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Parham v. J.R.: Civil Psychiatric Commitment of Minors

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CASE-COMMENTS

PARHAM v. J.R.: CIVIL PSYCHIATRIC COMMITMENT OF MINORS

In general, the laws and policies of this country affecting minors reflect a judicial effort to protect this special class of individuals from harm inflicted upon them by either themselves or others.[1] Yet, the civil psychiatric commitment procedures for minors are an anomaly and do not reflect this strong judicial effort to protect children. Not only are special procedures absent where children are concerned, but most of the ordinary constitutional safeguards available to adults have been deemed unnecessary by the U.S. Supreme Court when a child faces a deprivation of his or her liberty through psychiatric commitment.

This Comment discusses three aspects of civil commitment of minors: the current commitment procedures approved by the Supreme Court, a comparison between due process requirements for adults and children, and a comparison between commitment of children through the civil system versus the criminal system.

This analysis is followed by recommendations for alternatives, when commitment of a minor is indeed appropriate, in order that involuntary psychiatric commitment may accomplish its goals of benevolent treatment and reintroduction of the child into functioning society.

THE SUPREME COURT'S VIEW

In 1979, after a year and a half of deliberation on the issue, the Supreme Court, in a 5-1-3 decision, established the guidelines under which minors may be committed to state administered mental health care facilities.[2] The

1. For example, persons under the age of sixteen may not drive automobiles because of the inherent dangerousness of the vehicle to themselves and to other drivers on the road. *See* Nebraska *ex rel.* Oleson v. Graunke, 119 Neb. 440, 229 N.W. 329 (1930); Berberian v. Petit, 118 R.I. 448, 374 A.2d 791 (1977). Minors are not held liable for their contracts so as to discourage businessmen from taking advantage of their inexperience in the marketplace. *See* 1A A. CORBIN, CORBIN ON CONTRACTS, 227 at 335 (1963). Special procedures exist within the criminal law system to segregate juvenile offenders from the dangers they would encounter in adult prisons. U.S. v. Frasquillo-Zomosa, 626 F.2d 99 (9th Cir. 1980), *cert. denied*, 449 U.S. 987; U.S. v. Canniff, 521 F.2d 565 (2d Cir. 1975), *cert. denied*, 423 U.S. 1059 (1976).

2. Parham v. J.R., 442 U.S. 584 (1979). This suit was originally filed on behalf of two

issue presented in *Parham v. J.R.* was whether a child facing commitment to a state mental hospital was entitled, under the Constitution, to an adversarial hearing before being hospitalized. The Court referred to three factors which must be balanced in making such a due process analysis: the private interest alleged to be affected by the challenged action, the risk to that private interest by the action and the probable value of additional procedural safeguards, and the governmental interest affected by the imposition of such additional safeguards.[3]

Utilizing these three factors, the Court in *Parham* held that the Constitution does not compel a pre-commitment adversarial hearing for minors.[4] Adequate safeguards of a child's liberty interests were found to exist when a state institution has in place procedures where admission decisions are made by a "neutral factfinder"[5] and where justification for continued care is accomplished through periodic review of the child's mental and emotional status.[6] Unfortunately, the *Parham* decision rests on logical inconsistencies, a misinterpretation of the data, and a blurring of the issues.

The Court began by identifying the child's interest in not being committed as the primary private interest affected by a commitment procedure.[7] Yet, when the balancing equation was written out, the Court concluded that when a child is recommended for psychiatric commitment, the actual private interest in question is a combination of the child's liberty interest coupled with the parents' interests and obligations for the welfare and health of their child. The Court viewed these two separate interests as "inextricably linked."[8] The Court's inclusion of the parents' interest in performing their familial obligations to the child effectively tipped the scale in this delicate balance away from the effect of commitment on the child to the effect of non-commitment of the child on the family.

A focus on parental rights, rather than on the rights of the child facing commitment, is further emphasized in the Court's conclusion that absent a finding of neglect or abuse, parents should be afforded the substantial, if not dominant, role in the decision to institutionalize their children.[9] Yet, the proposed mechanism for determining neglect or abuse of their children —

youngsters, J.R. and J.L. While the suit was pending review by the Supreme Court, J.L. died as an inpatient in the Georgia State Hospital.

3. *Id.* at 599-600 (citing Mathews v. Eldridge, 424 U.S. 319, 335 (1976)).
4. *Id.* at 620.
5. *Id.* at 606.
6. *Id.* at 607.
7. *Id.* at 600.
8. *Id.*
9. *Id.* at 604.

the precommitment hearing — was rejected by the Court.[10] Rather, a child's liberty rights were held to be dependent on a presumption that parents act in the best interests of their children. In performing the *Parham* balancing test in that case, the Court gave greater weight to the privacy interests of the family than to the liberty interests of the child. The Court noted that some families might be dissuaded from seeking psychiatric admission for their children if such care was made contingent on a proceeding which would probe their parental motives or delve into other private family matters.[11] This supposition implies a greater concern for the presumed integrity of the family unit than for liberty interests of any particular individual member of that protected family.

