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CIVIL COMMITMENT OF MINORS: DUE AND UNDUE PROCESS†

ELLIOT M. SILVERSTEIN††

In recent years, the legal system has become increasingly involved in overseeing mental health care. In this Article, Dr. Silverstein, a lawyer and clinical psychologist, analyzes the effect of this legal monitoring on the mental health system's treatment process, particularly its effect on the treatment of minors. Dr. Silverstein first traces the growing intervention of the legal system in the commitment and treatment of mentally ill minors and then, from a clinical standpoint, sets out the problems caused by legal intervention. Dr. Silverstein believes that from a clinical vantage point recent changes in mental health laws, for the most part designed to afford due process safeguards to minors, are fundamentally misdirected and not mandated by recent Supreme Court decisions. He believes that the effect of the legal intervention is not to help but to harm the minor by making treatment more difficult and thus less likely to succeed. Dr. Silverstein concludes that if society continues to permit civil commitment of minors, state legislatures, instead of imposing stringent due process requirements on the mental health system's commitment and treatment processes, should work with the mental health system to improve the quality of treatment by increasing expenditures to state mental health facilities.

There has been no more important change in the delivery of mental health care services in recent years than the growing involvement of the legal system in that process. Changes in mental health statutes, important judicial decisions, and the large scale emptying of our mental institutions are all testaments to the major impact of the growing legal involvement on the adults, adolescents, and children being serviced by the mental health system. These changes have not been limited merely to procedural safeguards regarding the institutionalization of individuals in need of mental health care, but have involved the gamut of services provided by the mental health system.¹ Perhaps the

† This Article combines two earlier articles. One, entitled *Emotionally Disturbed Adolescents and the Law: Implications of Current Legal Trends on Residential Treatment*, appeared in 4 NEW DIRECTIONS FOR MENTAL HEALTH SERVICES: COPING WITH THE LEGAL ONSLAUGHT 47 (1979). The other, entitled *Civil Commitment of Minors in North Carolina: The Case for Change*, appeared in 9 N.C.J. OF MENTAL HEALTH 1 (summer 1980).

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1. The legal system's imposition of procedural safeguards on the mental health system's

biggest shift, however, has been in the attitude of clinicians toward their craft and their increasing sense of helplessness, frustration, and defensiveness. Many mental health professionals tend to feel that changes mandated by courts and legislatures are imposed externally by those who are insensitive, unsophisticated and perhaps even hostile to clinical realities.

In exploring the ramifications of these changes and the current trends on the treatment of mentally disturbed adolescents, four propositions will be advanced. First, while there may be excellent reasons to question the efficacy, morality and theoretical underpinnings of the mental health system in general and involuntary civil commitment in specific, it does not necessarily follow that wise reform will come from allowing the legal system to dictate any necessary changes. Second, there is an overwhelming likelihood that further legal involvement will change the course of adolescent mental health treatment. Third, from a clinical standpoint, the prevalent legal reforms are fundamentally misdirected, and the safeguards they create provide no real protection to those affected and may, in fact, prove an insurmountable detriment to the treatment process. Fourth, those teenagers who will suffer the most are those with the fewest emotional and economic resources. Yet, paradoxically, it is just this group of severely disturbed and disturbing youngsters that legal reforms are apt to try to "protect" from the mental health system.

INSTITUTIONALIZATION OF JUVENILES

Since changes in mental health laws for juveniles have been patterned after changes in criminal procedure in juvenile cases, it is helpful to examine those changes first. The basic philosophy of the legal system in dealing with juveniles has been very different from that in dealing with adults. Beginning in 1899 with the first juvenile court in Cook County, Illinois, the goal of the juvenile justice system was to offer the adolescent "individualized justice and treatment rather than

commitment process is of course an obvious indication of the involvement of the legal system in the area of mental health care. See generally A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 51-59 (1975); *Constitutional Law: Due Process, The Supreme Court, 1978 Term*, 93 HARV. L. REV. 62, 89-99 (1979). The legal system's impact, however, is felt in a variety of other ways. For example, malpractice suits filed against mental health care practitioners, the burdensome rules promulgated by various "watchdog agencies", see, e.g., 42 U.S.C. § 1395ff (1976), and judicial decisions that set guidelines for many aspects of the treatment process, see, e.g., *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972), modified *sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), all serve to inject the legal system into the process of treating individuals in need of mental health care.

impartial justice and punishment.”² Therefore, instead of being dealt with as a criminal, the minor was committed for treatment in a civil proceeding. In addition, hearings were often conducted informally and secretly in an effort to spare the juvenile embarrassing publicity. Since the goal was to insure help for the child, the standard of proof of guilt was not the same as with adults, and offenses such as truancy, talking back to one’s parents, or incorrigibility could draw potentially lengthy sentences.

