skills" learned at school were often antisocial and showed regression); *see also* Teitlebaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 FAM. L.Q. 153, 184 (1978) (citing Guthrie, Butler & Gorlow, *Personality Differences Between Institutionalized and Non-Institutionalized Retardates*, 67 AM. J. MENTAL DEFICIENCY 543 (1963) (negative self-attitude); Mitchell & Smeriglio, *Growth in Social Competence in Institutionalized Mentally Retarded Children*, 74 AM. J. MENTAL DEFICIENCY 666 (1970) (deterioration in social competence unless special programming provided)).

21. Teitelbaum & Ellis, *supra* note 20, at 183 (citing Silverstein, *Changes in the Measured Intelligence of Institutionalized Retardates as a Function of Hospital Age*, 1 DEVELOPMENTAL PSYCH. 125 (1969); Sternlicht & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. MENTAL DEFICIENCY RESEARCH 119 (1968)).

22. Humphrey v. Cady, 405 U.S. 504, 509 (1972).

23. Breed v. Jones, 421 U.S. 519, 530 n.12 (1975).

24. Teitelbaum & Ellis, *supra* note 20, at 181 (citing R. SCHEERENBERGER, DEINSTITUTIONALIZATION AND INSTITUTIONAL REFORM (1976); Mason & Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface*, 10 CREIGHTON L. REV. 124 (1976)).

25. N. HOBBS, THE FUTURES OF CHILDREN 127-28 (1975). For instance, in 1968 the U.S. government reported that the daily expenditure on patients in mental health care facilities ranged between $3.00 and $12.00. During the same time period five of the nation's largest zoos were spending an average of $7.00 a day to care for their larger animals. *Id.*

26. *See In re* Gault, 387 U.S. 1, 23-24 (1967) ("delinquent" label has come to involve almost as much stigma as "criminal" for adults).

27. Social stigma, self-stigmatization, and job and license discrimination are products of commitment to mental institutions. *See, e.g., In re* Ballay, 482 F.2d 648, 668 (D.C. Cir. 1973); Lessard v. Schmidt, 349 F. Supp. 1078, 1088-89 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

28. Once committed to an institution, a minor mental patient remains institutionalized longer, on the average, than his adult counterpart. Dept. of Health, Educ. & Welfare, NIMH, Statistical Note 90, *Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, United States, 1971*, table 9 [hereinafter cited as NIMH Statistical Note 90].

and feel unable to change.[29] In 1975 the most common diagnosis (54.3%) of juveniles admitted to state and county mental institutions was "transient situational disorders and behavioral disorders of childhood."[30] Often, less stringent treatment alternatives have not been attempted prior to seeking commitment of the child, and a majority of juveniles (53% in 1969) entering mental health care facilities have not received any prior psychiatric treatment.[31] This statistic may reflect the socioeconomic posture of many parents who wish to institutionalize their children.[32] Thus, even parents who desire the advice of an independent psychiatrist or psychologist prior to seeking commitment of the minor,[33] or who might prefer less drastic forms of treatment, simply may not be able to afford it.[34]

Even if a parent is able to obtain the services of an independent psychiatrist or psychologist prior to seeking the institutionalization of the child, the doctor might not make his diagnosis with the best interests of the child foremost in his mind. Although the traditional position taken by medical professionals is that they operate in a fiduciary capacity on behalf of their patients,[35] when the parent rather than the child comes to the doctor for advice, it may not be possible for the doctor to make a truly independent diagnosis.[36] The parent is generally the most readily available, reliable source of information relating to the child's environment and life experiences, as well as the person who compensates the doctor for his services.[37]

Studies also indicate that the diagnosis of an admitting physician at a state or private mental hospital may not be valid.[38] In one experiment designed to test the validity of such evaluations,[39] eight healthy persons

29. B. ENNIS & L. SEIGEL, THE RIGHTS OF MENTAL PATIENTS 38 (1973); *see* Comment, *Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill*, 56 YALE L.J. 1178, 1182-83 (1947).

30. Dept. of Health, Educ. & Welfare, NIMH, Statistical Note 138, *Diagnostic Distribution of Admissions to Inpatient Services of State and County Mental Hospitals, United States, 1975*.

31. NIMH Statistical Note 90, *supra* note 28, table 9.

32. T. LIDZ, S. FLECK & A. CORNELLISON, SCHIZOPHRENIA AND THE FAMILY 131 (1965).

33. A survey of the parents of voluntarily committed minor mental patients at California's Napa State Hospital Children's Unit indicated that parents were influenced by independent professional psychiatric or medical advice in only 36% of the commitment cases. In 73% of the cases the parents' only outside advice was provided by probation officers, welfare workers, and public school officials. Ellis, *supra* note 6, at 851 (citing REPORT ON SERVICES, *supra* note 16, at 227.

34. Upper-middle-class families have access to alternate forms of treatment, such as private psychiatric counseling or clinical treatment, that are not available to families in the lower socioeconomic categories. T. LIDZ, S. FLECK & A. CORNELLISON, *supra* note 32, at 131.

35. *See generally* 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* §§ 166-73 (1981).

36. T. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 147-49 (1966).

37. *Id.* Sociologist Scheff tells of an interview with a committing doctor who did not feel that an in-depth, objective valuation was needed in cases involving the voluntary commitment of minors. The doctor felt that if the child's family had sought commitment, a pathology was surely present. *Id.*

38. Rosenhan, *On Being Sane in Insane Places*, 179 SCIENCE 250 (1973), *reprinted in* 13 SANTA CLARA LAW. 379 (1973).

39. *Id.*

applied for voluntary admission at twelve different mental hospitals. The eight pseudopatients claimed to have heard voices saying "empty" or "thud." In each attempted admission the pseudopatient was diagnosed as schizophrenic or manic-depressive and admitted to the mental hospital.[40] In a followup study staff members at a mental hospital were warned of a similar false attempt. No pseudopatients were presented to the hospital for voluntary admission, but out of 193 patients evaluated by admitting staff following the warning, 21% were identified as pseudopatients by at least one staff member, and 12% were so identified by at least one psychiatrist.[41]

II. THE TREND TOWARD RECOGNITION OF THE CONSTITUTIONAL RIGHTS OF MENTAL PATIENTS

Concern for the constitutional rights of voluntary minor mental patients is but one aspect of the broader movement for increased recognition of the rights of all mental patients. Persons suffering from mental illness were once thought to be possessed by spirits.[42] Once committed to a mental institution a person generally had little hope for a return to society unless friends or relatives strenuously sought release through outside channels.[43] Commitment thus amounted to permanent incarceration designed to remove the mentally ill from the mainstream of life. Given the permanence of commitment, there was some early concern that debtors and beggars might be singled out for institutionalization in order to circumvent the prohibitions against imprisonment of debtors.[44] Widespread apprehension about commitment procedures did not surface, however, until the late 1800s, following the highly-publicized story of a wrongful commitment.[45] The ensuing outcry resulted in the adoption in numerous states of legislation that provided for close judicial scrutiny of the commitment process.[46]

The growing concern for procedural safeguards sparked a controversy that continues to this day between the legal and medical professions over the form such safeguards should take. The basic argument by the psychiatric community contends that an unnecessary emphasis has been placed

40. 13 SANTA CLARA LAW. at 384.