In *Parham*, the Court considered whether a distinction in procedure for commitment should exist between a child who lives with his or her natural parents and a child who is a ward of the state.[12] The majority determined that such a distinction was not necessary and that special procedures were not required for a child who was a ward of the state to protect his individual privacy interest in not being committed. The strongest dissents centered on this issue. It was argued that the presumption that an adversarial hearing need not be performed when a parent volunteers his or her child — because of a tradition that parents act in their child's best interest — fails when the state is seeking to commit a minor. It was recommended by the dissent, but rejected by the majority, that a two-tier system for minors be instituted — one for children living with their parents and one for children who are wards of the state.[13]

The Court did acknowledge that there was some "risk of error inherent in the parental decision to have a child institutionalized."[14] Therefore, *Parham* addressed this concern by setting up a requirement for evaluation of the child by a "neutral factfinder."[15] Yet, the decision upholds, as indicative of "neutral factfinding," admission of a child after evaluation by the psychiatric staff of the same hospital into which admission is sought.[16] Data from 1980

10. *Id.* at 605. The Court characterized the proposed preadmission hearing as "time-consuming procedural minuets." *Id.*

11. *Id.*

12. *Id.* at 617-18.

13. *Id.* at 637. In reaching this position in *Parham*, the Court ignored its earlier decision of *In Re* Gault, 387 U.S. 1 (1967) that held that although the State purports to act in the juvenile's best interests under a parens patriae rationale, the State's good intentions provide no substitute for procedural due process protection. *In Re* Gault, 387 U.S. at 16.

14. *Parham*, 442 U.S. at 606.

15. *Id.*

16. *Id.* The Court established a presumption that state employed mental health professionals are . . . "[c]onscientious public employees [who] implement the State's beneficent pur-

indicate that the median stay for children up to the age of fourteen held in state and county mental hospitals was ninety-two days; for children aged fifteen to seventeen, discharge from the psychiatric hospital, either private or state managed, usually occurred within thirty days.

By contrast, children in the same age groups in private psychiatric hospitals and non-federal general hospitals were discharged in one-half to one-quarter the time.[17] The figures cited above lend strong support to the findings of the groups who filed *amici curiae* briefs in the *Parham* case that hospital administrators may not actually be neutral and detached because of institutional financial pressures to admit a child who may not have need for hospital care.[18]

Perhaps the most egregious error in the *Parham* decision resulted from the Court's abdication of its responsibility to set standards and guidelines for the constitutional deprivation of an individual's, albeit a child's, right to liberty. In this case, a parent's right to volunteer his or her child for psychiatric admission was analogized to the rights of a parent to seek emergency medical admission for a child.[19] Yet, with the exception of suicidal behavior, psychiatric disorders, as opposed to medical emergencies, are rarely immediately life-threatening.[20] Rather, mental and/or emotional disorders tend to impact on the quality of life, as opposed to the continuation of life. Thus, these disorders usually afford mental health care professionals and the family realistic opportunities to make the most beneficial arrangements for the child's therapy without the time constraints notable in medical emergencies.

Further, the Court's denial of pre-admission hearings subjects the rights of liberty and privacy for juveniles to the "vagaries of haphazard application"[21] of unclear criteria and standards. The field of psychiatry, and child psychiatry in particular, is not an exact science. Psychiatric diagnosis is more subjective than medical diagnosis, and, therefore, it is in need of greater judicial review. A psychiatrist can manipulate the symbols and labels of "mental

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poses . . ." and that allegations of other than such behavior could . . . "be dealt with individually." *Id.* at 616.

17. U.S. DEP'T OF HEALTH AND HUM. SERVICES, NATIONAL INSTITUTE OF MENTAL HEALTH, MENTAL HEALTH STATISTICAL NOTE NO. 175 (April 1986). Male children under the age of fifteen are usually held longer than females of the same age; females of and over the age of fifteen are held longer than their male counterparts. *Id.* at 27.

18. *Parham*, 442 U.S. at 616.

19. *Id.* at 603.

20. J. GIBBS, SUICIDE 64 (1968) (Suicide is rare in the extremely young, defined as below the age of ten. In the age group ten to fourteen years, the suicide rate is 1 in 100,000; the rate for the age group fifteen to nineteen then jumps to 5.9 in 100,000. The suicide rate doubles in the age group twenty to twenty-four and steadily increases until age eighty-five).

21. Johnson v. Solomon, 484 F. Supp. 278, 294 (D. Md. 1979).

illness" so that a person is sometimes sick, sometimes not sick. A person may be labeled sick so that medical insurance will pay for his treatment, but not sick so that his employment is not jeopardized. Unlike doctors in other fields of medicine, the psychiatrist has great freedom to shift diagnostic labels, to apply them at one time and not at another, or to apply them for one purpose and not for another.[22]

For example, until 1973, homosexual behavior was considered a treatable psychiatric condition.[23] Indeed, behavior modification and aversion therapies were considered standard practice in the psychiatric field for patients who exhibited even homosexual fantasies. In 1973, however, the American Psychiatric Association altered its view about homosexuality as a "condition," and recommended treatment only when the individual "explicitly states [that his/her homosexuality] has been unwanted, and [is] a persistent source of distress [for him/her]."[24] Moreover, since the newest edition of the psychiatric diagnostic manual was issued, other social behaviors have fallen from grace. Insurance companies now pay medical benefits for the "diagnoses" of "alcoholic jealousy,"[25] "non-compliance with medical treatment,"[26] and "caffeine intoxication."[27] In the specialized field of child psychiatry, a person under the age of eighteen may be diagnosed and treated as an inpatient if he or she suffers from "stuttering,"[28] "shyness disorder,"[29] or "oppositional disorder of adolescence."[30]

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22. J. ROBITSCHER, THE POWERS OF PSYCHIATRY 164 (1980).