As a result of their supposed *parens patriae* function juvenile courts were accorded substantial latitude and authority. Juveniles coming before a juvenile court judge were to be helped instead of punished. On this theory, juveniles who were institutionalized for what would be criminal offenses if committed by adults were sent not to prison, but to so-called “reform” or “training” schools. The goal of such special treatment was to temper the severity of the traditional criminal justice system. There has been a growing suspicion, however, that this *parens patriae* function, instead of providing wayward youth with rehabilitation, has unfortunately “served society only as an old-fashioned jailor.”³ As a result, the juveniles received the worst of both worlds: they were stripped of many of the due process safeguards accorded adults, and were often thrust into brutal and punitive state institutions.

Another problem endemic to the juvenile justice system was the lack of real dispositional alternatives. For example, in many states, juvenile statutes did not differentiate between neglected and delinquent children in describing the judge’s dispositional alternatives.⁴ As a result, youths with very different needs and very different backgrounds would end up in the same facilities. The system then adequately helped neither the most seriously delinquent nor the more mildly troubled. In addition, lack of a broad spectrum of services, overcrowding in existing facilities, and lack of training of those supposedly servicing the juvenile all combined to create conditions mirroring some of the problems of adult corrections.

This disparity between the theory and practice of the juvenile justice system is illustrated by the facts of the United States Supreme

2. S. HALLECK, *PSYCHIATRY AND THE DILEMMAS OF CRIME* 265 (1967); see generally N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 102-68 (1971).

3. N. KITTRIE, *supra* note 2, at 105.

4. C. FOOTE, R. LEVY, & F. SANDER, *CASES AND MATERIALS ON FAMILY LAW* 444 (1966).

Court's landmark decision in *In re Gault*.⁵ On June 8, 1963, fifteen year old Gerald Gault was taken into custody for allegedly making a lewd phone call to a neighbor.⁶ He was taken by police officers from his home to a detention center while his parents were at work.⁷ No notice was left for his parents of his whereabouts, and at a hearing in the juvenile court judge's chambers the next day, neither Gerald's father nor the complainant were present when the judge questioned the boy.⁸ No transcript or recording was made of the proceedings.⁹ Gerald was released several days later with no further explanation to him or his parents.¹⁰ At a second hearing the following week, a referral report by probation officers was read without the presence of the complainant,¹¹ and Gerald was committed to the State Industrial School "for a period of his minority [that is, until 21], unless sooner discharged by due process of law."¹² Gerald could have been incarcerated for six years.

The Supreme Court's reversal of Gerald's conviction became a milestone in the establishment of legal rights for minors. While the opinion was limited to the adjudicatory stage of the juvenile court process and thus did not consider questions raised by arrest, detention, or disposition,¹³ it did provide for rights in the areas of notice,¹⁴ counsel,¹⁵ privilege against self-incrimination,¹⁶ and confrontation of witnesses available for cross-examination.¹⁷

5. 387 U.S. 1 (1967).

6. The actual communication consisted of moderately suggestive sexual questions. *Id.* at 4. At the time of his arrest, Gerald was still under a six month probation order for being in the company of another adolescent who had stolen a wallet from a lady's purse. *Id.*

7. *Id.* at 5.

8. *Id.*

9. *Id.*

10. *Id.* at 6.

11. *Id.* at 7.

12. *Id.* at 7-8.

13. *See id.* at 13.

14. *Id.* at 31-34.

15. *Id.* at 41.

16. *Id.* at 55.

17. *Id.* at 56. The Supreme Court later expanded its protection of juvenile rights in the case of *In re Winship*, 397 U.S. 358 (1970), in which the Court held that the burden of proof in juvenile cases is the same as that in adult cases—"beyond a reasonable doubt" and not merely "a preponderance of the evidence." *Id.* at 368.

Both these cases, then, do much to involve lawyers with juveniles in order to assure the traditional safeguards of due process. The more traditional adversary system supposedly mitigates absolute discretion by a juvenile court judge. Whether this helps alleviate the ills of the existing system or merely creates different ones is subject to much debate. Obviously juveniles will have a different entry process into the system and more juveniles probably will be kept away from state institutions. This development, however, raises a fundamental question about whether such pro-

CIVIL COMMITMENT OF JUVENILES

Accompanying the significant changes in juvenile court procedures in the past decade have been efforts to similarly revise mental health laws for minors.¹⁸ These efforts, however, have been complicated by the traditional role of parents in our society. For example, parents are often allowed to force or "volunteer" their children for services that the children might not choose for themselves.¹⁹ In addition, it is permissible in most states for parents or legal guardians to "voluntarily" admit their children into a hospital.²⁰ This type of parental prerogative has recently come under vigorous attack. The criticism has been focused on the loss of liberty involved in such "voluntary" hospitalizations and the need for the same type of due process safeguards accorded those subject to the juvenile justice system. Nevertheless, as one commentator has pointed out,

[t]here are three justifications that could be used for forcing hospitali-

cedures merely serve to lower juveniles' sense of self and social responsibility. See N. KITTRIE, *supra* note 2, at 158:

Thus, those seeking to expand the availability of legal services in the juvenile court must shoulder a dual burden: to accord the child his constitutional safeguards while guarding against a diminution of the child's sense of social responsibility, so that the child who requires treatment in his own and in society's interest is not merely turned loose to become the eventual victim of Pyrrhic courtroom victories.

