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Institutionalized Delinquent and Maladjusted Juveniles: A Psycholegal Systems Analysis

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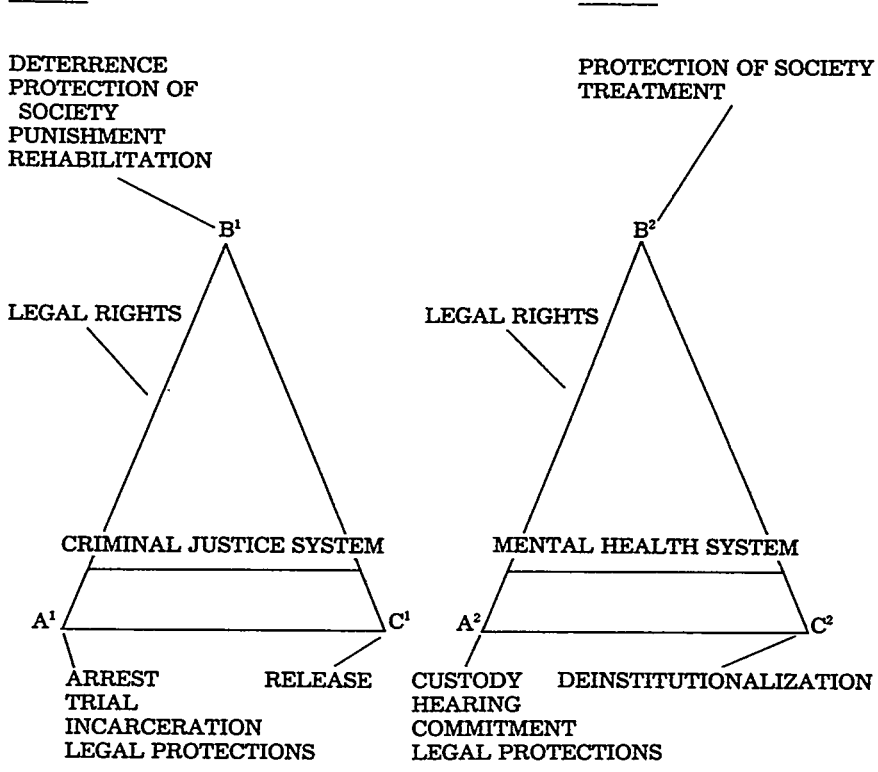
I. INTRODUCTION

One way that contemporary American society manifests its heightened concern for the well-being of children is by providing specialized systems for dealing with problems of juvenile misconduct and maladjustment. This specialization is most apparent in the creation of juvenile courts, but is also evident in society's response to mental health problems among children. It is, however, increasingly apparent that these differentiated systems are not producing the results that were expected to flow from recognition of the unique nature of delinquency and mental illness in children.

The inadequacy of these interventions is part of a larger pattern of development: systems that were designed to diverge from the criminal justice model—most notably, the mental health system—have instead taken on the characteristics of criminal justice, to the dismay of almost all concerned. Yet the best of motives produced the "legalization" of these systems, and the wish to return to their imagined "prelegal" forms is naive, if not sinister. Nevertheless, the causes and dynamics of this legalization, and the effects it has had on these alternative systems and their clients must be studied because the process is ongoing.

This Article will describe this process of imitation, first in the paradigm case of the mental health system, and then in the juvenile justice system and in the evolving system for commitment of juveniles to mental health facilities. The Article first compares the criminal justice and mental health systems, showing the growing similarity of the two; this part of the Article also introduces a visual representation of the process within each system (Figure 1). Second, this Article uses the visual representation to show a parallel development in the juvenile justice system. The last part of this Article demonstrates the potential for analogous evolution in that portion of the mental health system devoted to juveniles (Figure 2).

FIGURE I



II. THE CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS

The mental health system is increasingly being patterned after a criminal justice system that has already proved itself inadequate for accomplishing its primary goals of punishment, deterrence, rehabilitation, and protection of society, as well as its secondary goal of treatment of mentally ill criminals. By design and by default, the mental health system has assumed a pattern of imprecise induction, perfunctory rehabilitation, and arbitrary release identical to that seen in prison systems throughout our history. Indeed the two systems are merging, in that the most deviant clients of both systems are being aimlessly shifted back and forth between the two systems.

Visual depictions of the mental health and criminal justice systems are presented in Figure 1. The A angles of the triangles represent induction into each system; the B angles represent treatment and re-

habilitation; and the C angles represent the inmates' conduit to society outside of the institution. Progress from one angle to the next may be described along the connecting sides, which are rife with analogous issues of treatment, personal rights, thwarted good intentions, benign neglect, and conscious abuse.

A. Angles A^1 and A^2

Development of angles A^1 and A^2 is crucial in both systems because it is the point at which the twin losses of liberty and privacy occur for those committed into the mental health system or detained by agents of the criminal justice system. Persons can enter the mental health system voluntarily or involuntarily, and the area of involuntary civil commitment has brought a flood of discussion, debate, and legislation over the past fifteen years.[1] Most, if not all states have enacted mental health laws that provide specific procedures to be followed in the involuntary commitment process to provide due process to these persons. However, involuntary commitment hearings are being conducted more and more like adversarial criminal trials, and they have adopted much of the apparatus of the legal system.[2] Thus, it is with the apprehension of the involuntary commitment of mentally ill persons that the legalization of the mental health system first becomes apparent.

Upon close examination of this systemwide legalization, two methods in which the mental health system mimics the criminal justice system emerge. First, procedures are being copied. Second, developmental patterns are similar: high development at angles A^1 and A^2; confusion, often misguided experimentation, and failure at angles B^1 and B^2; and utter arbitrariness at angles C^1 and C^2. In discussing the developments in and merger of the two systems, one should ask several questions, such as who instigates or inhibits change; who benefits and who loses from the developments; and whether mental health and criminal justice professionals have formed a pitiful sort of

1. For a thorough presentation of statutory provisions for involuntary institutionalization in all states and the District of Columbia, see S. BRAKEL, J. PARRY & B. WEINER, THE MENTALLY DISABLED AND THE LAW 76-81 (3d ed. 1985). *See also* National Center for State Courts, *Guidelines for Involuntary Civil Commitment*, 10 MENTAL HEALTH & PHYSICAL DISABILITY L. REP. 409 (1986).

2. In the past decade, the states' power to commit persons who have not committed crimes has been substantially diminished. Mental illness is a necessary requirement for involuntary civil commitment, and this definition relies upon the legal interpretation of state statutes. Most states now require representation by counsel, judicial hearings with patient notification, and a standard of "clear and convincing evidence" for proving dangerousness and mental disorder. These innovations are grounded in the fourteenth amendment's due process and equal protection clauses. *See generally* R. SIMON, CLINICAL PSYCHIATRY AND THE LAW 176-78 (1986).

alliance that allows them to keep society's most impaired people either hidden away or wandering precariously between the systems.

There has been a high degree of development at angle A^1 in the criminal justice system for many years. Protections that have developed include the fourth amendment's prohibition of unlawful searches and seizures; *Miranda v. Arizona*,[3] which requires that a person placed under arrest must be informed of his rights, including the right to remain silent; *Gideon v. Wainwright*,[4] which guarantees the right to defense counsel in criminal cases; fifth and sixth amendment guarantees of the right to a fair trial and not to incriminate oneself; and more recently, sentencing guidelines which help to ensure that suspects' rights to due process are not violated. The various mental health acts that govern the involuntary detention and processing of the mentally ill also provide considerable protections and mirror the importance given liberty and privacy rights.

Lawyers, not mental health professionals, were most instrumental in creating these safeguards and protections at angles A^1 and A^2. Lawyers not only responded to crises that resulted in litigation; some also became accomplished advocates for the mentally ill as they pressed an agenda that has made detention and commitment proceedings closely approximate to those associated with arrest and conviction. Fundamental to these developments is the need to define the goals of involuntary commitment and to ask if mental health practitioners have largely abdicated their role as primary advocates for the mentally ill. If involuntary commitment is designed to prevent the mentally ill from harming themselves or others, and to get them into environments where they can be helped, mental health professionals should support such commitment. If the legalization at angle A^2 is to be prevented from increasingly duplicating processes in the criminal justice system, such as lockups and adversarial hearings, mental health professionals must become both active participants in the induction of mentally ill persons at angle A^2 and informed advocates concerning appropriate procedures for the population involved. Policemen, lawyers, judges, and hearing masters who allegedly run a harsh and inappropriate system of involuntary commitment of mental patients will change only after mental health professionals help to instigate and shape the desired change. Moreover, isolated criticism of the induction process diverts attention away from the potentially more serious problem of ineffective, damaging, or nonexistent treatment modalities that inductees know await them. If mental health professionals are to gain and maintain control over the mental health system, they will not only have to increase their input into the induction process at angle

3. 384 U.S. 436 (1966).
4. 372 U.S. 335 (1963).