23. *Id.* at 170. It is interesting to note that prior to 1961, homosexuality was not viewed as a psychiatric illness, but rather was a crime in most states. Thus, we have seen a social behavior first decriminalized, and now, fortunately, declassified from a mental illness to an alternative lifestyle.

24. American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 281 (3rd ed. 1980).

25. *Id.* at 413. This diagnosis is considered a paranoid psychosis, a serious categorization, manifested by jealousy experienced while intoxicated.

26. *Id.* at 333. This diagnosis can be made even in light of knowledge of religious beliefs that preclude compliance with recommended medical treatment, or a "considered decision that the treatment is worse than the illness." *Id.* The DSM-III acknowledges that this diagnosis may be made in the absence of a finding of mental disorder.

27. *Id.* at 160-61. This diagnosis can be made if at least five of the following symptoms are found: insomnia, restlessness, nervousness, excitement, flushed face, stomach complaints, muscle twitching, cardiac problems, periods of inexhaustibility, or water loss. *Id.* The condition is considered an organic mental disorder, a condition directly attributable to a brain defect rather than an emotional or psychological disturbance.

28. *Id.* at 78-79. Stuttering is included as a diagnosis because of the possibility that the affected person may suffer from "teasing and social ostracism by peers [which] may result in impaired peer relations . . . [or] academic difficulties if [the child] avoids speaking in class." *Id.*

29. *Id.* at 53-54. This condition is characterized by "persistent . . . shrinking from contact with strangers . . . [and] a clear desire for affection and acceptance." *Id.* These children, according to the DSM-III, are unassertive and lack self-confidence.

30. *Id.* at 63-64. This diagnosis may be made if two of the following symptoms are found:

It should be noted that children can be very symptomatic yet suffer from no serious psychological problems. For instance, ninety-five percent of children will develop a phobia, and thirty to forty percent will develop night terrors.[31] Although these behaviors can indeed be very disruptive in a family setting, the decision of whether they are indicative of a mental or emotional disturbance should be made by a psychiatric professional after an examination of the child, but prior to institutionalization and the severe deprivation of liberty that this would entail. Child psychiatrists acknowledge that a relationship may exist between inappropriate juvenile behavior and underlying familial discord.[32] Justice Brennan in his dissent in *Parham* noted numerous studies revealing that parental decisions to institutionalize their children often are the result of a dislocation in the family unrelated to the child's mental condition.[33]

The second prong of the *Parham* due process analysis concerns the risks to a child's liberty interest posed by a wrongful commitment. The Court dismissed the argument that a psychiatric hospitalization may produce adverse social consequences — a stigma — for the child. The Court held that a child is not stigmatized by the commitment, but rather by the symptomatology that led to the commitment.[34]

This holding is inconsistent with the realities of the consequences of psychiatric hospitalization. In a concurring opinion in *Parham*, Justice Stewart echoed the concerns of Justice Brennan, that the "aberrant behavior may disappear, while the fact of past hospitalization lasts forever."[35] For exam-

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violation of minor rules set by parents, teachers or other authority figures; temper tantrums; argumentativeness; provocative behavior; or stubbornness. Using these criteria, almost every child in the United States would be subject to involuntary commitment under *Parham*.

31. W. GOOD AND J. NELSON, PSYCHIATRY MADE RIDICULOUSLY SIMPLE 56 (1984).

32. *Id.* at 60-61. The authors suggest that a "VACUUM" test be employed by psychiatrists when evaluating a child for potential hospital admission:

- V: Violence is often present in the family of a child who has committed an antisocial act (i.e. hurt someone, stolen).
- A: Alcoholism is more common in families with children who exhibit antisocial behavior.
- C: Child abuse is frequently found in his family.
- U: Unempathic parenting often leads to antisocial behavior.
- U: Underprivileged environment may teach a child as well as his family.
- M: Maternal deprivation may cause anger in the child to be vented through antisocial acts.

Clearly the focus here for any potential juvenile admission is to evaluate the family before any successful treatment of the child can be undertaken. *Id.* at 61.

33. *Parham*, 442 U.S. at 632.

34. *Id.* at 601. The Court observed that "[a] person needing, but not receiving, appropriate medical care may well face even greater social ostracism resulting from the observable symptoms of an untreated disorder" (footnote omitted). *Id.*

35. *Id.* at 622 n.3.

ple, a former psychiatric patient is automatically disqualified from state and municipal civil service ranking;[36] many professional schools (even medical schools) may deny a former mental patient admission solely because of his hospitalization history.[37] Many official forms such as applications for employment, driver's licenses, licenses to carry a gun, or voter's registration ask whether the applicant has ever been a patient in a mental hospital.[38] Only one state statute contains a provision prohibiting discrimination against former mental patients; however, the provision only applies to and protects voluntary patients.[39] Further, the Court ignored the fact that childhood and adolescence are formative years, and hence, the effects of an erroneous hospitalization may leave deeper scars on a child than on an adult.