This admonition is even more warranted when discussing changes or potential changes in mental health laws.

18. For a discussion of North Carolina's efforts in this regard, see notes 46-59 and accompanying text *infra*. Most of the legal commentary has been highly critical of leaving commitment decisions to mental health professionals and parents. See notes 24-27 and accompanying text *infra*; Note *The Mental Hospitalization of Children and The Limits of Parental Authority*, 88 YALE L.J. 186 (1978). But see Slovenko, *Criminal Justice Procedures in Civil Commitment*, 24 WAYNE L. REV. 1 (1977).

While the trend toward greater involvement of the judicial system with juveniles is apparent, changes for adults have been even more dramatic. Based on several important judicial decisions, there has been increasing legal involvement in the decision to hospitalize and keep individuals in the hospital. See generally, A. STONE, *supra* note 1. Generally, it has become more difficult to force adults into a mental hospital or keep them there merely because they are "mentally ill." See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Instead, it has been increasingly necessary to demonstrate at a court hearing an "imminent danger to oneself or others" in order to justify civil commitment. See A. STONE, *supra* note 1, at 25-51. One by-product of this trend is the increasing emphasis on voluntary commitments, in which adults can sign themselves into and out of hospitals, obviating the need for a hearing.

19. See generally Bezanson, *Toward Revision of Iowa's Juvenile Commitment Laws: Thoughts on the Limits of Effective Governmental Intervention*, 63 IOWA L. REV. 561, 565-69 (1978).

20. See Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840, 840 n.1 (1974). The term "voluntary" is a misnomer since the admittance is possible with or without the child's consent. Classifying the admittance as "voluntary" allows the circumvention of the court hearing or review that might otherwise be necessary for "involuntary" admissions. Since the parent was acting for and on behalf of the minor, the typical standard for a voluntary admission was thought applicable—presence of "mental illness" and not necessarily "imminent danger." See *id.* at 845-48.

zation on young patients who would not be subject to such commitment if they were adults. (1) Children are not old enough to make a mature judgment about whether they need treatment or not, and therefore someone else must make it for them. (2) Children are subject to the decisions made for them by their parents, and a commitment decision is within the scope of parental authority. (3) Mental disorders are much more tractable when the patient is young, and therefore there is a greater state interest in forcing treatment on mildly ill young persons than on mildly ill adults.²¹

Furthermore, "[t]he autonomy of the natural family unit from external control by the state and others, and the concomitant authority over the conduct of a child, are deeply imbedded values in our society,"²² and have long been "central to the American concept of freedom and individuality."²³ Interference, then, with a joint decision by a mental health facility and parents to commit a child runs contrary to some basic American values and departs from the privileges and responsibilities that parents customarily exercise in raising their children. It is nonetheless argued that commitment to a mental hospital is so serious a step as to justify challenging these parental rights, and that the traditional check against parental excess, the screening by the admitting psychiatrists, is more theoretical than real. As Professor Ellis points out:

Experience shows that in the most blatant cases of parental error psychiatrists do screen out admissions which are not warranted by apparent pathology in the child. In less obvious cases, however, psychiatrists may fail to perform an effective screening function. There are three reasons for this failure: (1) The performance of psychiatrists in precommitment interviews and examinations is often perfunctory and tends toward over diagnosis; (2) Psychiatrists may be insensitive to legally important commitment issues; (3) The effectiveness of the psychiatrist in the admitting process is weakened by uncertainty over whose agent he or she is in such circumstances—the parent's or the child's.²⁴

21. Ellis, *supra* note 20, at 850 n.54. This is especially true when intervention seems to be necessary to prevent graver and more ingrained problems.

22. Bezanson, *supra* note 19, at 565.

23. *Id.* at 566.

24. Ellis, *supra* note 20, at 864 (footnote omitted).

Another criticism is that many states allow legal guardians, such as social service agencies, to act as a parent. This creates the possibility of collaboration or collusion between state agencies, which may consign juveniles to state hospitals for reasons other than treatment. *See generally* Bezanson, *supra* note 19, at 575-79; N. KITTRIE, *supra* note 2. *See also* Szasz, *The Child As Involuntary Mental Patient: The Threat of Child Therapy to the Child's Dignity, Privacy, and Self Esteem*, 14 SAN DIEGO L. REV. 1005 (1977). Thus, some commentators argue that the most effective and objective protection for children would be independent legal counsel. *See* note 18 *supra*.

Underlying this concern with the adequacy of the screening process and the concomitant willingness to challenge the traditional notion of parental autonomy would appear to be two often cited and fundamental criticisms of the mental health system. First, mental health professionals, under the guise of treatment, have allowed and perhaps even fostered execrable conditions in their institutions. Second, the theoretical basis for much mental health care is highly disputed and unproven. There is little unanimity within the profession, and "the present use of [mental health] expertise [in the courtroom] obfuscates moral issues and promotes the mistaken view that the issues that concern the law are primarily scientific in nature."²⁵ These criticisms do much to undercut the credibility of the mental health profession and thereby undermine the rationale for civil commitment. It is not easy to defend involuntarily committing someone to an institution where he will receive inadequate treatment from someone working from what many believe is a theoretically unsound base, and it is hardly persuasive merely to assert that this is for the benefit of the individual without some proof.