41. *Id.* at 386. The foregoing is not intended to foster an alarmist attitude or cloud with emotionalism the issues to be discussed later in this Comment. Losing sight of these basic causes for concern regarding the commitment of minors to mental institutions, however, is easy when discussing entrenched constitutional principles in an academic fashion. The practical concerns of many psychiatrists, psychologists, attorneys, and others must be emphasized in order to motivate the courts to protect more adequately the liberty interests of children voluntarily committed to mental hospitals by their parents.

42. M. MCDONALD, MYSTICAL BEDLAM 7, 11 (1981).

43. *See, e.g.*, M. FOUCAULT, MADNESS AND CIVILIZATION 202-03 (1965).

44. N. KITTRIE, THE RIGHT TO BE DIFFERENT 64 (1971).

45. *See* Comment, *supra* note 29, at 1192 n.61. Mrs. Dorothy Packard was the victim of wrongful commitment at the hands of her husband, an evangelist, who was angry with her for publicly expressing theological views in conflict with his own. Once Mrs. Packard had won her release from confinement, she began to campaign actively for legislation providing more stringent procedural safeguards for the involuntary commitment of citizens to mental institutions. In addition, Mrs. Packard wrote a seven-volume critique of the psychiatric profession and the means by which individuals were committed to institutions. *Id.*

46. N. KITRIE, *supra* note 44, at 64.

upon the constitutional rights of persons who are ill and in need of immediate treatment.[47] Furthermore, the requirement of stringent judicial review of commitments pits family member against family member and causes harmful delay in implementing treatment programs.[48] Regardless of the validity of these arguments, they had a significant impact during the post-World War II era, resulting in the relaxation of many commitment statutes and a shifting of power from jurists to psychiatrists.[49] Judicial deference to the interests of mental health care professionals in the commitment and treatment process continues today, and may help to explain recent judicial decisions regarding the voluntary commitment of minors to mental institutions.[50]

Several recent cases dealing with the rights of involuntarily committed mental patients illustrate the conflict over the nature of procedural safeguards and the Supreme Court's position on the issue. In *Youngberg v. Romeo*[51] a severely retarded adult brought suit against state hospital officials, alleging a three-fold violation of his constitutional rights.[52] The plaintiff contended, first, that his fourteenth amendment liberty interest had been infringed by the institution's staff in shackling him to his bed. Second, the staff's failure to guard his personal security and protect him from other patients similarly violated his liberty interest. Finally, he argued that the institution had failed to provide him with minimal rehabilitative training. The Third Circuit Court of Appeals vacated and remanded the district court's determination because it had improperly based its decision on the eighth amendment protection against cruel and unusual incarceration, a protection inapplicable to civil confinement.[53] The court of appeals did conclude, however, that even institutionalized mental patients have a residuum of liberty that cannot be infringed without due process.[54] The court further held that the first two alleged violations could only be justified by a showing of compelling necessity, while

47. *See* Curran, *Hospitalization of the Mentally Ill*, 31 N.C.L. REV. 274, 293 (1953). *See generally* Kadish, *A Case Study in the Significance of Procedural Due Process—Institutionalizing the Mentally Ill*, 9 W. POL. Q. 93 (1956).

48. Curran, *supra* note 47, at 293; *see also* Treffert & Krojek, *In Search of a Sane Commitment Statute*, in PSYCHIATRY AND THE LEGAL PROCESS: A CONTINUING DEBATE (R. Bonnie ed. 1977); Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976); McGarry, *The Holy Legal War Against State Hospital Psychiatry*, 294 NEW ENG. J. MED. 318 (1976).

49. Ellis, *supra* note 6, at 842-43. Some of these "relaxed" state statutes have been ruled unconstitutional as violative of the due process clause of the fourteenth amendment. *See* State *ex rel.* Fuller v. Mullinax, 364 Mo. 858, 269 S.W.2d 72 (1954).

50. *See* Parham v. J.R., 442 U.S. 584, 612 (1979) (state's interest in efficiency permits review of commitment decisions by state hospital psychiatrist, a neutral factfinder); Secretary of Public Welfare v. Institutionalized Juveniles, 442 U.S. 640, 646 (1979) (independent psychiatric review by one psychiatrist is adequate protection against improvident commitments).

51. 457 U.S. 307 (1982).

52. Although *Youngberg* dealt with the rights of a severely retarded, not a mentally ill, person, the issues presented in such a case are largely the same as in one involving a mentally ill child.

53. Romeo v. Youngberg, 644 F.2d 147, 156 (3d Cir. 1980).

54. *Id.*

the third was subject to more flexible review due to the mixed medical-legal nature of the issues raised with regard to rehabilitative training.[55]

The Supreme Court agreed in *Youngberg* that involuntarily committed persons possess a residuum of liberty that is protected by the fourteenth amendment,[56] but differed on the appropriate standard for reviewing alleged infringements of that liberty. The Court stated that a professional's decision is presumed valid.[57] Consequently, such a decision violates the patient's due process rights only when that decision is "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[58] Chief Justice Burger concurred in the judgment, but argued that virtually any decision made by an institutional physician could meet such a standard.[59]

In *Rogers v. Okin*[60] and *Rennie v. Klein*[61] mentally ill patients challenged the institutions' ability to forcibly administer antipsychotic medication, which can have severe side effects. In both cases the district courts held that mental patients have the right to refuse forcible treatment under the constitutional right of privacy implicit in the fourteenth amendment.[62] Both courts qualified this right of refusal by holding that it could be bypassed in emergency situations involving a substantial likelihood of physical harm to the patient or others in the hospital.[63] On appeal the First Circuit Court of Appeals held in *Rogers* that the emergency situation definition was too narrow and unworkable.[64] Instead, the court stated that attending physicians must engage in an ad hoc balancing of the need to prevent either violence or the further deterioration of the patient's condition with the possibility of harmful side effects to the medicated individual.[65] In addition, the doctors must have ruled out other reasonable alternatives.[66] The court remanded the case and instructed the district court to fashion suitable procedures to ensure that a patient's interests are properly weighed in such a balancing process.[67] In *Rennie* the Third Circuit also agreed that mental patients may be forcibly medicated in emergency situations, but held that due process must be provided in nonemergency situations.[68] The court found the constitutional due process