The *Parham* court was concerned that requiring a formalized fact-finding hearing before a child could be admitted to an institution would pose a significant intrusion into the parent-child relationship. The Court analyzed the possible effects of such an adversarial process on the child's return to his home after hospitalization.[40] However, throughout the opinion, the Court neglected to consider the possibility that the pathology attributed to the child may rest rather within the family structure. The dissent urged recognition of studies that revealed that oftentimes committed children are simply scapegoats for deep-seated family conflicts, and urged that the majority's presumption that parents act in their children's best interest is often not applicable in the civil commitment context.[41] Indeed, the dissent offered the opinion that a child who has been ousted from his family has even greater needs for an independent advocate than other persons for whom psychiatric admission is sought.[42] It should be noted that if a child should be erroneously admitted by his parents, no escape mechanism exists for his release; the persons who are authorized to commit the child are the same ones authorized to seek his release in the event of a mistake in hospitalization.[43]

The third prong of the *Parham* due process analysis, the interests of the state, is essentially economic — confining the use of costly mental health

36. T. SZASZ, INSANITY: THE IDEA AND ITS CONSEQUENCES 59 (1987).

37. *Id.*

38. *See generally* B. ENNIS, THE RIGHTS OF MENTAL PATIENTS 85 (1973).

39. New York Mental Hygiene Law § 33.01: "Notwithstanding any other provision of law, no person shall be deprived of any civil right, . . . solely by reason of receipt of services for a mental disability. . . ." *Id.*

40. *Parham*, 442 U.S. at 610.

41. *Id.* at 632.

42. *Id.* at 631.

43. Mabbutt, *Juveniles, Mental Hospital Commitment and Civil Rights: The Case of Parham v. J.R.*, 19 J. FAM. L. 27, 34 (1980-81).

facilities to cases of genuine need.[44] The Court admonished that "[b]ehavioral experts in courtrooms and hearings [rather than in the hospital] are of little help to patients,"[45] and that the cost of additional procedural safeguards would have to come from the monies allocated to the mental healthcare budget from the state legislature.[46] It is interesting to note that the Court failed to consider that the cost of the evaluation of the child's mental status is a constant figure — the same money is expended if the child is interviewed before admission or after. Had the dissent in *Parham* prevailed, the scarce funds allocated for mental health care could be spent more efficiently and productively by providing a diagnosis to the treating psychiatrist at the time of admission rather than at some undetermined point in the future.

The *Parham* decision allows a child to be admitted to a psychiatric hospital solely on the recommendation of his or her parents, and requires only that a "neutral factfinder" perform an evaluation of the child within a reasonable period of time after the hospitalization. It requires nothing more from the state for protection of a child's right to liberty. It should be noted that a child committed by his parents is considered a voluntary admission,[47] while an adult committed against his wishes on the recommendation of a physician or any other person, or by the court, is considered an involuntary admission.[48] It is primarily this fiction in definition that has allowed for the denial of due process rights for psychiatrically committed children.

THE RIGHTS OF AN ADULT FACED WITH INVOLUNTARY COMMITMENT

In a concurring opinion in *O'Connor v. Donaldson*,[49] Chief Justice Burger stated that, "there can be no doubt that involuntary commitment to a mental hospital, like an involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due pro-

44. *Parham*, 442 U.S. at 604-05.

45. *Id.* at 606. *See also* Silverstein, *Civil Commitment of Minors: Due and Undue Process*, 58 N.C.L. REV. 1133, 1140 (1980). However, Silverstein points out that the primary objections to pre-admission hearings come from the mental health professionals, rather than from the legal profession or the families involved in the proceeding. In general, the families fear that an adversarial proceeding will make the rapport necessary for later treatment of the patient more difficult.

46. *Parham*, 442 U.S. at 606.

47. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CAL. L. REV. 840 (1974).

48. *See, e.g.*, ALASKA STAT. ANN. § 47.30.690 (1984); CONN. GEN. STAT. ANN. § 17-205f(a) (West 1988); OFFICIAL CODE OF GA. ANN. § 37-3-20(a) (1982); ME. REV. STAT. ANN. tit. 34-B, § 3831 (1964); MICH. COMP. LAWS ANN. § 330.1415 (West 1988).

49. 422 U.S. 563 (1975).

cess of law."[50] *O'Connor* established that the state's interest in committing an adult must be demonstrated in an appropriate proceeding prior to that commitment.

Equally important, *O'Connor* set a standard — admittedly broad, but a standard nonetheless — for involuntary hospitalization of adults. Under that standard, "no constitutional basis [exists] for confining . . . persons involuntarily if they are dangerous to no one and can live safely in freedom."[51] In *O'Connor*, dangerousness was not equated with eccentricity or nuisance behavior. However, at least one state statute has defined dangerousness so broadly as to include not only an individual's potential for suicide or self-injury, but also his or her inability to exercise self-control, judgment or discretion in the activities of daily living.[52] Similarly, legislation is pending in some states to allow for involuntary commitment of adults if a possibility of dangerousness exists, rather than the current standard of requiring a demonstration of imminent danger of self-injury or injury to others before commitment is authorized.[53]

An adult facing involuntary commitment is entitled to an adversarial hearing in which the necessity for hospitalization must be established by at least clear and convincing evidence; some states require the mental illness to be proven beyond a reasonable doubt.[54] Further, in an involuntary commitment proceeding, an adult is entitled to fair notice of the hearing, to counsel to represent his liberty interest, to the opportunity to offer evidence of his own, and to cross-examine witnesses against him.[55]

An involuntarily admitted adult does not leave his constitutional rights at the hospital admission office. Once the need for hospitalization has been

50. *Id.* at 580.

51. *Id.* at 575.

52. *See, e.g.*, N.C. GEN. STAT § 122C-3(11) (Supp. 1986) which defines dangerousness to oneself to include a demonstrated inability "to exercise self-control, judgment, and discretion in the conduct of [one's] daily responsibilities and social relations, or to satisfy the need for nourishment, personal or medical care, shelter or self-protection and safety" (footnote omitted).