The two criticisms, however, are of a very different nature. The first questions the adequacy of treatment, while the second questions even the possibility of adequate treatment. There is clearly a logical linkage between the two since it is only reasonable to expect shoddy treatment from a system without a solid, proven theoretical base. Nevertheless, it is far different for a system's underlying assumptions to be unverified or difficult to prove and quite another for them to be clearly wrong. This distinction is an important one if much of the criticism of the mental health system comes more from a dissatisfaction with actual treatment than from a concern about theoretical deficiencies. If, however, many underlying assumptions about human nature are difficult to prove, it is not likely that an outside observer will be sympathetic to what are defined as clinical needs when faced with evidence of poor or nonexistent treatment.²⁶

25. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 530 (1978). In essence, much of what mental health professionals do is to provide personal care and attempt to engraft a meaningful human relationship on what poses as a technical service. See A. STONE, *supra* note 1, at 13.

26. In fact, it can be argued that the mental health system has gotten itself into needless difficulties by participating in the misuse of civil commitment. For example, one of the traditional rationales for civil commitment has been to relieve society and families of caring for people who are bothersome or eccentric. Stone labels this a "convenience function" and states:

Its implementation all too obviously calls for a macrosocietal policy judgment of a type which a free society is unwilling to confront in an open forum. It is, therefore, a typical instance of the clandestine decisionmaking role of mental health practitioners which al-

Since the promise of treatment has been an empty one for many who have been civilly committed, hospitalization has borne more of a resemblance to incarceration than treatment for a mental disorder. In such circumstances a jaundiced view of the mental health field is somewhat appropriate, and the judicial trend toward providing procedural safeguards paralleling those of the criminal justice system is certainly understandable, even if incorrect. However, identifying a problem is one thing, but it is quite another to impose on the mental health system a method of reform derived from another context. "Surely no one familiar with the American criminal justice system would suggest that it deals effectively with either the problem of crime or of correction. There is, therefore, no reason to hope, *ab initio*, that imposing one terrible system on another will be productive."²⁷

In assessing the impact of applying the same procedural safeguards to the civil commitment process that are used in the criminal justice system, it is important to examine the costs of that application. One obvious economic cost is the time mental health professionals spend on legal matters that is then unavailable for direct care and therapy.²⁸ Another less easily demonstrated cost is the deleterious effect that many clinicians believe due process procedures have on treatment. While it can be argued that a denial of legal safeguards is also damaging to treatment, it is necessary to examine the purpose of a systematic legal scrutiny of civil commitment.²⁹ If the purpose is to protect rights deemed to be so fundamental in a free society that their preservation

lows society to do what it does not want to admit to doing, i.e., confining unwanted persons cheaply.

A. STONE, *supra* note 1, at 46. The plight of the mentally retarded in many jurisdictions provides a striking example of this process. See *Halderman v. Pennhurst State School & Hosp.* 446 F. Supp. 1295 (E.D. Pa. 1977), *modified*, 612 F.2d 84 (3rd Cir. 1979); *New York State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973); *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972), *modified sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

27. A. STONE, *supra* note 1, at 3.

28. Another important consideration is the cost of the entire procedure. For example, in *Addington v. Texas*, 441 U.S. 418 (1979), the jury trial to commit Addington lasted over *six* days, even though Addington did not dispute the State's evidence which showed that he "suffered from serious delusions, that he often had threatened to injure both of his parents and others, that he had been involved in several assaultive episodes while hospitalized and that he had caused substantial property damage both at his own apartment and at his parents' home." *Id.* at 420-21. In addition, there was undisputed expert testimony that the appellant "required hospitalization in a closed area to treat his condition because in the past he had refused to attend outpatient treatment programs and had escaped several times from mental hospitals." *Id.* at 421.

29. See Stone, *The Myth of Advocacy*, 30 HOSP. & COMMUNITY PSYCH. 819 (1979). "Legal advocates for the mentally ill have not been willing to consider seriously the needs of the mentally ill and to formulate those needs as legal rights. Instead they have done the reverse. They have treated rights as if they constituted the needs of the mentally ill." *Id.* at 820.

outweighs any detriments to treatment, then this is a clear moral and legal policy decision and should be recognized as such. If, on the other hand, due process procedures that impose adversarial hearings on the mental health system are designed to protect individuals from shoddy and inadequate treatment, it is important to examine both the nature and effectiveness of this "protection." As will be discussed below,³⁰ judicial decisions, though couched in language of "fundamental rights," may merely result in reducing the effectiveness of the therapeutic enterprise by imposing on the mental health system a cadre of lawyers who can do little to remedy underlying problems.