A^2, but they will also have to clearly define and operationalize what happens after induction.

B. $A^1 \rightarrow B^1$, or $A^2 \rightarrow B^2$

After confinement, both mental health patients and prisoners have rights they may assert regarding their well-being and ultimate release. These rights are most appropriately considered in our visual depiction on the sides between A^1 and B^1 and A^2 and B^2. Again, the mental health system is copying and catching up with the criminal justice system.

Over the past hundred years, the issue of whether prisoners retain fundamental rights has been debated and litigated. The original attitude of the courts that a prisoner had the status of "a slave of the state" with no rights[5] has given way to the view that "a prisoner retains all the rights of an ordinary citizen except those expressly, or by necessary implication, taken from him by law."[6]

While the conflict between safeguarding prisoners' rights and observing institutional requirements relating to custody, security, rehabilitation, discipline, punishment, and resource limitations is continuous, prisoners have always been able to rely on constitutional protections of fundamental rights, particularly the eighth amendment's prohibition against cruel and inhuman punishment.

Over the past fifteen to twenty years, legislation and cases have begun to create laws similarly protecting the rights of institutionalized mentally ill persons. During this upsurge of debate over rights of the mentally ill, the right to treatment, and the right to refuse treatment, established in cases such as *O'Connor v. Donaldson*[7] and *Rennie v. Klein*[8], have been major developments for the mental health system. Again, it has been lawyers who have led in this reform movement, while mental health professionals have responded defensively to this creation of rights as they attempt to particularize the new legal regime. Like the criminal justice system, the mental health system has reacted to attempts by lawyers, legislators, and judges to buttress the rights of the incarcerated. Like their counterparts in the prison system, mental health professionals have failed to provide the impetus for reform, in spite of the fact that they are the most informed concerning the indignities suffered.

This further legalization of the mental health system raises additional questions about the professed and actual goals of that system.

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5. Ruffin v. Commonwealth, 62 Va. (21 Gratt.) 790, 796 (1871).
6. Coffin v. Reichard, 143 F.2d 443, 445 (6th Cir. 1944).
7. 422 U.S. 563 (1975).
8. 476 F. Supp. 1294 (D.N.J. 1979). For a comprehensive presentation of the rights of institutionalized mentally ill patients, see S. BRAKEL, J. PARRY & B. WEINER, *supra* note 1, at 251-325.

Modern mental health professionals speak with disdain and disbelief about the days of the "snake pits" when mentally ill patients were confined in filthy, dungeon-like facilities. Yet the fact that the issue of whether there is a right to treatment reached the courts suggests that while treatment is the professed goal, in many cases it may be a secondary goal of the mental health system, with confinement as the primary goal.

C. Angles B^1 and B^2

Although treatment of mentally ill patients and rehabilitation of criminals are the systems' professed primary goals, failure predominates at both angles B^1 and B^2. This would appear to be an area of potential control and achievement for mental health professionals, free from the demands of lawyers, and uninfluenced by the structure and function of the criminal justice system. This has not been the case. Instead, mental health professionals have faced competing agendas: treatment and rehabilitation versus warehousing.

The failure of diagnosis and treatment has resulted in mental health practitioners once more succumbing to the temptation to let lawyers intervene to put their therapeutic house in order. They periodically look to the criminal justice system to "handle" problem groups such as alcoholics, drug abusers, child abusers, and those simplistically labeled "sociopaths." Furthermore, they acquiesce in the relabeling of groups so that "clients" can more readily be floated between the two systems. The labeling and relabeling of sex offenders is a case in point. Previously called "sexual deviants" and "sexual psychopaths," such persons are now called "mentally disordered sex offenders" (MDSO). In spite of this recognition that sexual offenders require treatment, there is ongoing debate over whether they belong in the mental health or criminal justice imprisonment systems.[9] This ambivalence has often resulted in the mental health system adopting the same sort of gratuitous warehousing of society's most deviant persons that characterizes the criminal justice system.

Failure to achieve the goals of treatment and rehabilitation, and the indecision regarding what to do with those neither system can help, summarize the two most salient similarities between the mental health and criminal justice systems at angles B^1 and B^2. The most apparent difference is that the criminal justice system has practically admitted its failure to rehabilitate, while the mental health system has only partially acknowledged its ineffectiveness at angle B.

Thus, widespread resignation and a shifted focus to other goals, such as deterrence, punishment, and protection of society now

9. *See, e.g.*, Weiner, *Legal Issues Raised in Treating Sex Offenders*, 3 BEHAVIORAL SCI. & L. 325 (1985).

predominate the criminal justice system. Efforts to rehabilitate are ad hoc, piecemeal, and often superficial. Such resignation largely accounts for the fact that there is no viable reform movement within the criminal justice system. Rather, maintaining the status quo, avoiding individual or class action lawsuits, and merely keeping society's most dangerous misfits "off the streets" are primary concerns of that system. Meanwhile, court dockets build up, plea bargaining takes place at a furious pace, jails remain indecently overcrowded, and the public fights the building of new jails and prisons if it will mean higher taxes or that those facilities will be located in their neighborhoods. Although the mental health system is having little success treating its most severely impaired people, defeat has not yet been admitted. Wild sweeps at solutions to problems associated with treatment are still being made, such as the ill-fated community mental health movement and the massive use of antipsychotic drugs. Ironically, these very attempts at reform and innovation have evoked charges of irresponsibility and abuse from mental health lawyers, patients, and their families. Once again lawyers have intervened in the mental health system with cases involving the right to refuse mind-altering drugs[10] and other intrusive technologies such as electroconvulsive therapy[11] and psychosurgery.[12] Therefore, mental health lawyers have also influenced the type of treatment that mental health practitioners can legally administer.

Thus, the influence that lawyers have had in shaping what methods are used to bring people into the mental health system, to determine which rights they maintain, and to set limits on the types of permissible treatment is clear.

D. The Shuffle: $A^1 \rightarrow C^1 \rightarrow A^1$ or A^2; or $A^2 \rightarrow C^2 \rightarrow A^2$ or A^1; or $A^1 \rightarrow B^2$ or $C^1 \rightarrow B^2$

Habitually failing to achieve their professed goals, the criminal justice and mental health systems dump their misfits, aberrants, and incurables into the streets to survive on their own. Angles C^1 and C^2 are where the mentally ill are voluntarily or involuntarily deinstitutionalized,[13] and criminals are released either because they have served their sentences or because the facilities are illegally overcrowded.

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10. Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980).
11. Bell v. Wayne County Gen. Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974).
12. Kaimowitz v. Michigan Dep't of Mental Health, Civ. No. 73-19434-AW, *reprinted in* R. REISNER, LAW AND THE MENTAL HEALTH SYSTEM 176 (1985).
13. *See generally Down and Out—But Determined*, TIME, Nov. 23, 1987, at 29; *Revolving Doors Trap Mentally Ill*, INSIGHT, Oct. 19, 1987, at 22; *Abandoned*, NEWSWEEK, Jan. 6, 1986, at 14; *The Light that Failed*, HOSPITALS, Aug. 16, 1983, at 88; *Deinstitutionalization: The Data Demythologized*, HOSPITAL & COMMUNITY PSYCHIATRY, Feb. 1983, at 129.

During confinement, many mentally ill patients become more adept in the maladaptive ways they have used to survive inside and outside of the institution, just as do incarcerated criminals. Most releasees in both groups leave their confinement as dependent, unemployable, stigmatized drifters whom society rejects. Recidivism is extraordinarily high in spite of feeble attempts at aftercare for the mentally ill and postconfinement guidance for criminals. Deinstitutionalization of mentally ill people was a cornerstone of the community mental health movement of the late 1960s and the 1970s. The concept was designed to remove patients from overly restrictive institutions that provided little or no effective treatment and place them in more helpful facilities within their communities. Unfortunately, the movement was unable to generate the funding and public support to build, staff, and maintain such needed local facilities, and thousands of the newly deinstitutionalized became homeless, preyed-upon street people. Many of them drifted into petty crime and found themselves entering the criminal justice system at angle A^1, while others became the targets of reinstitutionalization efforts.[14]

Similarly, many criminals released on early parole, probation, work release, furloughs, house arrest, and similar programs either became vagrants that society rejected and feared, or they returned to crime and reentered the criminal justice system at angle A^1 to resume their hopeless trek. The intense focus on the crimes committed by furloughed convict Willie Horton during the 1988 presidential campaign is a clear example of the general awareness of public perceptions of alarm and dismay over what takes place at angle C^1.