53. N.Y. Times, Dec. 9, 1986, at C1, col. 1. The legislation pending in New York would make it possible to commit persons who are unable to provide for basic needs such as shelter, or would suffer "severe and abnormal mental, emotional or physical distress" if they are not hospitalized. *Id.* The new law is expected by psychiatrists to allow for hospitalization to prevent future mental deterioration, as compared with the current involuntary commitment legislation which requires a demonstration of present dangerousness. The state of Washington adopted such legislation in 1979 and studies reveal that the number of involuntary commitments in that state almost doubled by 1981.

54. *See, e.g.*, MICH. COMP. LAWS ANN. 330.1465 (West 1980); MO. STAT. ANN. § 632.335(4) (Vernon 1988); OHIO REV. CODE ANN. § 5122.15(B) (Anderson 1989); VT. STAT. ANN. TIT. 18 § 7616(b) (1987); W. VA. CODE § 27-5-4(j)(3) (1986).

55. Vitek v. Jones, 445 U.S. 480, 494-95 (1980).

determined through a judicial hearing, due process further requires that the adult "receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition."[56] Additionally, at any time during the hospitalization, an adult may make application for release which must be reviewed by the hospital.[57] If at the time of application for release, the adult is not considered dangerous, he must be released. His release is not contingent upon the completion of any prescribed therapy.[58]

No such release mechanism exists for children committed involuntarily. Rather than imposing specific guidelines for release of children, the Court in *Parham* relied on periodic staff reviews of the child's mental status to safeguard the child's right to a speedy release; the period for review, however, remained undefined. As noted previously, the state statutes that allow parents to volunteer their children for psychiatric treatment also allow the parents to voluntarily terminate that treatment.[59]

The current trend in psychiatric hospitalization of adults is "de-institutionalization."[60] Under this plan, adults are kept in hospitals only until they are no longer dangerous. Crisis management has become the goal of involuntary hospitalization, with treatment of underlying problems being reserved for voluntary patients. Due in large part to "de-institutionalization," from 1969 to 1983, the numbers of persons hospitalized per 100,000 population dropped from 859.1 to 799.1.[61] Yet, between 1980 (the year following the *Parham* decision) and 1984, a period during which psychiatrists have claimed that pharmacological treatment of mental illness has made dangerousness easier to control and made hospitalization of otherwise dangerous adults largely unnecessary, adolescent admissions to mental facilities increased more than 350%, from 10,765 to 48,375.[62]

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56. Connor v. Donaldson, 442 U.S. 563, 572 (1975).

57. *See, e.g.*, MICH. COMP. LAWS ANN. 330.1465 (West 1980); MO. STAT. ANN. § 632.335(4) (Vernon 1988); OHIO REV. CODE ANN. § 5122.15(B) (Anderson 1989); VT. STAT. ANN. tit. 18 § 7616(b) (1987); W. VA. CODE § 27-5-4(j)(3) (1986).

58. Release standards generally are defined in terms of an absence of the condition that brought on commitment, i.e. dangerousness. *See, e.g.*, MICH. COMP. LAWS ANN. 330.1465 (West 1980); MO. STAT. ANN. § 632.335(4) (Vernon 1988); OHIO REV. CODE ANN. § 5122.15(B) (Anderson 1989); VT. STAT. ANN. tit. 18 § 7616(b) (1987); W. VA. CODE § 27-5-4(j)(3) (1986).

59. Mabbutt, *Juveniles, Mental Hospital Commitment and Civil Rights: The Case of Parham v. J.R.*, 19 J. FAM. L. 27, 34 (1980-81).

60. Comment, *Bitter Freedom: Deinstitutionalization and the Homeless*, 3 J. CONTEMP. HEALTH L. & POL'Y 205 (1987).

61. U.S. DEP'T OF HEALTH AND HUM. SERVICES, MENTAL HEALTH-UNITED STATES 34 (1987).

62. T. SZASZ, INSANITY: THE IDEA AND ITS CONSEQUENCES 108 (1987).

COMMITMENT OF "CRIMINALS" VERSUS CIVIL COMMITMENT

Because of the substantial liberty interest at stake, no one, adult or child, may be imprisoned without due process of law.[63] While in criminal proceedings a child's due process rights may attach somewhat later than do those of an adult, many federal and state courts have held that detained juveniles have constitutional rights. These rights are comparable to the rights of a detained adult, calling for a probable cause determination prior to continued detention.[64] One court has extended this protection to non-detained juveniles as well.[65] Some courts have found that, for children, a right to a hearing to determine probable cause logically implies a right to counsel.[66] However, regardless of when the right to due process protection attaches for juveniles, it is important to note that children who are accused of committing crimes and who face possible criminal punishment are entitled to a hearing, a lawyer, and to have evidence presented on their behalf.[67] This concept is in stark contrast to the Court's holding in *Parham*, where no such due process rights attach to a child volunteered by his parents or guardian even after being committed to a mental hospital.