Significantly, the United States Supreme Court recently has refused to impose the adversary system with its full range of due process requirements on the mental health system. In *Parham v. J.R.*³¹ and *Secretary of Pub. Welfare v. Institutionalized Juveniles*,³² two cases de-

30. See notes 31-60 and accompanying text *infra*.

31. 442 U.S. 584 (1979). This was a suit filed for two minors alleging that they and others similarly situated had been deprived of their liberty without due process by the mental health laws of Georgia, which were similar to those in Pennsylvania in 1966 before all the subsequent Pennsylvania changes. See note 32 *infra*. Under the Georgia statute a minor could be signed into a hospital by a parent or guardian "[i]f found to show evidence of mental illness and to be suitable for treatment. . . ." GA. CODE ANN. § 88-503.1(a) (1979). The only discharge mechanism, in addition to that provided by the hospital before the minor attained the age of eighteen, would be by application of the parent or guardian. *Id.* § 88.503.3. While this statute was in effect, "children [were] institutionalized without a hearing or other procedural safeguards; [were] hospitalized without initial or periodic consideration of placement in the least drastic environment necessary for treatment; and [were] not afforded a hearing at any time to determine an appropriate required time for discharge." *J.L. v. Parham*, 412 F. Supp. 112, 136 (M.D. Ga. 1976).

32. 442 U.S. 640 (1979). *Institutionalized Juveniles* has a rather complex history. The original case, *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), was instituted on behalf of five mentally ill individuals between fifteen and eighteen years old challenging the constitutionality of a 1966 Pennsylvania statute governing voluntary admission and voluntary commitment to state mental health institutions of persons aged eighteen or younger. The statute provided that a juvenile could be admitted upon a parent's application and was free to withdraw only with the consent of the parent admitting him or her. See *Kremens v. Bartley*, 431 U.S. 119, 123-24 (1977).

After the commencement of the suit, the Pennsylvania Department of Public Welfare promulgated regulations that substantially increased procedural requirements with regard to minors thirteen years of age or older by requiring that they be given notification of their rights, the telephone number of counsel, and the right to institute an involuntary commitment hearing. *Id.* at 125. Notwithstanding those changes, however, the district court issued a decision holding those provisions violative of due process. 402 F. Supp. at 1053-54. This decision was appealed to the United States Supreme Court. In July 1976, a year after the district court decision and after the Supreme Court had noted probable jurisdiction to hear the case, a new statute was passed that, in essence, allowed fourteen year olds to be treated as adults. They were allowed to admit and discharge themselves, with parents being restricted to admitting children thirteen or younger. See *Kremens v. Bartley*, 431 U.S. at 126. The Supreme Court thus easily disposed of the case by claiming that all the original plaintiffs (appellees) would now be treated as adults and free to leave the hospital, obviating their demand for a hearing and other procedural protection. They and other mentally ill children over fourteen years of age would now have the same freedom as adults to leave the hospital and not be forced to return without their consent. *Id.* at 128-29. The Court declined to pass judgment on those classes unaffected by the changes in Pennsylvania law; namely,

cided on the same day, the Court reversed two district court decisions involving state statutes that authorized a parent to admit a child to a mental health institution without a formal hearing. While the two cases have a rather dissimilar history, they each raise essentially the same due process questions, and in each case the lower court held the statute to be unconstitutional for failing to provide adequate procedural safeguards for the juvenile during the commitment process.³³ By a

mentally ill children under fourteen and mentally retarded minors under eighteen, *id.* at 129-33, and remanded the case to the district court. *Id.* at 137. On remand, the case was later decided under the name Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30 (E.D. Pa. 1978). See note 33 *infra*.

33. The district court in *Parham* concluded that the statute was unconstitutional and ordered "the defendants to proceed as expeditiously as is reasonably possible (1) to provide necessary physical resources and personnel for whatever non-hospital facilities are deemed by them to be most appropriate for these children, and (2) to place these children in such non-hospital facilities as soon as reasonably appropriate." 412 F. Supp. at 139.

In order to understand the reason for this remedy, it is important to note that the court took pains to examine the type of treatment available to troubled youngsters in Georgia at the time the suit was instituted. *Id.* at 119-26. If a minor could not be placed in a foster home or specialized foster home, hospital confinement was the only service offered by the state. The court observed that a 1973 Study Commission Report indicated that both hospital personnel and the Commission felt that more than half of the hospitalized children and youth would not need hospitalization if other forms of care were available. *Id.* at 122. In the more than two years after the Commission Report and before the undertaking of the lawsuit, the State of Georgia made no effort to establish group homes or other facilities besides hospital treatment despite the fact that such care seemed less expensive. See *id.* at 138. In such circumstances, it is not surprising that a court would order legal redress for the children who could be placed elsewhere. It is also not surprising that a court would look with disfavor on a statutory system that allows a state agency to gain custody of the juvenile and thereby provides the vehicle for what may amount to consignment to a mental institution for the duration of a youth's minority. The district court in *Parham* did not fashion the exact nature of due process protection needed, but drawing strong support from *In re Gault*, 387 U.S. 1 (1967), recognized that due process has traditionally included at least the right, after notice, to be heard before an impartial tribunal. *J.L. v. Parham*, 412 F. Supp. at 137.