55. *Id.* at 165.
56. 457 U.S. at 315.
57. *Id.* at 323.
58. *Id.*
59. *Id.* at 330-31 (Burger, C. J., concurring).
60. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.* Mills v. Rogers, 457 U.S. 291 (1982).
61. 462 F. Supp. 1131 (D.N.J. 1978) (motion for preliminary injunction denied), 476 F. Supp. 1294 (D.N.J. 1979) (class certified; preliminary injunction granted), *modified*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 458 U.S. 1119 (1982).
62. *Rogers*, 478 F. Supp. at 1366; *Rennie*, 462 F. Supp. at 1144.
63. *Rogers*, 478 F. Supp. at 1365; *Rennie*, 476 F. Supp. at 1313.
64. Rogers v. Okin, 634 F.2d 650, 659-60 (1st Cir. 1980).
65. *Id.* at 661.
66. *Id.*
67. *Id.*
68. Rennie v. Klein, 653 F.2d 836, 850-53 (3d Cir. 1981) (en banc).

standard satisfied by the informal administrative procedures offered under New Jersey law.[69] Under the New Jersey statute a patient could be forcibly medicated if, after an independent review, the institution's medical director agreed with the attending physician that antipsychotic drugs were mandated.[70] The medical director was further required to make a weekly review of such cases.[71]

The Supreme Court granted certiorari in both cases. In a brief opinion, the Court vacated and remanded *Rogers* for reconsideration in light of a recent decision by the Massachusetts Supreme Judicial Court.[72] The Court noted that the state court decision may have created liberty interests under state law that exceeded those required by the federal Constitution. *Rennie* was remanded for consideration in light of *Youngberg*.[73] The Supreme Court's disposition of these cases suggests considerable deference to the professional judgment of attending physicians. Such deference is especially evident in the standard of review enunciated in *Youngberg*.

III. THE MOVEMENT FOR RECOGNITION OF THE CONSTITUTIONAL RIGHTS OF MINORS

The movement for recognition of the constitutional rights of voluntary minor mental patients also has roots in the child advocacy movement. Until fairly recent times, children were generally accorded second-class status by the law. For instance, when English courts developed the concept of tort liability in damages for the wrongful death of a family member, parental recovery for the loss of a child was limited to the pecuniary loss that a parent would suffer as a result of the discontinuation of the child's services.[74] The status of the child was viewed as closely analogous to that of the parent's servant. American courts later limited recovery in a similar fashion, making use of the master/servant analogy.[75] By the beginning of the twentieth century, however, there was a growing recognition of the problems facing children and the child's need for special social protection, resulting in the creation of many social mechanisms designed to promote the welfare of children.[76] The United States Supreme Court confirmed the new status of the minor as a person in *In re Gault*,[77] stating that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."[78]

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69. *Id.* at 851-52.
70. *Id.* at 848.
71. *Id.* at 848-49.
72. Mills v. Rogers, 457 U.S. 291, 304-06 (1982); *see In re* Roe, 421 N.E.2d 40 (Mass. 1981).
73. Rennie v. Klein, 458 U.S. 1119 (1982).
74. Blake v. Midland Ry., 118 Eng. Rep. 35 (1852).
75. *See, e.g.*, McGarr v. National & Providence Worsted Mills, 24 R.I. 447, 53 A. 320, 325-26 (1902); March v. Walker, 48 Tex. 372, 375 (1877).
76. *See* Takanishi, *Childhood as a Social Issue: Historical Roots of Contemporary Child Advocacy Movements*, 34 J. SOC. ISSUES 8 (1978). Such mechanisms included child developmental psychology, pediatrics, and child welfare programs. *Id.* at 8-9.
77. 387 U.S. 1 (1967).
78. *Id.* at 13.

In *Gault* a juvenile court adjudged a fifteen-year-old delinquent for purportedly making lewd telephone calls and ordered him placed in an industrial school until he reached twenty-one. The maximum penalty for the same offense by an adult offender was a few months in jail or a relatively small fine. The minor was not afforded counsel, no witness appeared against him, no record was made of the proceedings, and a purported admission was used against him although he was not informed of his right to remain silent. The state supreme court refused his mother's writ of habeas corpus, but the United States Supreme Court reversed the decision.[79]

Prior to *Gault* the statement that the basic right of a juvenile is "not to liberty but to custody" was widely accepted.[80] If the parents defaulted in effectively performing their custodial functions, the state could intervene. Thus the state was substituted as custodian, but no rights of the child were implicated.[81] Consequently, the child need not be accorded procedural due process. The Supreme Court rejected this reasoning, stating that children, like adults, have a constitutionally recognized interest in freedom from physical restraint.[82] Children are thus entitled to due process in juvenile proceedings since that is the "primary and indispensable foundation of individual freedom."[83] The Court concluded that due process requires that an alleged juvenile offender be given notice of the charges against him, a right to counsel, the opportunity to confront and cross-examine witnesses, and the privilege available in adult criminal proceedings against self-incrimination.[84]

While the United States Supreme Court has continued to emphasize that the constitutional guarantees of the fourteenth amendment extend to children as well as adults,[85] the Court has limited the rights of children in two ways: by holding that the parens patriae doctrine[86] allows the state to exercise greater control over the conduct of children than it can exercise over adults,[87] and by giving constitutional status to the right of parents to control the upbringing and conduct of their children.[88] The Court has justified these limitations on constitutional rights on the grounds that chil-

79. *Id.* at 59.

80. *Id.* at 17 (citing *Ex parte* Crouse, 4 Whart. 9, 11 (S. Ct. Pa. 1839)).

81. 387 U.S. at 17.

82. *Id.* at 27; *see also* Breed v. Jones, 421 U.S. 519, 528-29 (1975) (extension of constitutional guarantees associated with traditional criminal prosecution).

83. 387 U.S. at 20.

84. *Id.* at 33-57.

85. Carey v. Population Servs. Int'l, 431 U.S. 678, 692 (1978); Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976); Tinker v. Des Moines Indep. Community School Dist., 393 U.S. 503, 511 (1969); *Gault*, 387 U.S. at 13.

86. Parens patriae is the legal doctrine that provides that the state may care for those of its citizens who suffer from actual or legal disabilities such as insanity, mental incapacity, or minority. BLACK'S LAW DICTIONARY 1003 (5th ed. 1979).

87. Carey v. Population Servs. Int'l, 431 U.S. 678, 692 (1977); Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976); Ginsberg v. New York, 390 U.S. 629, 638 (1968).

88. Wisconsin v. Yoder, 406 U.S. 205, 231 (1972); Pierce v. Society of Sisters, 268 U.S. 510, 534 (1925); Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

dren are more susceptible to harm than adults,[89] children generally do not possess the capacity for rational judgment that an adult has,[90] and the constitutional preference for the sanctity of the family unit may necessarily entail a curtailment of the child's rights.[91] The Court has expressly declined, however, to formulate a rule of widespread applicability that would define the boundaries of the constitutional rights of children in most situations.[92] Instead, the Court has taken an ad hoc approach to resolving conflicts between the competing constitutional interests of parent, child, and state that are presented in the many cases dealing with the constitutional rights of children.

Of the cases ruled on by the Court concerning the boundaries of the constitutional rights of children, some have presented conflict between the interests of the parent and the state,[93] while others have presented conflict between the interests of the child and the state.[94] Whenever possible, the Court assumes that the interest of parent and child coincide and that the only conflict presented is between the interests of the child and the state.[95] In the child versus state situation, the test of constitutionality asks whether a significant state interest justifies a limitation upon the rights of the child.[96] The Court's analysis is different, however, when the interests of the parent and child conflict.