Many citizens would prefer that there are no angles C^1 and C^2, but that the mentally ill and criminals would stay forever within either system. However, because release is inevitable, these opponents instead favor quick reinstitutionalization, thus recycling these outcasts at angles A^1 or A^2. Such opponents to release have little knowledge about or interest in what occurs at angles B^1 and B^2. In fact, those who advocate retribution are frequently incensed when criminal defendants and convicts are transferred to the mental health system—from A^1 or C^1 to B^2—because of the perception that confinement in a mental institution constitutes "easy time." Furthermore, because many view the alumni of both systems as interchangeable menaces, fear and outrage are expressed when release from either system is seen as prema-

14. New York Mayor Edward Koch initiated a plan in 1987 to reinstitutionalize those mentally ill street people who posed an imminent danger to themselves or others. While some mental health professionals supported the plan because they saw it as a chance for the impaired to receive needed treatment, some civil libertarians denounced the policy as an unwarranted infringement on individual rights. *See Revolving Doors Trap Mentally Ill*, *supra* note 13, at 22. *See also Down and Out—But Determined*, *supra* note 13, at 29.

ture or unwarranted.[15]

This confusion about into which system a "deviant" person should be placed is not confined to uninformed lay persons. Professionals in each system are often equally perplexed and indecisive, and they actively participate in the cruel game of shuffling some of society's most vulnerable citizens between two dysfunctional systems.

E. The Merger

The increasing similarity between the mental health and criminal justice systems can be attributed to several factors. The influx of lawyers in the mental health system has forced mental health professionals to respond. Some have actively resisted this incursion, while others have appended "forensic" to their titles and become adept at operating within the criminal justice system. In addition, the growing number of J.D.-Ph.D. "law psychologists" has infused both systems with hybrid professionals, many of whom primarily seek to take advantage of lucrative consulting options in two systems that view each other as a dumping ground for their respective unreformable and unwanted detainees.

Thus, the restructuring of the mental health system in the image of the criminal justice system, and the cross-fertilization and interchange of professionals in the two systems have created a situation rife with confusion and conflict. This condition is perhaps best illustrated by the shuffling of what are perhaps society's most deviate, the criminally insane, between the two systems as a result of increasingly blurred concepts and practices.

Probably since the inception of the insanity defense centuries ago in England, people have vehemently objected to the verdict "not guilty by reason of insanity" (NGRI). Jurors have refused the option of granting NGRI verdicts in famous cases such as those involving the "Son of Sam,"[16] John W. Gacy,[17] and England's "Yorkshire Ripper."[18]

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15. Former merchant seaman Lawrence Singleton raped and hacked off the forearms of a 15-year-old girl in 1979. He was convicted of rape and attempted murder, and sentenced to 14 years and four months. A 1983 California work-incentive law that reduces sentences by one day for each day spent working as a teacher's aide in prison classrooms was applied to Singleton, resulting in his early release and in predictable public outrage. Jones, *Early Release Set For Man Who Cut Off Arms of Girl He Raped*, L.A. Times, Oct. 16, 1986, at 3, col. 5.

16. "Son of Sam" is David Berkowitz, sentenced in 1978 to 25 years of life imprisonment for each of six slayings, the infamous ".44 caliber killings" in New York City. Berkowitz was found fit to stand trial although his NGRI plea stated that a 6000-year-old dog told him to kill. Seigel, *Berkowitz Given 25 Years To Life In Each Of 6 "Son of Sam" Slayings*, N.Y. Times, June 13, 1978, at 1, col. 5.

17. John W. Gacy, Jr., confessed to the murder of 33 young males found strangled and buried underneath his house in Des Plaines, Illinois. He was found competent to stand trial and was convicted in 1980. He is currently on death row. Shep-

When John Hinckley was found NGRI after shooting President Ronald Reagan in 1981, it was considered an aberration by many who called for the immediate abolition of the NGRI verdict. Subsequently, eight states[19] created an even more controversial verdict, "guilty but mentally ill" (GBMI), partially to silence those adamantly opposed to NGRI verdicts, and partially because no one really knows what to do with the criminally insane. Such people probably belong in both systems at different times. Yet, the question of when and why they are inducted into and released from one or the other system often appears to be decided with a coin toss. Substance abusers who commit crimes, child molesters, and those who commit murder using particularly unsavory methods frequently find themselves in limbo, floating between the ideologically similar and therapeutically bankrupt mental health and criminal justice systems.

Another perplexing example of the merger between mental health and criminal justice is the case of Alvin Ford, who became psychotic during an eleven-year wait for his execution. The United States Supreme Court ruled in a divided opinion that executing an incompetent person offends the eighth amendment ban against cruel and unusual punishment.[20] With this decision, mental health professionals acquired the bizarre task of restoring Mr. Ford's competence so that he could face his executioner.

If one were to predict future trends within and between the two systems, two scenarios at opposite ends of a continuum seem possible. Reform, characterized by clear goals, effective methods of treatment and rehabilitation, rationally based criteria for release, and purposeful aftercare may occur. However, indifference toward the fate of the clients of these systems, collusion on the part of the systems' professionals to merely keep such clients out of sight and out of the courts, and greater melding of the systems could result in a system similar to that allegedly operating in the Soviet Union. There, reportedly, psychiatric diagnoses are often the result of or interchangeable with criminal convictions. This makes the fate of dissenters, of others who commit

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pard, *Gacy Is Found Guilty of Killing 33, Record For U.S. Mass Murderer*, N.Y. Times, Mar. 13, 1980, at 1, col. 1.

18. Thirty-five-year-old truck driver Peter Sutcliffe was convicted in Yorkshire, England, in 1981 of murdering 13 prostitutes over a period of five years, usually with a hammer and knife. Sutcliffe stated that he was on a divine mission to kill prostitutes, and received a sentence of life imprisonment for each individual murder. Rattner, *Briton Is Given 13 Life Sentences For The "Yorkshire Ripper" Murders*, N.Y. Times, May 23, 1981, at 6, col. 3.

19. Alaska, 1982; Conn., 1982; Ga., 1982; Ill., 1982-1983; Ind., 1982-1983; Ky., 1982; N.M., 1982; Mich., 1977. *See also* Savitsky & Lindblom, *The Impact of the Guilty But Mentally Ill Verdict on Juror Decisions: An Empirical Analysis*, 16 J. APPLIED SOC. PSYCHOLOGY 686, 687 (1986).

20. Ford v. Wainwright, 477 U.S. 399 (1986). *See also* Sargent, *Treating the Condemned to Death*, HASTINGS CENTER REP. 5 (Dec. 1986).

crimes against the state, and of the mentally ill the same whenever such dispositions serve the goals of the state.[21]

F. Prospects for Change

Before any meaningful reform can occur in the mental health and criminal justice systems regarding the most problematic clients the systems handle, goals and roles must be clarified. As long as forensic psychologists and psychiatrists and mental health lawyers are willing to alternately switch their focus as they expediently move between the systems, confusion and conflict are likely to prevail.

This assertion can be supported by a review of several articles written by mental health professionals that reflect an impatience with, and resistance to, the "overlegalization" of the mental health system. The press by lawyers for more laws to protect patients' rights also indicates an intermingling or imposition upon the mental health system by those lawyers. At times, the current situation may appear warlike, with lawyers and psychologists fighting over turf and autonomy as vigorously as over patient rights and care. Phrases from the titles of articles written by practitioners in both systems, such as "Rotting with Their Rights On,"[22] "Synthetic Sanity,"[23] and "Invisible Manacles,"[24] all of which discuss the right of mental patients to refuse antipsychotic medication, reflect cynicism and displeasure. The title of one law review article, "The Right of People (Misfits) to Refuse (Avoid) Treatment (Control) in Medical Facilities (Closed Institutions),"[25] clearly implies many of this article's assertions about the mental health system.