Before the Supreme Court ruled on the *Parham* case, the successor to *Bartley* reappeared. When *Bartley* was remanded to the district court in Pennsylvania, there was still the substantive issue of whether the newer Pennsylvania statutory framework was acceptable for mentally retarded minors under eighteen and mentally ill minors under fourteen. The district court, in *Institutionalized Juveniles v. Secretary of Pub. Welfare*, 459 F. Supp. 30 (E.D. Pa. 1978), held that the current statutes were unconstitutional. *Id.* at 47. The majority felt that despite differences between mental retardation and mental illness, the differences did not justify different analyses for due process purposes. *Id.* at 38-39. The majority also stressed the potential for conflict of interest between parent and child, the risks of misdiagnosis, and the stigma of being labelled mentally retarded or mentally ill. *Id.* at 43. To rectify these problems, the majority, unlike in *Parham*, ordered very specific procedural requirements be adhered to before these minors could be committed to a mental health or mental retardation facility. These include: (1) the right to notice; (2) the right to counsel; (3) hearing rights, including an opportunity to be present and to offer testimony, as well as the right to confrontation and cross-examination of adverse witnesses; (4) the right to a probable cause hearing within 72 hours; and (5) the right to have a full commitment hearing within two weeks of the initial admission with a finding by clear and convincing proof that institutionalization is needed. *Id.* at 43-44.

Judge Broderick, in his dissenting opinion, reiterated his fear that the majority had prescribed an "overdose" of due process and was concerned that this might discourage parents from seeking treatment for a child suffering from a mental or emotional disorder. *Id.* at 53. He also questioned the facile way in which the majority lumped mental retardation and mental illness together and

six to three majority in each case, the Supreme Court reversed the rulings of the district courts and held that neither statute violated the Due Process Clause of the Fourteenth Amendment.³⁴

Chief Justice Burger, writing for the majority in *Parham*,³⁵ felt the case essentially involved a balancing of three competing interests: The child's liberty interest, the parent's interest in the welfare and health of the child, and the state's significant interest in properly utilizing its mental health facilities. Using this balancing approach, the Court concluded:

[T]he risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied. That inquiry must carefully probe the child's background using all available sources, including, but not limited to, parents, schools, and other social agencies. Of course, the review must also include an interview with the child. It is necessary that the decisionmaker have the authority to refuse to admit any child who does not satisfy the medical standards for admission. Finally, it is necessary that the child's continuing need for commitment be reviewed periodically by a similarly independent procedure.³⁶

The Court stated, however, that the "neutral factfinder" need not be a lawyer or a judicial or administrative officer, but that "a staff physician will suffice, so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment."³⁷ It is clear that the Court was wary of judicial involvement in commitment decisions and preferred leaving those decisions to the judgment of physicians, who the Court believed to be more skilled than law trained factfinders in ascertaining when a child does or does not need to be hospitalized.

This concern with the burden that would be placed on the mental health system by affording full due process protection to minors during the commitment process was evident when the Chief Justice stated:

As the scope of governmental action expands into new areas creating

could not see how the procedures mandated by the majority would alleviate the alleged conflicts between parent and child, the problem of misdiagnosis, or the alleged stigma attached to mental illness and mental retardation. *Id.*

34. *Parham v. J.R.*, 442 U.S. at 620; *Secretary of Pub. Welfare v. Institutionalized Juveniles*, 442 U.S. at 650.

35. The court's opinion in *Institutionalized Juveniles* is based on standards enunciated in *Parham*.

36. 442 U.S. at 606-07 (citations and footnote omitted).

37. *Id.* at 607.

new controversies for judicial review, it is incumbent on courts to design procedures that protect the rights of the individual without unduly burdening the legitimate efforts of the states to deal with difficult social problems. The judicial model for factfinding for all constitutionally protected interests, regardless of their nature, can turn rational decisionmaking into an unmanageable enterprise.³⁸

In assessing the likely impact of the Supreme Court's decisions in *Parham* and *Institutionalized Juveniles*, several points are worth noting. First, until the Court's opinion in *Parham*, only Judge Broderick's thoughtful dissenting opinions in the lower court in *Institutionalized Juveniles*³⁹ focused on the fundamental issue of whether substantial intervention of the legal system into the civil commitment process would actually do anything to protect the affected juveniles or would merely

38. *Id.* at 608 n.16. The Court also concluded that no different procedures, either preceding or immediately after admission, need be devised for children who are wards of the State. *Id.* at 618-19. With respect to such a minor's need for continuing care, it is possible that different procedures may be applicable for children committed by state appointed guardians, but the Supreme Court left this issue up to the district court on remand. *Id.* at 619. In fact, the whole area of what procedures for review are necessary to justify continuing a child's commitment was left open since the district court did not decide the issue and thus the Supreme Court felt no need to consider it.