In 1966, thirteen years before the *Parham* decision, the Supreme Court considered the rights of juvenile delinquents facing incarceration in a mental hospital. The holding of *In Re Gault*[68] made clear that when incarceration in an institution may result, "it would be extraordinary if our Constitution did not require the procedural regularity and exercise of care implied in the phrase 'due process.' "[69] In *Vitek v. Jones*,[70] the Court held that the involuntary transfer of a prisoner to a mental hospital implicates a liberty interest protected by the due process clause.[71] Interestingly, in *Vitek*, the Court considered the stigma that may attach to a prisoner who is transferred to a mental hospital as a factor when determining his due process rights before that transfer.[72] Yet, the concept of a stigma from psychiatric hospitalization for a child volunteered against his or her wishes was dismissed by the *Parham* Court.[73]

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63. U.S. CONST. amend. V.
64. R. HORWITZ, LEGAL RIGHTS OF CHILDREN 430 (1984).
65. Brown v. Fauntleroy, 442 F.2d 838 (D.C. Cir. 1971).
66. *See, e.g.*, T.K. v. State, 126 Ga. App. 269, 190 S.E.2d 588 (1972); Doe v. State, 487 P.2d 47 (Alaska 1971).
67. R. HORWITZ, *supra* note 64, at 439.
68. 387 U.S. 1 (1967).
69. *Id.* at 31.
70. 445 U.S. 480 (1980).
71. *Id.* at 487-88.
72. *Id.* at 494.
73. *Parham*, 442 U.S. at 601.

A person accused of a crime who suffers from a mental disease or defect at the time the crime was committed has the option of raising a defense of insanity at his trial. Even if mental disease or defect could be proven beyond a reasonable doubt, the accused is not required to plead the insanity defense.[74] Psychiatric detention does not carry with it a finite sentence as does a prison term. Release from a psychiatric admission, as an alternative to a prison sentence, is dependent solely upon subjective findings of the staff psychiatrists as to the convict's recovery. This is the same criteria used in the determination of release for any involuntary psychiatric patient.[75] For this reason, it is common for defense counsel not to put the insanity question into issue.[76] Issues of unreasonable punishment have also been raised by defendants facing psychiatric hospitalization because of the poor conditions of state mental hospitals.[77]

RECOMMENDATIONS FOR IMPROVING THE SYSTEM FOR COMMITMENT OF MINORS

Need for Diagnosis Before Treatment

Due process has been held to require that the nature and duration of the commitment bear some reasonable relation to the purpose for which the individual is committed.[78] Logically, in order to determine the reasonable duration of psychiatric hospitalization, one must first determine the purpose for that hospitalization. *Parham* makes that first step of a proper diagnosis completely unnecessary in the case of minors who are admitted for psychiatric treatment against their wishes. An analysis of the economic effects of requiring pre-admission hearings to determine the need for psychiatric hospitalization of a child (in light of the information available from the admitting parents) led the *Parham* Court to conclude that in the face of limited resources, the benefit to individuals from such an additional safeguard was substantially outweighed by the cost of providing such protection.[79]

Unfortunately, the current data available on the costs of mental health care does not support the Court's conclusion. In 1980, twenty-three percent of all persons under the age of eighteen admitted for inpatient psychiatric

74. W. LAFAVE AND A. SCOTT, CRIMINAL LAW § 4.5 (2nd ed. 1986).

75. Habeas corpus proceedings may be maintained by the person, criminally or civilly committed, to show that he has regained his sanity. 21 ALR 2d 1004, 1006.

76. A. GOLDSTEIN, THE INSANITY DEFENSE 20 (1967).

77. Lynch v. Overholser, 369 U.S. 705 (1962).

78. Jackson v. Indiana, 406 U.S. 715, 738 (1972); *See also* Bell v. Wayne County General Hosp., 384 F. Supp. 1085, 1096 (E.D. Mich. 1974).

79. *Parham*, 442 U.S. at 605-06 (citing Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267, 1276 (1975)).

services were hospitalized for less than one week.[80] Most states, while they do not require a pre-admission diagnostic hearing, do require an evaluation at some point during the hospitalization.[81] It would appear that some youths may be "warehoused" in these institutions until such time as a diagnostic hearing finally reveals that there was no need for their hospitalization in the first place. Since a psychiatrist must perform an evaluation of the child at some point in the hospitalization process, either before the child is admitted for care or at some time afterward, the dollar figure for evaluation is therefore a constant one. The issue then should be when those dollars are best spent. It is the opinion of this author that the most efficient use of these scarce funds is made when the diagnosis is determined prior to admission.

Figures indicate that in 1979, on average, a state spent approximately $70.00 per day to maintain a person as an inpatient in a mental hospital.[82] This figure of $70.00 represented a twenty-five percent increase in costs from 1977, just two years previous.[83] Extrapolating these figures, an erroneous admission caught early in the hospitalization process (within a week) would cost an institution the unnecessary amount of $490 ($70.00 per day times seven days). Justice Brennan, dissenting in *Parham*, cited figures from 1975 that indicated that only thirty-six percent of patients below the age of twenty confined at St. Elizabeth's Hospital in Washington, D.C. actually required psychiatric hospitalization.[84] Clearly, then, it is in the state's own best economic interests to screen potential state-supported hospital residents in order to prevent expenditures of state funds for unnecessary patient care and maintenance.

Diagnosis before admission is cost effective from another perspective as well. Assuming that a treatable mental health condition is determined to be present, different medications and therapy modalities are required for different psychiatric conditions. Certainly, no effective treatment can be accomplished in the absence of an understanding of the underlying condition.[85]

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80. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, NATIONAL INST. OF MENTAL HEALTH, MENTAL HEALTH STATISTICAL NOTE NO. 175 at 26 (1986).