Concurrent with this quiet rebellion is another battle front where mental health professionals are responding to laws passed to protect not only patient rights, but those of victims as well. A noted psychiatrist, in discussing the famous *Tarasoff* case[26] (which led to legislation mandating a duty of mental health professionals to warn people whose lives might be threatened by the practitioner's patient-clients), writes that as a result of that decision a "rising tide" of suits against psychotherapists has occurred, and that psychotherapists are seeking protec-

21. *See generally* A. SOLZHENITSYN, CANCER WARD (N. Sethell & I. Burg trans. 1968).
22. Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979).
23. Gutheil & Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence" and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77 (1983).
24. Plotkin & Gill, *Invisible Manacles: Drugging Mentally Retarded People*, 31 STAN. L. REV. 637 (1979).
25. Kaimowitz, 13 DUQ. L. REV. 863 (1975).
26. Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

tive legislation.[27] Six states have enacted laws that are designed to free psychotherapists of legal liability for a patient's violent act unless he or she has failed to make a reasonable effort to warn the potential victim and has failed to notify law-enforcement officials.[28]

Some responses to this legislation further illustrate how the legalization of the mental health system has affected both practitioners' procedures and clients within the system at every angle in Figure 1. For instance, resentment and dismay over the threat of lawsuits, largely based on the inability of mental health professionals to predict dangerousness or their alleged misuse of antipsychotic drugs, have resulted in more thorough psychiatric evaluations, and increasing willingness to see involuntary commitment in borderline cases[29] (both affecting potential inductees at angles A^1 and A^2). To be sure, numerous other changes are occurring, or can be anticipated at all angles as long as mental health professionals allow lawyers to shape and reshape their discipline. It is also fair to say that psychologists and psychiatrists must accept much of the responsibility for the influx of lawyers into their profession and the subsequent loss of autonomy and control. Copying a defective criminal justice system or colluding with the lawyers to maintain a truce is the ultimate "cop-out."

G. Summary

When people are involuntarily brought into and kept within a system, someone must be accountable when rights are abridged and abuses occur. Where those rights are nonexistent or ill-defined, or when abuses continue unchecked, it is certain that the law will eventually intervene. This has been the case with the mental health system.

Patterns that have been established in the older criminal justice system are either being copied by practitioners in the mental health system or they are being imposed upon it by lawyers. There is a blurring of boundary lines between the two systems that is causing harm to the mental health system and its clients. In fact, the near dysfunctional criminal justice system often encourages the blurring, because to do so creates a place to dump its most problematic cases, such as the criminally insane.

There is no "quick fix." However, if mental health professionals passively abdicate their decisionmaking powers to lawyers, and cooperate in the ad hoc relabeling, gratuitous warehousing, and arbitrary

27. Otten, *More Psychotherapists Held Liable For the Actions of Violent Patients*, Wall St. J., Mar. 2, 1987, at 21, col. 3.

28. *Id.*

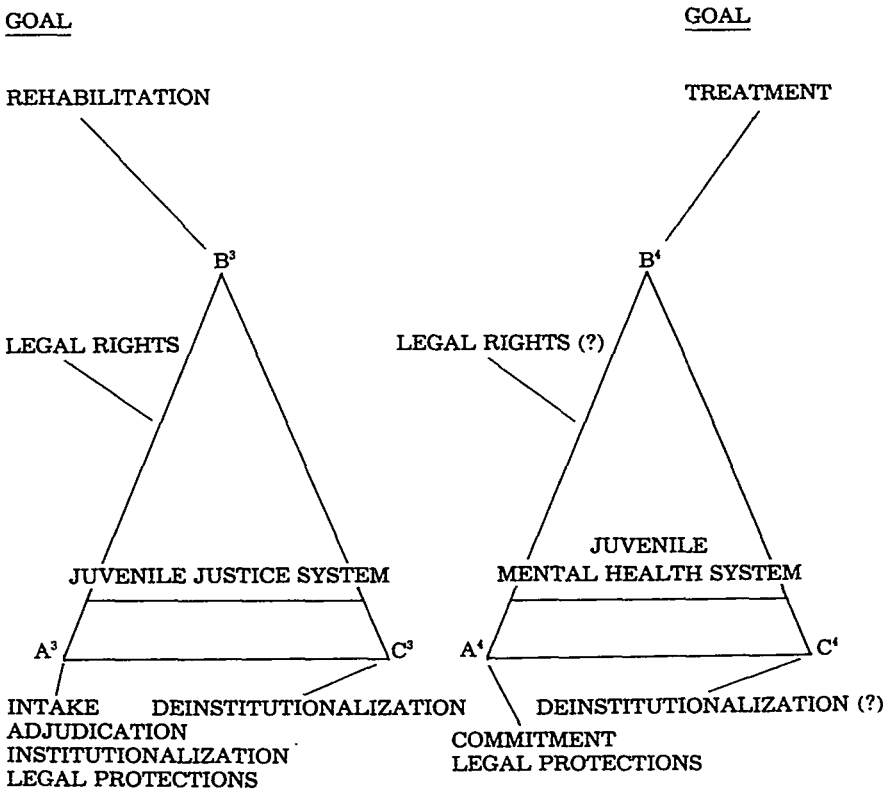
29. *Id.*

deinstitutionalization of society's most deviant people, their system's collapse is predictable.

III. THE JUVENILE JUSTICE SYSTEM

As in the mental health system, the past quarter century has seen an increasing legalization of the juvenile justice system and a corresponding decline in confidence in the results of that system. The same trends noted in the contemporary mental health system—greater rights at induction and after confinement; confusion over rehabilitation, the system's primary treatment goal; "dumping" and shuffling from one system to another; and merger with the criminal justice system—are apparent in juvenile justice.

FIGURE II



A. Legal Rights at Intake in the Juvenile Justice System (Angle A^3)[30]

Prior to 1967, induction of children into the juvenile justice system was an informal matter. *In re Gault*[31] of course changed that, opening the way for Supreme Court recognition of several trial-type rights at adjudicatory hearings: rights to notice, to counsel, to confrontation of opposing witnesses, and the privilege against self-incrimination in *Gault*; proof of guilt beyond a reasonable doubt in *In re Winship*[32]; protection against double jeopardy in *Breed v. Jones*[33]; and freedom from unreasonable searches and seizures in *New Jersey v. T.L.O.*[34] A few lower courts have accorded juveniles the rights to bail[35] and to a public trial.[36] Statutes and court rules have gone much farther in creating rights,[37] so that at present the rules of procedure applicable in juvenile court read much like those applicable in criminal courts.

Another important aspect of the legalization of intake in the juvenile justice system has been the contraction of the juvenile court's jurisdiction. In its initial inception, the juvenile court had jurisdiction to hear all allegations of misconduct, criminal and noncriminal. Since *Gault*, the court's noncriminal jurisdiction—consisting largely of claims of "incorrigibility" and "truancy"—has been attacked on all fronts. There have been numerous court challenges,[38] and in 1977 the prestigious Juvenile Justice Standards Project recommended jettisoning jurisdiction over noncriminal misbehavior.[39] Though most states still retain this jurisdictional category, it is invoked far less frequently today than twenty years ago, and it seldom results in incarceration.

Even diversion, the process of informal probation that once was the dominant response to juvenile misconduct, has become the subject of legal regulation. Led once again by the Juvenile Justice Standards

30. This section relies heavily upon W. WADLINGTON, C. WHITEBREAD & S. DAVIS, CASES AND MATERIALS ON CHILDREN IN THE LEGAL SYSTEM (1983).

31. 387 U.S. 1 (1967).

32. 397 U.S. 358 (1970). *But cf.* McKeiver v. Pennsylvania, 403 U.S. 528 (1971) (no right to trial by jury in juvenile court).

33. 421 U.S. 519 (1975). *But see* Swisher v. Brady, 438 U.S. 204 (1978).

34. 469 U.S. 325 (1985).

35. *See, e.g.*, Trimble v. Stone, 187 F. Supp. 483 (D.D.C. 1960). *But see* Schall v. Martin, 467 U.S. 253 (1984).

36. *See, e.g.*, RLR v. State, 487 P.2d 27 (Alaska 1971).

37. *See, e.g.*, FLA. STAT. §§ 39.02-.337 (1987); FLA. R. JUV. P. 8.010-.330.

38. *See, e.g.*, Lamb v. Brown, 456 F.2d 18 (10th Cir. 1972); District of Columbia v. B.J.R., 332 A.2d 58 (D.C. 1975); Commonwealth v. Brasher, 359 Mass. 550, 270 N.E.2d 389 (1971); A. v. City of New York, 31 N.Y.2d 83, 286 N.E.2d 432, 335 N.Y.S.2d 33 (1972); *In re* Walker, 282 N.C. 28, 191 S.E.2d 702 (1972); E.S.G. v. State, 447 S.W.2d 225 (Tex. Civ. App. 1969).