Justice Brennan, writing for three justices in dissent, rejected the argument that parents and mental health professionals should be allowed to commit children in this manner. Clearly equating hospitalization with incarceration, he stated:

Children incarcerated in public mental institutions are constitutionally entitled to a fair opportunity to contest the legitimacy of their confinement. They are entitled to some champion who can speak on their behalf and who stands ready to oppose a wrongful commitment The risk of erroneous commitment is simply too great unless there is some form of adversary review. And fairness demands that children abandoned by their supposed protectors to the rigors of institutional confinement be given the help of some separate voice.

Id. at 638-39 (Brennan, J., dissenting).

Similarly, Brennan did not feel that children who are wards of the State should be dealt with in the same manner as children with natural parents. *Id.* at 632. He felt that, with regard to children committed by their natural parents, a hearing prior to hospitalization might deter these parents from seeking needed treatment, and, by challenging parental authority, might make the child's eventual return to his or her family more difficult. *Id.* at 633. For these reasons, a hearing for such children need not be held until after admission. *Id.* A later hearing, by merely involving a conflict between the child's physician and advocate, was not likely to lead to family discord. *Id.* at 635. Brennan could, therefore, see no legitimate state interest suffering as a consequence of such procedures. *Id.* at 636.

On the other hand, Brennan felt that children committed by their guardians should be required to have hearings before commitment. *Id.* at 638. He rejected the idea that these children would be protected from unwarranted commitments merely because their social workers were obligated by statute to act in their best interest. "With equal logic, it could be argued that criminal trials are unnecessary since prosecutors are not supposed to prosecute innocent persons." *Id.* at 637. He concluded that preadmission hearings would not deter state social workers from seeking psychiatric attention for their disturbed clients and saw the decisions of one group of state workers reviewed by another group of state officials as unlikely either "to traumatize the children or hinder their eventual recovery." *Id.* at 638.

39. See *Bartley v. Kremens*, 402 F. Supp. 1039, 1054 (E.D. Pa. 1975) (Broderick, J., dissenting); *Institutionalized Juveniles v. Secretary of Pub. Welfare*, 459 F. Supp. 30, 47 (E.D. Pa. 1978) (Broderick, J., dissenting).

create other problems. Second, as mentioned earlier, the Court concluded that commitment decisions should be considered medical rather than legal matters.⁴⁰ For this view, Burger is likely to draw praise from the mental health community. Finally, the Court felt that an untreated child's abnormal behavior may be more "stigmatizing" than "labeling" the child in need of treatment.⁴¹

While the Supreme Court's decision will not necessitate any changes in current state laws concerning civil commitment hearings,⁴² it is likely to slow the movement toward the imposition of adversary hearings on the civil commitment process. It is, however, not likely to end all efforts toward increasing or maintaining legal involvement in and monitoring of the treatment process. For those who equate hospitalization with incarceration, as does Justice Brennan, legal "champions" are still needed to battle for those "children abandoned by their supposed protectors to the rigors of institutional confinement."⁴³ Because *Parham* dealt only with initial commitment of juveniles, the Court's opinion leaves the way open for proponents of legal interventionism to challenge the later course of hospitalization, including the review procedures used to justify continuing commitment, especially when a less restrictive alternative is arguably necessary.⁴⁴ Unfortunately, from a clinical standpoint, such scrutiny at the later stages of treatment may prove more inherently deleterious than a hearing either immediately before or after admission.⁴⁵

NORTH CAROLINA LAW

Illustrative of the type of rigorous post commitment review procedures that remain unaffected by the *Parham* decision are those existing in North Carolina. Prior to 1975, parents or guardians in North Carolina could sign children into mental hospitals without any judicial hearings. A change occurred, however, following the 1975 case of *In re*

40. "The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgments of physicians in each case." *Parham v. J.R.*, 442 U.S. at 607-8.

41. *Id.* at 600-01.

42. After *Parham*, states are not required to hold legal hearings but are free to do so if they choose.

43. 442 U.S. at 638-9 (Brennan, J., dissenting).

44. Furthermore, both the majority and dissenting opinions leave open the question of whether different standards should apply, at least after the onset of hospitalization, for children not committed by their natural parents. See note 38 *supra*.

45. See notes 61-70 and accompanying text *infra*.

Long.⁴⁶ Today, as a response to the decision in *Long*, both a district court hearing within ten days after a minor's admission to a mental health facility⁴⁷ and periodic rehearings are required.⁴⁸

The facts in *Long* are simple. Michael Long, a fifteen year old, was admitted to the Forensic Unit at Dorothea Dix Hospital on April 2, 1974. He was admitted under the "voluntary" admission procedure applicable at that time, which provided that a parent, a person standing *in loco parentis*, or a guardian could act for a minor and commit him to a mental hospital without a pre or post admission hearing.⁴⁹ Subsequent to his admission a petition was brought in Wake County Superior Court seeking Michael's release. The judge found that Michael's "continued confinement at Dorothea Dix Hospital [was] illegal, in that, he [had] been denied the safeguards provided by the Due Process Clause of the Fourteenth Amendment to the United States Constitution."⁵⁰ The North Carolina Court of Appeals upheld this finding by the lower court stating, "the continued confinement of a minor based on [the voluntary admission procedure] require[d] procedural safeguards consistent with the Due Process Clause. Such procedural due process should be afforded at the earliest possible time after admission."⁵¹ The State had argued that the compulsory examination of a minor within twenty-four hours after admission⁵² provided adequate protection against improvident admission.⁵³ The court of appeals disagreed and pointed to several factors that may have vitiated an effective screening process.