The Supreme Court has recognized a right of family privacy or autonomy that is implicit in the moral fabric of the nation and seems to have elevated this right to constitutional status.[97] In *Pierce v. Society of Sisters*[98] the Court held that a statute prohibiting education at private schools unnecessarily interfered with the right of parents and guardians to control the upbringing and education of their children.[99] In *Wisconsin v. Yoder*[100] the Court again emphasized the crucial role of the parents in the upbringing of their children, noting that this relationship is implicit in the history and culture of western civilization, and is "now established beyond debate as an enduring American tradition."[101] In *Yoder* Amish parents challenged

89. Ginsberg v. New York, 390 U.S. 629, 641-42 (1968); Prince v. Massachusetts, 321 U.S. 158, 169 (1944) ("[S]treets afford dangers for [children] not affecting adults.").

90. Planned Parenthood v. Danforth, 528 U.S. 52, 102 (1976) (Stevens, J., concurring and dissenting); Ginsberg v. New York, 390 U.S. 629, 649-50 (1968).

91. Wisconsin v. Yoder, 406 U.S. 205, 231 (1972); Pierce v. Society of Sisters, 268 U.S. 510, 519 (1925).

92. Ginsberg v. New York, 390 U.S. 629, 636 (1968); *Gault*, 387 U.S. at 13.

93. *E.g.*, Wisconsin v. Yoder, 406 U.S. 205 (1972); Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923).

94. *E.g.*, Ingraham v. Wright, 430 U.S. 651 (1977); Tinker v. Des Moines Indep. Community School Dist., 393 U.S. 503 (1969); *In re* Gault, 387 U.S. 1 (1967).

95. *See* Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Tinker v. Des Moines Indep. Community School Dist., 393 U.S. 503 (1969).

96. Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976).

97. *See, e.g.*, Stanley v. Illinois, 405 U.S. 645, 651 (1972); Ginsberg v. New York, 390 U.S. 629, 639 (1968); Prince v. Massachusetts, 321 U.S. 158, 166 (1944); Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925); Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

98. 268 U.S. 510 (1925).

99. *Id.* at 534-35.

100. 406 U.S. 205 (1972).

101. *Id.* at 232.

Wisconsin's compulsory school attendance law as violative of the first amendment free exercise clause. The parents contended that formal education beyond the eighth grade was contrary to the Amish concept of life aloof from the world and its material values. A majority of the Court concluded that the statute impermissibly intruded on the parent's right to guide the upbringing of their children, notwithstanding the admitted power of the state in regulating basic education.[102] The majority stated that state intervention in the right of parental control would only be justified "if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."[103] The majority did not feel that a conflict between the interests of the parent and child had been properly presented.[104] Both Justice Douglas in dissent[105] and Justice White in concurrence,[106] however, noted the fact that the children of Amish parents might have religious preferences different from those of their parents, which would not be recognized under the majority opinion. Although the Court did not consider the issue of whether the interests of the parent and child were in opposition in *Pierce* and *Yoder*, the Court did preclude state action that unnecessarily interfered with the family right of autonomy.[107]

The Supreme Court has, however, limited parental rights of control and supervision over children in some specific circumstances.[108] Restrictive opinions by state and lower federal courts are more numerous, and have limited parental authority with respect to juvenile curfews,[109] drinking age laws,[110] sex education,[111] blood transfusions,[112] corporal punishment,[113] and abortion.[114] The parental right to consent to medical treatment[115] has often been usurped in favor of state control when the child is in danger of suffering grievous harm.[116] These opinions suggest that the family's right

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102. *Id.* at 231-32.
103. *Id.* at 234.
104. *Id.* at 230-34.
105. *Id.* at 242.
106. *Id.* at 240.
107. *Yoder*, 406 U.S. at 232; *Pierce*, 268 U.S. at 534-35.
108. *See* Planned Parenthood v. Danforth, 428 U.S. 52 (1976) (parental right to veto abortion decision invalidated); Prince v. Massachusetts, 321 U.S. 158 (1943) (sustaining conviction of parent under state child labor law for permitting child to sell religious materials on city streets).
109. Bykofsky v. Borough of Middletown, 401 F. Supp. 1242 (M.D. Pa. 1975).
110. Republican College Council v. Winner, 357 F. Supp. 739 (E.D. Pa. 1973).
111. Cornwell v. State Bd. of Educ., 314 F. Supp. 340 (D. Md. 1969), *aff'd*, 428 F.2d 471 (4th Cir.), *cert. denied*, 400 U.S. 942 (1970).
112. People *ex rel.* Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769, *cert. denied*, 344 U.S. 824 (1952).
113. Ware v. Estes, 328 F. Supp. 657 (N.D. Tex. 1971).
114. *In re* Smith, 16 Md. App. 209, 295 A.2d 238 (1972).
115. Parents generally have had the right to give or withhold consent for most types of medical treatment of their children. *See* Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941); Scaria v. St. Paul Fire & Marine Ins. Co., 68 Wis. 2d 1, 227 N.W.2d 647, 653 (1975).
116. *See, e.g.*, People *ex rel.* Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (1952); Muhlenberg Hosp. v. Patterson, 128 N.J. Super. 498, 320 A.2d 518 (Super. Ct. Law Div. 1974); *see also* Note, *Child Neglect: Due Process for the Parent*, 70 COLUM. L. REV. 465, 472 (1970) (state should not be allowed to interfere in parental decisions without demonstrating

of privacy is strongest when the parents claim authority within their own household to direct the rearing of children,[117] due to the great emphasis placed by the Supreme Court on family unity. When parents attempt to invoke the power of the state in controlling their children, however, their action indicates that the family unit is not able independently to resolve the problem. In such a situation the family right of privacy arguably should be given less prominence in any decision affecting the opposing views of parent, child, and state.

Although the Supreme Court has taken an ad hoc approach to the issues raised by voluntary commitment of minors to mental institutions, the Court has suggested several means by which to analyze such cases. The remainder of this Comment evaluates those decisions raising the concerns of minor mental patients, in the hope that through application of a more realistic analysis a conclusion can be reached that will more adequately protect the liberty interests of minor mental patients.

IV. CASES DEALING SPECIFICALLY WITH THE CIVIL RIGHTS OF VOLUNTARY MINOR MENTAL PATIENTS

The United States Supreme Court has decided only a few cases concerning the constitutional rights of voluntary minor mental patients,[118] but state and lower federal courts have frequently addressed the issue. The most significant state court decisions have extended the rights enjoyed by voluntary adult mental patients to adolescents of specified ages based upon interpretations of state legislation.[119] In *In re Lee*[120] an Illinois court held that the state's voluntary admission statute[121] would allow juvenile patients to request and obtain their own releases from institutionalization without parental consent. In *Melville v. Sabbatino*[122] a Connecticut court held that a state statute[123] that allowed voluntary commitment of minors below age sixteen and commitment upon personal application by minors sixteen years of age or older also allowed minors over sixteen to remove themselves from institutions regardless of whether their parents originally

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that child has been inflicted or threatened with serious harm); Note, *State Intrusion into Family Affairs: Justifications and Limitations*, 26 STAN. L. REV. 1383, 1398-99 (1974) (standard is one of "severity and irreversibility" of harm to child). *But see In re* Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942) (parental refusal to permit removal of daughter's grossly deformed arm upheld despite fact that condition would result in permanent psychological and circulatory damage).