39. STANDARDS RELATING TO NONCRIMINAL MISBEHAVIOR 1.1 (Juvenile Justice Standards Project, Tent. Draft 1977).

Project,[40] many states have adopted detailed regulations regarding who may be diverted from the juvenile court, as well as when and how diversion is to take place.[41] There could be no clearer demonstration of how much the spirit of legalization has penetrated the intake stage of the juvenile justice system.

B. Legal Rights During Juvenile Incarceration (A^3 to B^3)

As the assertion of "prisoners' rights" and treatment rights has transformed the mental health system, so has the claim of similar rights by incarcerated juveniles changed the juvenile justice system. Courts have recognized that children held in long-term juvenile facilities may assert the eighth amendment's limitation on cruel and unusual punishment, as well as other constitutional rights applicable to prisoners.[42] Juveniles have also successfully used the juvenile court's dedication to rehabilitation to derive an enforceable right to treatment in juvenile facilities.

The constitutional ban on cruel and unusual punishment has been applied to juvenile incarceration,[43] opening the way for challenges to conditions of imprisonment and forms of punishment.[44] Most interestingly for those intrigued by the comparison of the criminal, mental health, and juvenile systems, some courts have recognized the incarcerated juvenile's right to resist forced medication.[45] Besides showing the parallels among criminal, civil, and juvenile commitment, this legal development also produces the anomaly of enforceable rights both to obtain treatment and to avoid it.

The source of this right to treatment is the juvenile justice system's articulated commitment to rehabilitation. Originally conceived as a quid pro quo for reduced rights in the adjudicatory process,[46] after *Gault* the right to treatment has been more frequently justified as a

40. STANDARDS RELATING TO THE JUVENILE PROBATION FUNCTION 2.4 (Juvenile Justice Standards Project, Official Draft 1980).

41. *See, e.g.*, H. THOMPSON, CALIFORNIA JUVENILE COURT DESKBOOK ch. 4 (2d ed. 1981), *excerpted in* W. WADLINGTON, C. WHITEBREAD & S. DAVIS, *supra* note 30, at 342-45.

42. Regarding constitutional rights of incarcerated juveniles in addition to the eighth amendment, see Silbert & Sussman, *The Rights of Juveniles Confined in Training School and the Experience of a Training School Ombudsman*, 40 BROOKLYN L. REV. 605 (1974).

43. *See, e.g.*, Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974).

44. *See, e.g.*, Milonas v. Williams, 691 F.2d 931 (10th Cir. 1982), *cert. denied*, 460 U.S. 1069 (1983)(disapproving practices at private school, attendance at which was made a condition of juvenile probation).

45. *See* Nelson v. Heyne, 491 F.2d 352, 356-57 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974).

46. *See* Ketcham, *The Unfulfilled Promise of the Juvenile Court*, 7 CRIME & DELINQ. 97, 100-01 (1961).

way of forcing the state to live up to its commitments.[47] Under right-to-treatment analysis, however conceived, courts may focus on particular treatment modalities or on results; in either case, assessments may be made both individually and among inmates as a whole.[48]

The assertion of legal rights after commitment is an established feature of juvenile justice, which has thus joined the mental health system in mimicking criminal justice. The role of the rehabilitative ideal in this process is ironic, because the juvenile justice system seems to be losing faith in this goal just as it is bearing its most significant fruit, the right to treatment.

C. Controversy over the Goal of Juvenile Justice (Angle B^3)

Designed to protect the welfare of children who are considered immature, malleable, and deserving of a second chance, rehabilitation of juvenile offenders was the original animating goal of the juvenile justice movement,[49] and verbal commitment to this goal continues today in many quarters. However, among legal theorists there is a crisis of confidence in the rehabilitative ideal, which could well foreshadow a systemwide collapse of faith. Again, such a collapse would parallel similar developments in the criminal justice and mental health systems.

Two basic challenges have emerged to rehabilitation as the rationale for a separate system of juvenile justice. Among those who continue to believe that children's interests should predominate in the treatment of juvenile misconduct, there has grown a fear that the juvenile justice system does more harm than good. The prescription of these critics is best summarized in the title of one of the more influential works in this vein: *Radical Non-Intervention*.[50] The burden of this criticism is that misguided attempts at rehabilitation should be discontinued in favor of benign neglect; the abandonment of the juvenile court's noncriminal jurisdiction and the juvenile deinstitutionalization movement[51] are both outgrowths of this criticism.

The second form of dissent from the rehabilitative ideal takes its lead from society's interest in controlling juvenile misconduct. These critics argue that deterrence is the highest priority of any system of

47. *See, e.g.*, Morgan v. Sproat, 432 F. Supp. 1130 (S.D. Miss. 1977); Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972).

48. *See, e.g.*, Nelson v. Heyne, 491 F.2d 352, 360 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974).

49. *See* Mack, *The Juvenile Court*, 23 HARV. L. REV. 104 (1909). *See also* LEGAL RIGHTS OF CHILDREN § 11.01 (R. Horowitz & H. Davidson eds. 1984).

50. E. SCHUR, RADICAL NON-INTERVENTION: RETHINKING THE DELINQUENCY PROBLEM (1973).

51. *See supra* text accompanying notes 38-39 and *infra* text accompanying notes 55-57.

behavior control, and that accordingly the juvenile justice system must impose sanctions on young offenders first and seek rehabilitation only as a secondary matter.[52] This view, which eradicates one of the major distinctions between the criminal and juvenile justice systems, was adopted by the Juvenile Justice Standards Project, over strenuous objections.[53] One of the main manifestations of this view is the Standards Project's recommendation that relatively determinate sentences be established for juvenile misconduct, instead of the open-ended dispositions common in most jurisdictions.[54]

Though neither of these critiques of rehabilitation has had a thoroughgoing impact on juvenile law, their popularity among theorists suggests that in due course skepticism about rehabilitation will rewrite the statutes and rules defining the juvenile justice system. When this occurs, perhaps some will say that the law was only catching up with the skepticism currently reflected in the day-to-day realities of juvenile court.

D. Dumping (Angle C^3) and Shuffling ($A^3 \rightarrow C^3 \rightarrow A^3$ or A^1 or A^2; or $A^3 \rightarrow A^1$ or A^2) in the Juvenile Justice System

One of the more disheartening aspects of reality in the juvenile justice system is the fate of those who fail the project of rehabilitation. Prematurely deprived of the benefits of available treatment, releasees frequently end up back in the juvenile system or graduate to the criminal courts or, more rarely, to the process of civil commitment. In some cases, this movement to another system is aided by special juvenile court procedures for intersystem transfer.

Like the mental health system, juvenile justice has recently weathered a deinstitutionalization movement. Many jurisdictions have significantly lowered the number of incarcerated juveniles, and a few have gone so far as to abandon statewide institutions in favor of community-based programs.[55] While this development has obviously benefited many juveniles,[56] it has also resulted just as clearly in the premature return to society of some who might have profited from further treatment in an institutional setting. Such juveniles have become prime candidates for recidivism, in either juvenile or criminal court; others have found their way into the mental health system, either as children[57] or later as adults.

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52. STANDARDS RELATING TO DISPOSITIONS 1.1 commentary (Juvenile Justice Standards Project, Official Draft 1980).
53. *Id.*; *see also id.* at 133-35.
54. *Id.* at 1.2F commentary.
55. *See, e.g.*, R. COATES, A. MILLER & L. OHLIN, DIVERSITY IN A YOUTH CORRECTIONAL SYSTEM: HANDLING DELINQUENTS IN MASSACHUSETTS (1978).
56. *Id.* at 176-78.
57. *See infra* text accompanying notes 65-67, 70-78.

Special procedures available in juvenile court frequently accelerate this shuffling between systems. Almost all states have provisions for waiver of juvenile court jurisdiction and transfer to criminal court; the usual bottom-line standard for transfer is nonamenability to the treatment available in juvenile court.[58] Thus the central question in a transfer hearing is whether the subject of the inquiry "belongs" in the juvenile justice system—a question that increases the potential for dumping one system's mistakes into another.

Of course, the criminal justice system could be only a brief stop for the transferred juvenile, who may be quickly forwarded to the mental health system. The recommendations of the Juvenile Justice Standards Project exemplify one way in which this movement might begin. The standards specifically indicate that in making the transfer decision, the juvenile court may consider "the appropriateness of the services and dispositional alternatives available in the criminal justice system for dealing with the juvenile's problems."[59] Because criminal courts frequently have access to more diverse treatment alternatives for those with mental problems, the Project's recommendation could result in a pass through the criminal system for juveniles deemed to fall in this category.[60]

Like adjudicatory hearings, transfer proceedings have been subjected to extensive legal regulation, beginning with the United States Supreme Court's opinion in *Kent v. United States*,[61] which predated *Gault*. The careful attention that reviewing courts have given to legal rights in transfer proceedings[62] contrasts starkly with the relatively open-ended nonamenability standard, which has received much less judicial scrutiny. Transfer proceedings thus display in microcosm what has happened throughout juvenile justice (and the other systems for behavior control): legalization of procedures has masked the underlying reality of declining effectiveness.