81. *See, e.g.*, CALF. WELF. & INST. CODE § 5151 (West Supp. 1989); COLO. REV. STAT. § 27-10-105(b)(2) (1973 & Supp 1978); KAN. STAT. ANN. § 59-2908(a) (1978); ME. REV. STAT. ANN. tit. 34-B, § 3863(2) (1964); N.H. REV. STAT. ANN. § 135-B:23 (1983); R.I. GEN. LAWS, § 40.1-5-6(4) (1984); TENN. CODE ANN. § 33-3-602(1) (1984).

82. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, NATIONAL INST. OF MENTAL HEALTH, MENTAL HEALTH STATISTICAL NOTE NO. 162 at 21 (1983).

83. *Id.*

84. *Parham*, 442 U.S. at 629.

85. *See* Rennie v. Klein, 462 F. Supp. 1131, 1139 (N.J.D.C. 1978). Here, the court stated, "Obviously, before drugs can be prescribed [the] plaintiff's condition must be known." *Id.*

Until a diagnostic work-up is at least initiated, no effective treatment for that condition can even be contemplated.

"A person confined against his will at a state mental institution has 'a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.' "[86] Certainly, then, if children are to be given the same opportunities as adults for treatment and release into society, then hospital administrators and the judiciary should not abdicate their responsibilities to these children in need by postponing the initial diagnostic process.

In the case of children with purported mental or emotional disorders or disturbances, the need for pre-admission evaluation of the situation is even more critical than with adults. The *Parham* Court considered the effect an adversarial hearing might have on family dynamics once the child is returned to the family after successful hospitalization, and determined that the potential for family disruption outweighed the child's right to such a hearing. In making this determination, however, the Court failed to consider the fact that family therapy is frequently an essential treatment modality for children with mental or emotional problems. Indeed, significant childhood pathology is often merely a manifestation of problems within the family unit rather than a product of a particular child's physiology.[87] Unless incarcerated beyond the age of majority, a child admitted for psychiatric treatment must be returned to the family who committed him against his wishes. Certainly, every effort should be made to deal with any problems that a child may have in the family setting before the more drastic step of separation and hospitalization is undertaken.

No Distinction Between Criminal and Civil Incarceration

"Nowhere in the Constitution is the requirement of due process limited to criminal matters."[88] A commitment of any kind, whether to a prison for an alleged infraction of the law or to a mental hospital for a presumed mental illness, constitutes a significant deprivation of liberty for the individual and, as such, it requires due process protection.[89] The constitutional safeguards of due process should attach whenever the likelihood of incarceration exists

86. 422 U.S. 563, 572 (1975) (citing the appellate court opinion). On review, the Supreme Court did not address this issue.

87. A. Bry, Inside Psychotherapy 87-102.

88. Mabbutt, *Juveniles, Mental Hospital Commitment and Civil Rights: The Case of Parham v. J.R.*, 19 J. Fam. L. 7, 59 (1980-81).

89. *See* Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968); Jones v. U.S., 463 U.S. 354 (1983).

— regardless of the location of that incarceration or the age of the person to be affected.

At the same time the Supreme Court was considering *Parham*, the District Court of Maryland was considering *Johnson v. Solomon*.[90] The court in *Johnson* refused to distinguish between liberty threatened by criminal proceedings or as a result of civil commitment. The court held that whenever a "state undertakes to act in *parens patriae*, it has the inescapable duty to vouchsafe due process,"[91] which was defined to include both legal counsel and a commitment proceeding.[92] Other states are beginning to follow the *Johnson* lead in finding that a state's role in the commitment process establishes state action sufficient to invoke federal due process protection.[93] One state has gone so far as to declare unconstitutional a commitment procedure that allows the admitting hospital to be the "neutral factfinder" when determining whether or not to accept a minor for inpatient treatment.[94]

No Distinction Between Adult and Juvenile Commitment Standards

The current standard under which an adult may be involuntarily committed to a mental hospital is one of "clear and convincing evidence of imminent danger to oneself or to others."[95] Even the proposed legislation in New York to reduce the evidentiary requirement to a showing of only a "potential for danger"[96] provides greater protection to the adult than does *Parham* which requires no precommitment standard at all.[97] An admission standard for children that merely requires some evidence that benefit might be obtained from psychiatric treatment leaves open a floodgate for admissions that

90. 484 F. Supp. 278 (D. Md. 1979).

91. *Id.* at 286.

92. *Id.*

93. *See, e.g.*, P.F. v. Walsh, 648 P.2d 1067 (Colo. 1982).

94. *Id.* at 1072. The court held that "[g]iven the substantial liberty interest at stake and the risk of an erroneous admission decision, . . . the hospital, as the party ultimately responsible for determining whether a child will be admitted, cannot be delegated the legislative responsibility for defining the admission standard." *Id.* The *Walsh* court's refusal to allow the hospital discretion as a "neutral factfinder" was due to the Colorado legislature's failure to provide standards or limits in the admission statute to guard against arbitrary and inconsistent application of the admission criteria. A similar criticism was made by the appellants in Parham regarding the imprecise Georgia commitment criteria for children.

95. *See, e.g.*, MICH. COMP. LAWS ANN. 330.1465 (West 1980); MO. STAT. ANN. § 632.335(4) (Vernon 1988); OHIO REV. CODE ANN. § 5122.15(B) (Anderson 1989); VT. STAT. ANN. TIT. 18 § 7616(b) (1987); W. VA. CODE § 27-5-4(j)(3) (1986).