117. *See* Ginsberg v. New York, 390 U.S. 629, 639 (1968).

118. *See* Parham v. J.R., 442 U.S. 584 (1979); Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979).

119. Some states have statutes that enable minor children to seek psychiatric care without their parents' consent. *See, e.g.*, ALA. CODE § 22-52-51 (1977); MD. HEALTH-GENERAL CODE ANN. § 10-609 (Supp. 1983).

120. No. 68 (JD) 1362 (Cook County, Ill., Cir. Ct., Juv. Div., Feb. 29, 1972), *abstracted in* 6 CLEARINGHOUSE REV. 284 (1972); No. 68 (JD) 1362 (Cook County, Ill., Cir. Ct., Juv. Div., Aug. 24, 1972), *abstracted in* 6 CLEARINGHOUSE REV. 575 (1973).

121. ILL. ANN. STAT. ch. 91 1/2, §§ 5-1 to -2 (Smith-Hurd 1966).

122. 30 Conn. Supp. 320, 313 A.2d 886 (Super. Ct. 1973).

123. Patient's Bill of Rights, CONN. GEN. STAT. §§ 17-206a to -206k (1983).

sought the admission.[124] Such decisions reflect not only reasonable interpretations of state legislation and a proper concern for the care of minor mental patients, but also a view that has gathered great support among psychological researchers—that adolescents at approximately age fifteen are able to exercise rational judgment concerning their own institutionalization and treatment.[125]

The first federal decision that clearly addressed the issue of a minor's rights when the interest of minor, parent, and state conflict was *Saville v. Treadway*.[126] In *Saville* the minor was retarded, not mentally ill, but the constitutional issues presented to the court were largely the same as those in a case involving a minor mental patient. The court initially noted that the state commitment statute effectively permitted a parent or guardian to commit a child without restriction and that commitment is potentially lifelong in duration.[127] The court held that when individual liberty is at stake, it is "absolutely essential" under the due process clause that confinement be preceded by adequate procedural safeguards.[128] The court concluded that the statute's reliance on parental discretion was unconstitutional since children's and parents' interests can, and do, differ.[129] The court ordered the establishment of an independent review board to determine the appropriateness of admission of all chidlren under sixteen years of age.[130] *Saville* never reached the Supreme Court.

Bartley v. Kremens[131] involved a class action suit brought on behalf of the named plaintiffs and all persons eighteen years old or younger who had been or would be committed to Pennsylvania's mental health care facilities. The plaintiffs alleged that they had been denied equal protection and due process of law because they had been committed to Pennsylvania's mental health care facilities without adequate procedural safeguards. The federal district court noted initially that while parents are presumed to act in the best interests of the child, they do not always do so.[132] Consequently, the possibility of erroneous commitments clearly existed under the state's voluntary commitment system.[133] The court concluded that the state must therefore provide the child with substantial procedural protections, which may not be waived by the parent or guardian.[134] The district court did acknowledge, however, that the opinions and

124. 313 A.2d at 889.

125. *See, e.g.*, Grisso v. Vierling, *Minor's Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOLOGY 412 (1978); Rosenberg & Katz, *Legal Issues in Psychiatric Treatment of Minors*, 4 MENTAL HEALTH DIG. 54 (1972); Worsfold, *A Philosophical Justification for Children's Rights*, 44 HARV. EDUC. REV. 142 (1974).

126. 404 F. Supp. 430 (M.D. Tenn. 1974).

127. *Id.* at 432.

128. *Id.*

129. *Id.*

130. *Id.* at 438. The court required one of the three board members to be the parent of a retarded person. *Id.*

131. 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. 119 (1977).

132. 402 F. Supp. at 1047-48.

133. *Id.*

134. *Id.* at 1048.

observations of parents should continue to carry great weight in the commitment process, although they could no longer be conclusive.[135] The district court established the following procedural safeguards to ensure that the due process rights of voluntary minor mental patients would not be violated: a probable cause hearing within seventy-two hours of the initial commitment;[136] a postcommitment judicial hearing within two weeks;[137] written notice of the hearing to the minor detailing the grounds for the proposed commitment;[138] counsel for the minor, including indigent minors, at all significant points in the commitment process,[139] and a requirement of a finding established by clear and convincing proof that the child needs institutionalization.[140]

After the Supreme Court granted certiorari in *Bartley*,[141] the Pennsylvania Legislature enacted a Mental Health Procedures Act that substantially expanded the procedural safeguards afforded minors aged fourteen or older.[142] Although Justice Brennan was anxious to decide the case on its merits, a majority of the Court concluded that the enactment of the Pennsylvania statute had rendered the case moot and remanded the case.[143]

The Supreme Court finally addressed the due process issue in *Parham v. J.R.*[144] and *Secretary of Public Welfare v. Institutionalized Juveniles*.[145] In *Parham* two minor mental patients brought a class action suit[146] alleging that they had been deprived of their right to due process in two respects.[147] First, the minors claimed that Georgia's voluntary commitment statute[148] was unconstitutional in not providing a hearing prior to commitment. Second, the plaintiffs alleged that their due process rights had been violated because the state had made no attempt to determine whether or not treatment in a less restrictive environment would be more conducive to their rehabilitation. The challenged statute provided that upon application of the child's parent or guardian[149] the superintendent of the particular state mental hospital could temporarily admit a child for observation and diag-

135. *Id.* at 1048 n.12.

136. *Id.* at 1049.

137. *Id.* The district court provided that "[u]ntil the legislature acts to establish an unbiased tribunal to conduct the . . . hearings the present facilities of the Commonwealth court system shall be used for these hearings." *Id.* at 1049 n.18.

138. *Id.* at 1049-50.

139. *Id.* at 1050.

140. *Id.* at 1052. The district court may have been applying the standard of proof required in adult commitment proceedings. *See* Addington v. Texas, 441 U.S. 418, 433 (1979) (due process requires "clear and convincing" proof when committing adult involuntarily).

141. Kremens v. Bartley, 429 U.S. 882 (1976).

142. PA. STAT. ANN. tit. 50, §§ 7201-7206 (Purdon Supp. 1983-1984).

143. Kremens v. Bartley, 431 U.S. 119, 133-35 (1977).

144. 442 U.S. 584 (1979).

145. 442 U.S. 640 (1979).

146. 42 U.S.C. § 1983 (1976 & Supp. V 1981).