E. Merger with the Criminal Justice System

In its original design the juvenile justice system aimed to save children from the depredations inherent in exposure to the criminal justice system.[63] The contemporary reality of juvenile justice is that it,

58. *See generally* STANDARDS RELATING TO TRANSFER BETWEEN COURTS 2.2 commentary (Juvenile Justice Standards Project, Official Draft 1980).
59. *Id.* at 2.2C.4.
60. Of course, the juvenile court may also refer juveniles directly to the mental health system. *See, e.g.*, FLA. STAT. § 39.08(2) (1987).
61. 383 U.S. 541 (1966).
62. *See* W. WADLINGTON, C. WHITEBREAD & S. DAVIS, *supra* note 30, at 393-401 (discussing counsel, notice, evidentiary issues, standard of proof, self-incrimination, statement of reasons, and appeal).
63. *See generally* Mack, *supra* note 49; LEGAL RIGHTS OF CHILDREN, *supra* note 49, § 11.01, at 463-65.

like the mental health system, mimics criminal justice in virtually every phase. What was designed to be different has become strikingly similar, and the chance to achieve significantly different results has accordingly been lost.

A good symbol of this merger of the two systems and the confusion it produces is the current controversy over executing juveniles. Transferred to criminal court before being sentenced to death, these juveniles are thus officially adults, yet the courts cannot blind themselves to the fact that chronologically the capital defendants before them are still juveniles. If the juvenile court was truly a different, genuinely effective system, the transfer to criminal court could be meaningful. But because the systems are not significantly different, and because the transfer may say more about the exigencies of system management and law enforcement than about the defendant's amenability to treatment as a juvenile, some courts have balked at execution. In its most recent decision on this issue, it is clear that a majority of the United States Supreme Court has not yet sorted out these conflicting attitudes.[64]

Another example of merger concerns the impact of mental disease or defect on a juvenile court proceeding; this example also brings the mental health system into play, disclosing the merger of all three systems. When juveniles began asserting the insanity defense in adjudicatory proceedings, the courts' initial response was that the defense was not available in juvenile court and that mental disease or defect could be taken into account only at the dispositional stage;[65] the different goals and methods of the juvenile court arguably justified this result. However, the trend of more recent decisions has been to allow the defense at the adjudicatory stage.[66] While conforming to putative constitutional requirements derived from the criminal justice model,[67] these decisions effectively remove the children involved from the juvenile justice system, leaving only the mental health system to deal with them.[68] Thus mimickry of criminal justice has made the juvenile court less effective and accordingly has placed a greater burden on the mental health system.

F. Summary

The original philosophy of the juvenile justice system, protecting malleable youth from the harsh realities of the criminal justice system

64. Thompson v. Oklahoma, 108 S. Ct. 2687 (1988).
65. *See, e.g., In re* State *ex rel.* H.C., 106 N.J. Super. 583, 256 A.2d 322 (1969).
66. *See, e.g., In re* State *ex rel.* Causey, 363 So. 2d 472 (La. 1978).
67. *See id.* at 473-75.
68. The same result occurs when juveniles assert that they are mentally incompetent to stand trial, *see id.*, or that they lacked *mens rea* because of mental disease or defect. *Cf. In re* C.W.M., 407 A.2d 617 (D.C. 1979) (disallowing the claim).

in order to give them a fresh start, was sound. However, the will to create an effective system was lacking, and abuse and neglect of those in the system ensued, leading to legalization.

Now, an increasingly dysfunctional juvenile justice system is in crisis, because it does not serve troubled juveniles but instead fosters their aimless wanderings within and among the juvenile, criminal, and mental health systems. Concurrently, whatever malleability these juveniles once possessed is being transformed for many into indifference, anger, and contempt directed toward the people, communities, and society that have betrayed them.[69]

IV. JUVENILES IN THE MENTAL HEALTH SYSTEM

In the adult mental health and juvenile justice systems, the process of legalization is already substantially complete, and the primary issue is how to deal with the system that has resulted from this process. Regarding the mental health response to juveniles, however, legalization is still in its nascent stages. This fact provides both a potential for charting new developments in this area and an opportunity to manage those developments based on what has been learned from the previous legalization of other systems.

A. Commitment of Juveniles to Mental Health Facilities (Angle A^4)

While children considered difficult were treated at home without the aid of professional help fifty years ago, today's solution to such problem children appears to be the use of short- and long-term institutionalization in psychiatric hospitals. Such children are usually considered to be emotionally distraught by mental health professionals as evidenced by belligerence at home, truancy, running away, and disregard for commonly accepted rules. But these children usually do not evidence any severe psychotic disturbance, nor are they a danger to themselves or others. In the past such behavior was merely considered to be due to family difficulties or part of the child's growing struggle for autonomy, because the difficulties centered around issues with parents. Hospitalization of these children is usually against their wishes and focuses upon the child as the sole problem, rather than identifying the family difficulties that precipitated the child's behavior and seeking to resolve them.

A number of factors can be identified which have directly or indirectly led to the use of hospitalization to control unruly children. Chief among these factors is the deinstitutionalization of the juvenile

69. For a related discussion of the failure of these systems to serve impaired and troubled juveniles, see Garcia & Steele, *Mentally Retarded Offenders in the Criminal Justice and Mental Retardation Services Systems in Florida: Philosophical, Placement, and Treatment Issues*, 41 ARK. L. REV. 809 (1988).

justice system. Also relevant are insurance coverage that emphasizes traditional inpatient care and competition among hospitals to fill ever-increasing numbers of beds.

Until 1974, minors who committed status offenses, acts which were deemed illegal solely due to the age of the offender, were confined in juvenile detention and correction facilities for treatment. With the enactment of the Juvenile Justice and Delinquency Prevention Act of 1974,[70] however, yearly commitment of minors to correctional facilities decreased nationally by approximately 78,000 youths from 1974 to 1979.[71] As the role of the justice system in dealing with such problem children has decreased, a growing number of parents have been faced with acquiring alternative sources of assistance for dealing with problems they believe are beyond their ability to control.

A secondary factor that appears to be contributing to the increased hospitalization of children are current insurance practices. Generally, third-party health care providers have favored inpatient over outpatient treatment,[72] with coverage estimates ranging from eighty to one hundred percent for inpatient services as compared to fifty percent for outpatient services. Thus, when families are experiencing turmoil focused upon a child who is a behavior problem, they are more likely to have him or her admitted to a hospital because of financial reasons.

The growth of the psychiatric care market is another secondary factor. Several developments in the field have led to an increase in competition among psychiatric facilities.[73] Central to this competition is the increase in private psychiatric hospitals because they are such good investments. As the supply of hospital beds has exceeded the public demand for them, competition among hospitals to fill those beds has increased. Presently, nearly all forms of media contain advertisements that encourage people to seek help for emotional difficulties, and many appear to be targeting parents who are frustrated with coping with their difficult children.

The end result of such forces has been parents having their children admitted to inpatient facilities, to provide some sense of relief at home and to get the child into treatment. One article on recent trends in treatment of minors in inpatient facilities estimated a growth from 6,420 juveniles admitted in 1971 to 35,656 in 1986.[74] Other estimates of the growth in juvenile inpatient psychiatric care have arrived at a fig-

70. 42 U.S.C. §§ 5601-5751 (1982 & Supp. V 1987).

71. Krisberg & Schwartz, *Rethinking Juvenile Justice*, 29 CRIME & DELINQ. 333, 342 (1983).

72. Mosher, *Alternatives to Psychiatric Hospitalization: Why Has Research Failed To Be Translated Into Practice?*, 309 N. ENG. J. MED. 1579 (1983).

73. R. Lowman, Economic Incentives in the Delivery of Alternative Mental Health Services (Aug. 1987) (unpublished paper presented at the annual meeting of the American Psychological Association).

74. Jackson-Beeck, Schwartz & Rutherford, *Trends and Issues in Juvenile Confine-*

ure of a 400 percent increase over the years from 1980 to 1985.[75] In 1980 approximately one-half of juvenile admissions were given diagnoses consistent with relatively mild psychopathology, such as adjustment reactions, conduct disorders, and hyperactivity.[76] The bottom line of this trend in psychiatric treatment is that "48,000 kids in this country are working out their troubled adolescent years behind locked doors instead of weathering the storm at home as most of their parents did."[77]

What has enabled this growth in hospitalization of children are statutory differences between how children and adults enter inpatient facilities. While the laws vary to a considerable degree among the states, the procedures are quite similar.