96. N.Y. Times, Dec. 9, 1986, at C1, col. 1.

97. *See Parham*, 442 U.S. at 584.

would be precluded under the standard used to consider adults for admission.

It is understood by the psychiatric profession that effective therapy is often dependent upon the cooperation of the patient. Rarely are psychiatric or psychological conditions wholly treatable or curable by drugs alone.[98] Pharmacological intervention is used to better prepare a patient for the individual, group or family sessions that require the participation and cooperation of the patient.[99] While a pre-admission hearing has the potential to temporarily disrupt the cohesiveness of a family, it has greater potential to aid the child in understanding his or her need for hospitalization. A child who initially rejected the idea of his need for help may better understand his problem and appreciate the willingness of others to help him if he is given an opportunity to participate in the decision to get help. Conceivably, a child's initial participation in his hospitalization process may pave the way for participation in his recovery process.

"Constitutional rights do not mature and come into being magically only when one attains the age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights."[100] The *Parham* Court erred in treating the liberty interests of a child differently from those of an adult. Under medical circumstances which lend themselves to exact diagnoses, a parent's right to care for his child is less of a judicial concern. However, when incarceration for an indefinite period of time is at stake, the deference to parents should be withdrawn and children given the same protection of their constitutional liberties as adults.

LEAST RESTRICTIVE ALTERNATIVE

Assuming that commitment of children would be accomplished under the same standard of dangerousness used for adults, due process would then provide that a state cannot constitutionally confine a non-dangerous individual, adult or child, who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.[101] In the instance of a child deemed to be emotionally or mentally disturbed, but

98. L. COLEMAN, THE REIGN OF ERROR 151 (1972).

99. J. EWALT, PRACTICAL CLINICAL PSYCHIATRY 338 (1957).

100. *Parham*, 442 U.S. at 627.

101. Connor v. Donaldson, 422 U.S. 563, 576 (1975). Even more recently, the D.C. Court of Appeals reversed an adult psychiatric commitment where the court was not satisfied that the trial court had looked into less restrictive alternatives. The court held that "the idea of requiring the least restrictive appropriate treatment is based on the notion that government should not restrict the freedom of its citizens to any greater degree than the community needs require." *In re* Stokes, No. 85-1249 (D.C. Cir. July 13, 1988).

not dangerous to himself or others, due process would seem, therefore, to require something short of the radical deprivation of personal liberty that hospitalization entails. In such a situation, this author would recommend the two-tier system alluded to by the *Parham* Court, but for a different purpose.

When a child is living at home with his natural parents or guardian, facilities for outpatient therapy should be provided in lieu of inpatient treatment and indefinite hospitalization. From an economic perspective, the costs for outpatient treatment would be less. The same therapy could be provided without the daily "bed and board" expenses. Simultaneously, those persons who influence and interact with the child, and with whom the child must interact as well, generally his parents and siblings, will be able to participate in his recovery. Teaching a family how to cope with a mentally or emotionally disturbed child, or teaching a child how to cope with a disturbed family, may significantly reduce the possibility of the child's need for future therapy.

When a child is a ward of the state, however, the support group provided by the family is missing. In these cases, if the child is determined not to be dangerous, group homes may offer a greater opportunity for the child's recovery. If the goal of psychiatric treatment is to return the child to functioning society, providing a "society" for the child may be therapeutic in itself. Admittedly, group homes, especially for those stigmatized by society, are difficult to establish within the community. Yet, with the proper public relations and societal acceptance of its responsibility for its less fortunate members, these group homes may prove to be workable alternatives to the asylum.

For those children, living at home or as wards of the state, who are determined at the appropriate pre-admission hearing to be dangerous, hospitalization should not signal an end to their due process protection. Procedures should be implemented whereby a child has the same opportunity to request a discharge hearing as his adult counterpart in the same institution. Justice Brennan in *Parham* cited an alarming a 1979 National Institute of Mental Health study that estimated that one in every four children admitted to state hospitals can anticipate being permanently hospitalized for the next fifty years of their lives.[102] Failure to provide safeguards for these children amounts to a form of child abuse by the judicial system, and further results in the exorbitant waste of scarce mental health funds expended to needlessly confine these persons.

102. *Parham*, 442 U.S. at 634, n.21.

CONCLUSION

The issue of involuntary psychiatric commitment provides the courts with a difficult balancing test. On one side of the scale is an individual's right to be different, his personal autonomy and his right to be free from restrictions on his liberty. On the other side of the scale is society's right to be protected from dangerous persons and a deeper responsibility to take care of those less fortunate members of society who cannot properly care for themselves. When adults are the potential psychiatric patients, the courts have weighted that scale in favor of personal autonomy and have only allowed commitment after an appropriate judicial hearing in which a person has been demonstrated to be dangerous to themselves or to society. The Court in *Parham v. J.R.* was faced with a similar balancing test; the only distinguishing factor in that case was the age of the potential patient. The *Parham* decision was a poor one. The issue is not one of age, but rather of personal dignity. It is important for the state to have in place procedures and facilities to help persons with mental disabilities, but those procedures and facilities should be available to everyone similarly afflicted, and not dispensed differently because of the age of the patient. Certain persons should not be forced to make use of these facilities merely because of their age. Adequate due process safeguards for children will not make mental health care any less accessible to those children who need it. Rather, by potentially reducing the numbers of children in state mental hospitals to only those who truly require those restrictive services, the scarce mental health resources will be more efficiently utilized, and society's beneficent goal of helping its less fortunate children will be better accomplished.

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