147. J.L. v. Parham, 412 F. Supp. 112 (M.D. Ga. 1976).

148. GA. CODE ANN. §§ 88-503.1 to .3 (Supp. 1982).

149. The state may in fact be the minor's guardian in many cases.

nosis.[150] Once satisfied that the child was suffering from a mental illness, the superintendent could detain the child for an indefinite period of time or release him to obtain other forms of mental health care.[151] Once detained in this fashion, the child could be released only upon the application of his parent or guardian, or upon a determination by the hospital's superintendent that hospitalization was no longer necessary.[152]

The district court declared the Georgia statute unconstitutional because it gave parents the ability to commit their minor children to state mental hospitals in an arbitrary and capricious fashion and for an indeterminate length of time.[153] Recognizing that parents' motives in seeking commitment often conflict with the best interests of the child, the court determined that due process required that the child be represented by separate counsel.[154] The court did not establish any specific procedures for the protection of such children, however; it merely ordered that hearings be held in the state's juvenile courts to review the propriety of the commitment of minor children already institutionalized under the Georgia statute.[155]

The Supreme Court granted certiorari.[156] The Court first determined that the appropriate standard for deciding whether the commitment statute satisfied due process requirements was the three-pronged test enunciated in *Mathews v. Eldridge*.[157] The *Mathews* test requires balancing of the private interest that will be affected by the state action, the risk of an erroneous deprivation of such interest and the probable value, if any, of additional or substitute procedural safeguards, and the state's interest in maintaining the status quo.[158] In determining the private interest at stake, the Court essentially merged the interests of parent and child. Although the Court recognized the minor's interest in freedom from unnecessary bodily restraints and from erroneous labelling by state institution superintendents,[159] it found that those interests were largely subordinated to the parents' interest in controlling the upbringing of their child.[160] The Court conceded that parents do not always act in the best interests of their chil-

150. GA. CODE ANN. § 88-503.1(a) (Supp. 1982). Evidence presented at trial indicated that admission requirements at the various state hospitals were in fact left largely to the discretion of the particular institution's superintendent. Those admission requirements varied from independent recommendations by two psychiatrists, referral by a community mental health clinic, or a finding of "dangerousness" by the superintendent of the institution. 442 U.S. at 591-96.

151. GA. CODE ANN. § 88-503.1(a) (Supp. 1982).

152. *Id.* §§ 88-503.2 to .3. Review procedures at the various hospitals varied from weekly staff meetings to unspecified periodic review, and the average length of stay at hospitals varied from 71 to 456 days. 412 F. Supp. at 121 n.14.

153. *Id.* at 139.

154. *Id.*

155. *Id.* at 140.

156. Parham v. J.L., 431 U.S. 936 (1977) (prob. juris. noted).

157. 424 U.S. 319 (1976). In *Mathews* the claimant challenged the constitutionality of procedures used by the Social Security Administration to terminate disability benefits.

158. *Id.* at 335.

159. 442 U.S. at 600.

160. *See id.* at 604 (Court holding that it will ignore possibility of conflicting interests absent showing of parental neglect or abuse).

ren, but stated that that did not justify discarding the presumption that parents will act in their child's best interest.[161] Moreover, parents possess the judgment needed to make important decisions, judgment the child lacks.[162] The Court concluded, however, that the risk of error inherent in the parental decision was sufficiently great as to necessitate a neutral fact finder in the commitment process.[163]

In evaluating the state's stake in the commitment process, the Supreme Court recognized the state's parens patriae interest in providing mental health treatment to its children.[164] The Court also recognized the state's interest in allocating priority to the diagnosis and treatment of patients rather than to time-consuming precommitment proceedings.[165] Finally, the Court took note of the state's interest in efficiency, and of the dangers of pitting parent and child against one another in a judicial contest, in concluding that the neutral fact finder should be a psychiatrist at the state mental health facility rather than the judiciary.[166]

Justice Brennan, in his concurring and dissenting opinion, argued that the case should have been decided under the reasoning of *Planned Parenthood v. Danforth*[167] rather than under the *Mathews* test.[168] In *Danforth* the Court recognized that the interests of parent and child may differ and therefore held that the state could not condition a minor's right to secure an abortion on obtaining parental consent.[169] The Court stated that this result would tend to foster, rather than intrude on, family autonomy since it would avoid conflict over the abortion decision.[170] In *Parham* Justice Brennan contended that the voluntary minor mental patient's personal rights at issue were at least as great as those of the female adolescent seeking an abortion in *Danforth*.[171] Moreover, *Danforth* involved only a potential parent-child conflict over the abortion decision, while in voluntary commitment cases a break in family autonomy has already occurred when the parents seek to surrender custody of their child to a state mental institution.[172] Justice Brennan therefore argued that the presumption that parents act in the best interests of their children is not warranted in the commitment decision. Nevertheless, he agreed with the majority that due process did not require a precommitment judicial hearing.[173] The factors

161. *Id.* at 602-03.
162. *Id.* at 603.
163. *Id.* at 606. The Court held that risk of error alone did not provide a rational basis for holding unconstitutional a voluntary commitment scheme generally in effect in over 30 states. *Id.* at 612-13.
164. *Id.* at 605.
165. *Id.*
166. *Id.* at 613.
167. 428 U.S. 52 (1976).
168. 442 U.S. at 631 (Brennan, J., joined by Marshall, J., and Stevens, J., concurring in part and dissenting in part).
169. 428 U.S. at 75.
170. *Id.*
171. 442 U.S. at 631.
172. *Id.*
173. *Id.* at 634-35.

making precommitment judicial review undesirable, however, did not in Justice Brennan's view militate against a reasonably prompt postadmission hearing.[174] The postadmission hearing would not prevent the immediate treatment of the child. In addition, much of the evidence at the hearing would consist of the psychiatric observations and evaluations made by the institution's staff following commitment of the child. Consequently, the danger of a destructive parent-child confrontation would be minimized. Justice Brennan therefore concluded that at least one postadmission judicial hearing should be required.[175]

On the same day that *Parham* was decided, the Supreme Court announced its decision in the related case of *Secretary of Public Welfare v. Institutionalized Juveniles*.[176] In *Institutionalized Juveniles* the minor complainants sought a declaratory judgment that application of Pennsylvania's voluntary minor commitment statute[177] violated their constitutional rights and sought an injunction against further commitments under the statute. Unlike the varied admissions procedure found in *Parham*, the Pennsylvania statute codified specific admissions procedures that were in effect at all state mental hospitals.[178] These procedures required at least one independent psychiatric evaluation designed to determine the appropriateness of institutionalized treatment for the particular child. At the institution itself, a treatment team could interview parents, compile a complete medical and psychological history of the child, and at their discretion refuse to commit the minor. The child's continued need for institutional treatment was reviewed at least once every thirty days.[179] The Supreme Court found that the commitment statute clearly met the minimum procedural due process standards set forth in *Parham*.[180]

Although the Supreme Court held in *Parham* and *Institutionalized Juveniles* that voluntary minor mental patients were entitled to procedural due process protections, the Court emphasized the importance of family autonomy and the presumption that parents act in their children's best interests in limiting the children's freedom. As the recent case of *Doe v. Public Health Trust*[181] illustrates, however, considerable uncertainty remains concerning the extent to which parents may exercise their right of control over the child's treatment program. If state postcommitment monitoring and review can override parental authority, there is a danger that the voluntary minor mental patient may actually become an involuntary patient and hence be entitled to greater due process protections.