"Involuntary commitment," the process of confining individuals to a treatment facility against their will due to the severity of their mental impairment or their dangerousness, involves a number of procedural safeguards such as a precommitment hearing and regular review to insure the due process rights of the individual. "Voluntary admission" involves individuals entering inpatient treatment on the basis of having provided their full and informed consent for such treatment. This latter procedure carries with it relatively few safeguards because it is assumed that the individual can demand release from the facility if dissatisfied with the treatment.

The primary difference between the entry of children and adults into such facilities lies in the case of parents who choose to have their children enter inpatient treatment against the wishes of the children. While some limitations have been placed upon such procedures, the majority of the states consider this to be a voluntary admission and subject to almost no regulation.[78] Parents bring their child to the treatment facility, where the family is interviewed by several levels of hospital staff, from admissions personnel to social workers to physicians. This interview is designed to assess the treatment needs of the child, and recommendations are made to the family. At the conclusion of this procedure, the parents may choose to sign a petition for the admission and treatment of the child at the facility, regardless of the child's preferences.

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ment for Psychiatric and Chemical Dependency Treatment, 10 INT'L J.L. & PSYCHIATRY 153 (1987).

75. Breckenridge, *The Dangers in Hospitalizing Mildly Mentally Ill Youngsters*, Tampa Tribune, Sept. 3, 1987, at 14-A, col. 1; Ostroff, *Growing Up Behind Locked Doors: A Look Inside America's Hidden System of Teen Control*, Rolling Stone, Nov. 20, 1986, at 70, 72.

76. Jackson-Beeck, Schwartz & Rutherford, *supra* note 74, at 156.

77. Ostroff, *supra* note 75, at 72.

78. Beyer & Wilson, *The Reluctant Volunteer: A Child's Right to Resist Commitment*, in CHILDREN'S RIGHTS AND THE MENTAL HEALTH PROFESSIONS 133 (G. Koocher ed. 1976).

This procedure would appear to be quite functional in cases where the parties involved in the intake process have as their primary concern the best interests of the child. Unfortunately, this may not be the case in a large portion of admissions, considering the previously described need for hospitals to fill existing beds and the likelihood of the child's problems being familial in nature.

B. Incipient Legalization at Angle A[4]

After a number of lower court decisions had provided some legal protection to minors committed by their parents, the United States Supreme Court found a typically lax statute regarding procedures for voluntary admission of minors to be constitutional. But subsequent legislation enacted in a number of states has begun to provide more procedural protection for committed juveniles.

In one of the first court cases to examine a parent's right to have a minor admitted to a psychiatric hospital, *Hewellette v. George*,[79] Sallie Hewellette filed a suit for wrongful imprisonment against her mother and then, upon her mother's death, against her mother's estate. Miss Hewellette, although still a minor, was married but separated from her husband at the time her mother had her voluntarily committed. The Supreme Court of Mississippi concluded that the relationship of a parent to a minor child should create reciprocal immunity to torts, in order to maintain peace within families. While the nature of the parent-child relationship was uncertain, due to Miss Hewellette's marriage, the court nevertheless reversed a lower court decision in Miss Hewellette's favor. *Hewellette* has since become precedent for tort immunity between parents and minor children in suits regarding the confinement of children in psychiatric hospitals against their will. Alternative attacks on admissions procedures by challenging the structure and constitutionality of the statutes involved have met with more success.

Melville v. Sabbatino[80] involved an adolescent, Cameron Melville, who had been admitted to the Yale Psychiatric Institute in Connecticut at the request of his parents when he was fifteen years old. Following two years of confinement in the institution, Cameron requested in writing that he be released from the facility, but his request was refused by hospital personnel and his parents, at which time he applied for a writ of habeas corpus to secure his release. While he acknowledged his need for treatment, he also believed that he would benefit most from outpatient treatment. The Superior Court of Connecticut, after discussing relevant statutes, held that minors of age six-

79. 68 Miss. 703, 9 So. 885 (1891).
80. 30 Conn. Supp. 320, 313 A.2d 886 (Super. Ct. 1973).

teen years or greater have the rights of a voluntary patient, which include the right to request release after appropriate notification.

This case neither took issue with the initial admission procedures nor did it challenge the constitutionality of the statute regulating such admissions. The focus of examination was the statutory right of minors age sixteen and older to act in their own behalf as voluntary patients.

Another case, *Pyle v. Brooks*,[81] attempted to challenge the constitutionality of the Oregon statutes governing the admission of minors to state hospitals. In 1975, Wade Henry Pyle was committed to the Oregon State Hospital by his mother against his wishes. Approximately six months later, the minor applied for a writ of habeas corpus, claiming that the statutes under which he was committed violated his right to due process. The Court of Appeals of Oregon, in examining the relevant statutes, found them to be incomplete and therefore voidable upon challenge, but refused to comment upon the constitutionality of these statutes.

A similar case in California, *In re Roger S.*,[82] asserted that the California statute regarding voluntary admission of minors to inpatient psychiatric facilities violated the committed minor's due process rights. Roger S. was fourteen years old when he was admitted to a state hospital at the request of his mother. The Supreme Court of California found that the statutes involved did violate due process rights and held that the parents of minors age fourteen years or more could not waive the due process rights of the minor. The court also held that minors fourteen years or older were entitled to a precommitment hearing before a neutral factfinder when they disagreed with their parents regarding the necessity of inpatient treatment.

From these cases one can observe a growing concern with the procedural safeguards afforded children whose parents wish to have them admitted for inpatient psychiatric treatment. Thus it seemed to be quite appropriate when the United States Supreme Court granted certiorari to a similar case. In *Parham v. J.R.*,[83] two children, J.R. and J.L., were inpatients in a Georgia state mental hospital who filed a class action suit against officials of the Georgia Department of Human Resources and the chief medical officer of the state hospital. J.R. and J.L. were admitted to the state hospital at the ages of six and seven years, respectively, and both were considered to be incorrigible. J.L. was admitted following the request of his mother, while J.R., a ward of the state, was admitted by the Georgia Department of Family and Children Services.

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81. 31 Or. App. 479, 570 P.2d 990 (Ct. App. 1977).
82. 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977).
83. 442 U.S. 584 (1979).

The minors challenged the Georgia statutes for voluntary commitment of children on the grounds that they violated the due process clause of the fourteenth amendment. The statutes provide for the voluntary admission of minors age eighteen years and younger at the request of the minor's parent or guardian. When parents apply for the admission of their children, the hospital superintendent has the authority to temporarily admit any child for observation, diagnosis, and treatment, if necessary.

While the district court initially found the statutes to be in violation of due process, the Supreme Court reversed that decision. Having reviewed the existing procedures, the Court believed that they provided minimally adequate protection of due process rights such as initial evaluation by a neutral party, the superintendent, while avoiding excessive procedural burdens. More specifically, the Court held that parents should maintain the authority for seeking inpatient treatment for their children because parents in most cases act in the best interest of their children. The Court also stated that since a neutral party, the hospital superintendent, must also agree to the voluntary admission of the child, adequate protection existed for cases where the parents are not acting in the best interest of the child.

In a second case reaching the Supreme Court, *Secretary of Public Welfare v. Institutionalized Juveniles*,[84] similar challenges were made to the Pennsylvania statutes governing voluntary commitment of children. Here, the Court merely reiterated its opinion from *Parham v. J.R.* and stated that the Pennsylvania procedures also provided adequate protection of the due process rights of children.

Thus, at present, children cannot seek recourse against their parents for commitment against their wishes, due to parent-child tort immunity, and the statutes controlling voluntary commitment of children have been found to contain adequate protection of due process as guaranteed in the Constitution. While the battle in the courts for protection of children's precommitment rights appears to have been lost, considerable success has been achieved in the legislatures. Approximately two-thirds of the states currently provide some form of significant protection, either by prohibiting or severely restricting the voluntary admission of children by parents. These limitations include age limitations, a precommitment hearing if the minor objects, and restrictions on the duration of hospitalization.[85]

C. Prospects for Further Legalization at Angle A[4]

Judicial and legislative movement in the area of commitment pro-

84. 442 U.S. 640 (1979).

85. Zenoff & Zients, *If Civil Commitment Is The Answer For Children, What Are The Questions?*, 51 GEO. WASH. L. REV. 171, 191 (1983).

cedures appears to have provided at least minimal assurance of due process for minors. However, the combination of parents faced with finding some means of coping with their children, insurance coverage favoring inpatient treatment, and hospital competition to fill existing beds inevitably will result in the location and abuse of any loopholes available in the procedures. Thus, for reformers, it is imperative that these statutes and accompanying procedures be scrutinized to afford the maximum protection of the rights of these children.

In 1974, Professor James W. Ellis first wrote about the abuse of the procedures for voluntary admission of children by their parents.[86] While some judicial and legislative changes have taken place since his initial review of the system, many of the same weaknesses still exist. Thus, many of his proposals are still pertinent. Two of the primary ways for safeguarding due process suggested by Ellis were either a precommitment hearing or delayed commitment hearing. While the former would complicate current procedures, the latter would merely limit the duration of a dissenting child's hospitalization and provide him or her with a means of seeking release. Inserting the hearing after admission would appear to avoid complicating the admission process while still ensuring at least some due process rights for these children and providing some additional check on the motives of hospital personnel and parents.

Ellis also suggested the need for a standard for commitment beyond simply limiting admission to those children who "need treatment." Similar criteria for adults have included the inability to care for oneself or dangerousness to self or others. While these may be too restrictive to apply to childhood admissions, some intermediate definition could be developed. By defining specific criteria for admission, individuals in need of treatment would be detected more easily and those for whom inpatient treatment was not appropriate, such as status offenders, would have to be referred elsewhere.

Ellis also proposed the adoption of procedures through which children who were voluntarily admitted by their parents could seek release. He suggested that children be afforded the right to request release, at which time if the parents or hospital disagreed, a hearing could be held to determine whether continued treatment was necessary.

A related issue, case review, could also serve to protect the due process rights of children. Professor Zenoff and Dr. Zients[87] noted that while the Supreme Court did emphasize the need for review in *Parham v. J.R.*, the Court failed to stipulate any required frequency for review, thus nullifying its intentions due to the vagueness of its

86. Ellis, *Volunteering Children: Parental Commitment of Minors To Mental Institutions*, 62 CALIF. L. REV. 840 (1974).

87. Zenoff & Zients, *supra* note 85, at 190.

recommendations. Such procedures could be defined by law to avoid their abuse. Coupled with a child's right to seek release, these procedures would prohibit unnecessarily long hospitalization.

Perhaps one of the most important ways to ensure due process for children is by increasing their awareness of their rights. Children could be made aware of their rights upon admission in language they could easily understand. Additionally, Zenoff and Zients have recommended that children have access to legal counsel either from attorneys or law students. The awareness of their rights and access to counsel would provide children with a means of actively protecting their own interests.

D. Prospects for Treatment Rights ($A^4 \rightarrow B^4$)

In a proposal for a model law for commitment of children, Professor Gary B. Melton[88] has emphasized the need for a continuum of treatment settings, ranging in restrictiveness from outpatient treatment to partial hospitalization to full inpatient treatment. Development and maintenance of such alternative treatments could be seen as essential for proper placement of children in the environment best suited to their needs.

While a child's right to treatment has yet to be decided by the courts, legislative modifications could make such treatment available. Ellis has suggested that at least older children be given the right to seek treatment on their own behalf regardless of the wishes of their parents. He emphasized, however, that such decisionmaking should be conducted with the full knowledge of the alternatives available. This would provide children in neglectful and abusive homes with some means of seeking help for their problems even if their parents object. Here again, however, the mental health system is inadequate, and children and their families will have to begin to turn to the legal system to acquire treatment rights and protections.

It is abundantly clear from current reports that juveniles in the mental health system are frequently overmedicated, sometimes physically abused, allegedly brainwashed, and otherwise mistreated in various types of treatment programs.[89] Without a doubt, laws will be passed, and cases will be argued and won that will create a set of rights in the area of treatment for children. The legalization will press on

88. Telephone conversation with Gary B. Melton, Carl Adolph Happold Professor of Psychology and Law, University of Nebraska-Lincoln, to Richard E. Spana (Dec. 3, 1987).

89. *See generally* Parham v. J.R., 442 U.S. 584, 628 (1979) (Brennan, J., concurring in part and dissenting in part)(citing Wheeler v. Glass, 473 F.2d 983 (7th Cir. 1973)); New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

once the issue of release and recidivism catches the attention of enough mental health lawyers.

E. The Future of the Juvenile Mental Health System

Some of the most pervasive problems plaguing juveniles are substance abuse, eating disorders, suicide, delinquency, depression, and school-related problems such as underachievement. Despite the vast differences in the causes of these behavioral and mental problems of childhood and adolescence, it is conceivable that youth seeking help for all of these problems could be labeled "mentally ill" and committed to the same "treatment" program.

Such mislabeling and defective placement might happen for several reasons, some of which have been discussed previously. Personnel who first come into contact with troubled youth, such as those within the school systems and law enforcement agencies, may lack the training to distinguish between the manifestations of mental illness and other behaviors that might be nonconforming but that do not indicate mental illness. That some of these mislabeled juveniles are wrongfully committed to mental institutions is also the product of parental willingess to abandon their "problem" children and of the need to fill vacant psychiatric beds.

Perhaps key to this mistreatment of juveniles is the fact that the definition of mental illness that has occurred in the "adult" mental health system has not occurred for juveniles. Statutes have defined mental illness and provided criteria for commitment to mental health facilities. However, even with the best of such statutes, their effectiveness for juveniles is suspect, not because the acts are faulty, but because they have not been defined specifically to respond to the needs of juveniles, and because the very refinements in definition that the laws do make are not observed. For instance, the Florida Mental Health Act defines mental illness as:

> an impairment of the emotional processes, of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology; except that for the purpose of this act, the term does not include retardation or developmental disability. . ., simple intoxication, or conditions manifested only by antisocial behavior or drug addiction.[90]

The definition of mental illness in the first part of this provision seems straightforward enough to apply effectively to juveniles. It is those who should fall in the exceptions, however—the slow learner; the drunken juvenile who is acting out; the "incorrigible," defiant, or repeat runaway; the chronic truant; and the youth "tripped out" on drugs—who end up committed to mental institutions in violation of

90. FLA. STAT. § 394.455(3) (1987).

statutes like the Florida act. Moreover, the abuse is magnified when the treatment facility is totally unprepared to help these juveniles, particularly those who have been committed against their will and who consciously or unconsciously resist whatever help is offered.

It appears as though one of two processes will inevitably take place: 1) there will emerge a juvenile mental health system that abides by the mandates of existing laws in a way that specifically serves the needs of juveniles, including diagnosis, placement, and treatment; this would, of necessity, require the system to address the needs of those groups excepted under statutes like the Florida act; or 2) practitioners' misdiagnoses, improper placement, and ill-treatment or nontreatment will continue both for mentally ill juveniles and for those improperly labeled as mentally ill. As demonstrated above, this second outcome will eventually produce the legalization of the system, to protect juveniles' commitment and treatment rights and their rights following deinstitutionalization.

F. Summary

These best and worst scenarios, similar to the ones advanced for the adult mental health system, might seem a simple choice for well-meaning mental health practitioners. However, choosing the first option is fraught with problems of interpretation of definitions, attitudes toward mental illness, inadequate funding for facilities, the phenomenon of "throwaway" kids (forced to leave home because parents are fed up with them), and the societal indifference that has produced few visible advocates for the rights of troubled juveniles. If mental health practitioners are unable to create a workable juvenile mental health system and they leave it to the legislatures and courts to "fix" the current faulty system (or to substitute another for it), they must be prepared to respond to the influx of legislators and judges, and to the consequences of the legal decisions that will be made.

V. CONCLUSION

There is abundant evidence that the criminal justice system is characterized by faulty views of deviance and how to respond to it and by failed policies and procedures. The same can be said about the mental health system. Inductees into these two defective systems are frequently moved within and between them, with expediency apparently the prime reason for movement.

Those concered about the well-being of children need to study the merger of these two systems because there is mounting evidence that the same developmental patterns are well underway in the systems designed to handle juveniles in need of corrective and therapeutic intervention. As professionals seek to serve these troubled juveniles,

they can either develop more workable systems or allow the defective criminal justice model to take further hold.

Legalization of both juvenile systems continues apace. Perhaps correctional personnel and mental health professionals cannot adequately respond to juvenile "deviance." Perhaps it is time for them to admit their inability and to acknowledge that only the legal community can effectively safeguard the rights of a powerless and defenseless group with few advocates. Professionals can either take control and make reforms or mimic the criminal justice system and await the increasingly heavy hand of legalization.