In *Doe* the father of a voluntary minor mental patient brought a cause of action on behalf of himself and his daughter, alleging deprivation of

174. *Id.*
175. *Id.*
176. 442 U.S. 640 (1979).
177. PA. STAT. ANN. tit. 50, §§ 7201-7207 (Purdon Supp. 1983-1984).
178. 442 U.S. at 646-50.
179. *Id.* at 647.
180. *Id.* at 649.
181. 696 F.2d 901 (11th Cir. 1983).

constitutional rights caused by the mental hospital's no-communication rule and the hospital's refusal to allow the father access to his daughter and information regarding her condition and treatment. The Does had voluntarily admitted their daughter to an adolescent psychiatric care unit with the understanding that she would undergo a week-long evaluation period, during which they would not be allowed to communicate with her. The Does consented to this requirement, but following the evaluation period were never told of the diagnosis made by the hospital staff. The Does were told that their daughter had been placed on a privilege system whereby she would have to earn the privilege of communicating with her parents. The Does claimed that the hospital then led them to believe that their daughter would soon earn such a privilege. After a month had passed, however, the Does began attempts to visit their daughter. The hospital administration would not allow the Does to communicate with their daughter, and would not provide the parents with any information concerning the hospital's diagnosis or the child's immediate condition. The parents were able to learn that the hospital was not treating their daughter for a kidney problem as the Does had suggested it should and was administering medication to the child without parental consent.[182]

The federal district court granted the hospital's motion to dismiss for failure to raise a substantial federal question. On appeal the Eleventh Circuit Court of Appeals held that the case did raise a substantial federal question and remanded the case for trial on the merits.[183] In reaching its conclusion, the court redefined the complaint in some respects and provided the district court with guidelines for adjudication of the case on remand.[184] The court of appeals initially rejected the Does' claim that a voluntary minor mental patient must be treated in the least restrictive environment available.[185] The court found that the Does' child was a voluntary patient and, as such, had not suffered a massive curtailment of liberty.[186] Rather, a voluntary patient "carries the key to the hospital's exit in her hand."[187] The court also rejected the Does' claim that a parental right to supervise the treatment of the child forecloses the use of a bona fide therapeutic no-communication rule.[188] The court recognized that some right of communication is necessary for parents to act in the child's

182. At this point the Does attempted to find a new treatment program for their child, but were unsuccessful because their remaining insurance benefits were no longer adequate to guarantee completion of an alternate treatment program.

183. 696 F.2d at 905.

184. *Id.* at 904-05.

185. *Id.* at 903. In Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976), the district court held that involuntarily committed mental patients had suffered a massive curtailment of liberty and thus due process required the patients be treated in the least drastic environment available. *Id.* at 1217.

186. 696 F.2d at 903. In his concurring opinion in *Doe*, Judge Hatchett stated: "It overlooks reality to say, as the majority does, that a child admitted to a hospital by a parent is a voluntary patient and under the law, should be treated more like an adult voluntary patient than an adult involuntary patient." *Id.* at 905.

187. *Id.* at 903.

188. *Id.* at 905.

best interest, as the Supreme Court had emphasized in *Parham*,[189] but also stated that this right could be abridged by a treatment program if the treatment was medically legitimate and therapeutic,[190] and was part of the state benefit being conferred.[191] The court did state, however, that the Does should be allowed to attempt to prove that their rights had been violated because their daughter had become a de facto involuntary patient and that the no-communication rule was nontherapeutic, medically illegitimate, or an improper condition upon a state benefit.[192] The court did not prescribe any specific test for the district court to utilize in determining whether the no-communication program was in fact medically legitimate and therapeutic. The two tests that it did suggest,[193] however, would place a heavy burden on any plaintiff attempting to attack a given treatment program. The first suggested test was taken from *Youngberg v. Romeo*,[194] and applies where the "decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[195] The second suggested test would require the Does to prove that the medical or therapeutic basis for the rule was a mere pretext.[196] The court also left open the possibility that other actions taken by the hospital administrators, including the refusal to give the parents any information concerning the diagnosis of the child or her current status, turned the patient into a de facto involuntary patient.[197] Given the analysis by the court, however, and the suggested tests for determining the legitimacy of a treatment program, it is unclear to what extent parent-child communications can be legally impinged upon by the state, or how far the state could go before a court determined that the child had in fact become an involuntary patient.

Judge Hatchett, in his special concurring opinion in *Doe*, would require a parent either to submit to a particular treatment program or remove the child from the institution only when that program is the only one offered at that institution.[198] Thus if other less restrictive types of treatment were available at the facility, as would almost always be the case, the parents would have the power to demand less restrictive treatment and reestablish communication with the child. Judge Hatchett believes this procedure to be a necessary extension of the principles set forth in *Parham*, where the Supreme Court observed that the concern of family and friends will generally provide a check against erroneous commitments. Such an approach would greatly reduce the gray area left open by the panel majority's opin-

189. *Id.* at 904; *see Parham*, 442 U.S. at 602-03.
190. 696 F.2d at 904 (citing Wyman v. James, 400 U.S. 309 (1971)).
191. 696 F.2d at 904.
192. *Id.* at 905.
193. *Id.* at 904 n.1.
194. 457 U.S. 307 (1982).
195. *Id.* at 323.
196. 696 F.2d at 904 n.1.
197. *Id.* at 910 (Hackett, J., specially concurring).
198. *Id.* at 911.

ion and thereby lessen the likelihood of many otherwise justifiable institutional practices that could substantially impair the child's liberty interest and the parent's right to supervise the treatment of the voluntary patient.

Many complex questions still remain unresolved following the Supreme Court's decisions in *Parham* and *Institutionalized Juveniles*. The *Mathews v. Eldridge* analysis employed by the Court in those decisions sets up conflicting rights in the state and parent that could culminate in a situation, such as that presented by *Doe*, where a state treatment program impinges upon the parental right to supervise the treatment of a child and turns that child into a de facto involuntary mental patient. The Court should alter its analysis under the *Mathews v. Eldridge* test or adopt the *Danforth* analysis urged by Justice Brennan in his separate opinion in *Parham*. A realistic application of facts to those decision models should lead to a conclusion that would more adequately protect the liberty interests of voluntary minor mental patients.

V. PROPOSED GUIDELINES TO PROTECT MORE ADEQUATELY THE DUE PROCESS RIGHTS OF MINOR MENTAL PATIENTS

In *Parham* the Supreme Court applied the balancing test taken from *Mathews v. Eldridge*[199] to determine what process was due voluntary minor mental patients. Implicit in the Court's conclusion under the *Mathews* test are certain assumptions of questionable validity: that parents usually act in the best interests of their child when seeking to commit them to mental health care facilities; that concern for family unity and autonomy militates against judicial review of commitments; that institutional psychiatrists provide an adequate check against the risk of erroneous commitments; and that the state's interest militates against judicial hearings or independent observation intended to provide the minor with more adequate due process safeguards. This Comment proposes postcommitment judicial review and independent professional observation as a more realistic means of protecting the child's liberty interests and satisfying the parents' concern for the proper treatment of the child.

The Court's assumption that parents always act in the best interests of the child is not well founded. Lower federal courts have taken notice of the fact that the interests of parent and child may be diametrically opposed in the voluntary commitment situation.[200] A substantial number of psychologists and researchers believe that minors committed to mental institutions often do not truly suffer from mental illness, but rather exhibit behaviors of which their parents disapprove and feel unable to change.[201] As noted earlier, in a majority of voluntary commitment cases parents

199. 424 U.S. 319 (1976).

200. *See, e.g.*, J.L. v. Parham, 412 F. Supp. 112, 136-37 (M.D. Ga. 1976); Bartley v. Kremens, 402 F. Supp. 1039, 1047-48 (E.D. Pa. 1975),*vacated and remanded*, 431 U.S. 119 (1977).

201. *See, e.g.*, B. ENNIS & L. SIEGEL, *supra* note 29, at 38; Comment, *supra* note 29, at 1182-83.

have not sought any other form of mental health care for their child prior to seeking commitment.[202]

Not only are the interests of parent and child often opposed in the voluntary commitment situation, but the risk inherent in the commitment process is also far greater than the Court chooses to recognize. The Court's lack of awareness is particularly evident when one considers that the Court placed great emphasis on the ability of institutional psychiatrists to make independent judgments in the best interest of the child.[203] The probability of an erroneous psychiatric determination is quite high, and the harm that a child may suffer from an improvident commitment is significant. Although all persons committed to state hospitals face the dangers of poor care, lowered self-esteem, and reinforcement of aberrant behaviors, these dangers may be particularly acute in the case of minor mental patients. Reliance on the independent diagnosis of the institutional psychiatrist is therefore inappropriate. While the state may disfavor more stringent procedural safeguards out of fear that they will prevent quick treatment and will be fiscally unworkable, the state's interest in committing and spending funds on only those in need should be just as great.

For the reasons set out above, the procedural safeguards provided by the Court in its *Parham* decision are inadequate. More stringent measures, such as those suggested by the district court in *Bartley v. Kremens*,[204] are called for. A postcommitment probable cause hearing within seventy-two hours of the initial commitment would prevent totally unwarranted commitments while allowing parents to engage the services of mental health care professionals without preliminary judicial intervention. State concern for the prompt treatment of the mentally ill would be satisfied. The probable cause hearing could be followed in two weeks by a formal judicial hearing. By this time hospital staff members would have had an opportunity to observe the child and diagnose his condition. As Justice Brennan suggested in *Parham*, most of the evidence presented in that hearing would be provided by hospital psychologists or liaisons, thereby eliminating much of the feared conflict between parent and child in an adjudicative proceeding.[205] The minor should be represented by his own counsel at these proceedings, so that any evidence that would tend to show an improper parental motive or erroneous diagnosis could be presented. Although such an approach clearly deemphasizes the role of the parent in the initial commitment process, parental supervision of the treatment program and a parental right of access to the child and to relevant medical information are essential means of protecting the due process rights of the voluntary minor mental patient, and are essential elements in the Supreme Court's definition of a voluntary minor mental patient. The minor is in the hospital voluntarily only to the extent that his parents have volunteered

202. NIMH Statistical Note 90, *supra* note 28, table 9.
203. *See Parham*, 442 U.S. at 607.
204. 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. 119 (1977).
205. *Parham*, 442 U.S. at 638 (Brennan, J., concurring in part and dissenting in part).

him. Only through the parent may a voluntary minor mental patient refuse or seek to modify treatment, or seek release from the mental hospital. When the parents cannot supervise treatment and do not have access to the child and to information concerning the child's condition, the child has become a de facto involuntary patient. The parens patriae interest of the state is not served when parents are forced to remove their children from treatment facilities for the reason that the deprivation of their rights and their children's rights are part and parcel of the state benefit being conferred.[206]

Increased procedural safeguards may also be provided under the *Danforth* analysis[207] suggested by Justice Brennan in his *Parham* dissent.[208] In *Danforth* the Supreme Court held that a state cannot condition a minor's right to abortion on obtaining parental consent. In so holding, the Court emphasized that the minor's right to an abortion is an important one and that a confrontation between parent and child on the abortion issue should be avoided in order to preserve family unity.[209] When, as here, a juvenile is committed to a mental hospital, an important personal right is also involved. Minors should have the opportunity to participate in a decision-making process that may lead to their commitment. Moreover, a break in family unity has already occurred when parents have resorted to outside means of dealing with a problem by seeking to commit their child to a mental institution. Thus the Court's concern for family unity should not militate against some form of judicial hearing to determine the appropriateness of an initial commitment of the minor. The *Danforth* approach might provide a more workable means of analyzing cases involving the voluntary commitment of minors to mental institutions, since the *Mathews v. Eldridge* analysis involved the balancing of only one private interest against that of the state. Under a realistic analysis, two private interests, those of parent and child, must be balanced against the interest of the state in a case involving the voluntary commitment of a minor. The Supreme Court has held that state intervention in parental decision-making is justified where the parents' decisions are likely to jeopardize the health or safety of the child, or have a potential for significant social burdens.[210] Just such a situation is presented when parents seek to institutionalize their minor child due to the child's mental illness.[211]

VI. CONCLUSION

The Supreme Court's few pronouncements in cases involving the constitutional rights of minor mental patients have left unclear the extent of those rights as they interact with the rights of parents and the state. The

206. Doe v. Public Health Trust, 696 F.2d 901, 904 (11th Cir. 1983).
207. Planned Parenthood v. Danforth, 428 U.S. 52, 75 (1976).
208. *Parham*, 442 U.S. at 631 (Brennan, J., concurring in part and dissenting in part).
209. *Danforth*, 428 U.S. at 75.
210. Wisconsin v. Yoder, 406 U.S. 205, 234 (1972).
211. *See supra* notes 13-28 and accompanying text.

gray area created by these cases houses dangers for the minor mental patient and his parents. Only additional, more precise rulings will remove the uncertainty. This Comment has attempted to set forth the risks of improvident or ill-motivated commitments to mental institutions, in the hope that a more realistic appraisal of Supreme Court decision models will lead to more adequate protection of the liberty interests of voluntary minor mental patients. Minor mental patients are a politically powerless and relatively invisible group who must rely primarily on the wisdom of the judiciary, as opposed to the initiative of legislators, for protection of their rights. The issue of how to safeguard those rights presents a most appropriate arena for further Supreme Court action.