At the initial examination there may be an understandable tendency to "over-diagnose." In other words, a psychiatrist may be predisposed to find illness rather than health at the first examination on the assumption that it is better to err on the side of caution. Also, where the parent admits a child for treatment, the examining doctor may quite naturally identify with the interest of the parent. If either of these happens, the doctor would be unable to act effectively as a

46. 25 N.C. App. 702, 214 S.E.2d 626, *cert. denied*, 288 N.C. 241, 217 S.E.2d 665 (1975).

47. N.C. GEN. STAT. § 122-56.7 (Cum. Supp. 1979) (voluntary admission); *Id.* § 122-58.7 (involuntary commitment).

48. N.C. GEN. STAT. § 122-58.11 (Cum. Supp. 1979). *See generally* this Survey, *Administrative Law: Mental Health: Involuntary Commitment*.

49. *See id.* § 122-56.5 (Cum. Supp.).

50. The text of the trial court's order is set out in the opinion of the court of appeals in *Long*. *See* 25 N.C. App. at 704, 214 S.E.2d at 627.

51. *Id.* at 709, 214 S.E.2d at 630.

52. N.C. GEN. STAT. § 122-56.3 (Cum. Supp. 1979).

53. *See* 25 N.C. App. at 708, 214 S.E.2d at 629.

screening agent at the initial stage of examination.⁵⁴

The court's reasoning is troublesome in at least two respects. First, any prudent person would opt for a cautious approach when faced with a difficult and unclear situation, and mental health professionals have more training to distinguish those in need of hospitalization from those who could be managed outside of a hospital setting. Furthermore, any tendency to "overdiagnose" may be countered by the psychiatrist's pragmatic interest in keeping their census low.⁵⁵ Second is the court's assumption that the psychiatrist rather than the judge will identify with the interests of the parent. The implicit assumption in the court's opinion is obviously that the judicial system is more objective and thus better able to balance the competing interests of all parties. The merits of that assumption are debatable.

In any event, even assuming that the arguments about inadequate screening prior to hospitalization are meritorious, the court should logically opt for requiring a preadmission hearing to address that problem. Instead, the court held that while no preadmission hearing is required, a postadmission procedure is necessary. The court said:

The judicial deference afforded to parental authority along with the parent's interest in being able to seek immediate treatment and the policy of encouraging voluntary admissions outweigh any interest the minor may have in pre-admission hearings. However, the continued confinement of a minor based on that procedure requires procedural safeguards consistent with the Due Process Clause. Such procedural due process should be afforded at the earliest possible time after admission.⁵⁶

The court indicated, however, that it would not formulate a postadmission procedure, but would leave that to the wisdom of the legislature.⁵⁷

54. *Id.*

55. This probably is more the case with publicly operated hospitals, such as state mental hospitals than with private hospitals. In a privately owned residential hospital, the profit motive may exert an indirect, or even overtly direct, influence on the admitting physicians. Even in the public sector, however, there may be a variety of indirect pressures to keep the census up. When these pressures are prevalent there is a greater reason to question whether an independent therapeutically based decision about commitment has in fact been made. Nevertheless, in too many cases there is such a shortage of services that overcrowding is a more germane consideration. Unfortunately, this has been dramatic with many hospitalized mentally retarded. *See generally* Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295 (E.D. Pa. 1977), *modified*, 612 F.2d 84 (3rd Cir. 1979); New York State Ass'n for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E.D.N.Y. 1973); Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972), *modified sub. nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

56. 25 N.C. App. at 709, 214 S.E.2d at 630 (citation omitted).

57. *Id.* In fact, the latitude afforded to the Legislature seemed to be quite large. In discussing the type of protection to be accorded to minors, the court had earlier stated:

Such protective measures can be adapted to the peculiar needs of the minor. While there

One important point about the court's holding is that the language of the opinion argues more cogently for a pre-admission hearing to protect against unwise commitments by screening psychiatrists than for a post-admission hearing. After admission the treatment team should start to examine the minor carefully. Preadmission data can be verified, psychological testing can be administered, ward and school behavior can be observed, and further psychiatric interviews as well as the commencement of therapy can be undertaken. Once this process is started it should be much clearer whether the child does indeed need hospitalization and what sort of treatment is indicated. At this later stage in the process, it is difficult to see what purpose the court hearing actually serves. The judge, who has neither the training nor the expertise to design or carry out a treatment program, is, nonetheless, expected to make wise and competent decisions about the youth's future from information limited to that presented in an adversarial court hearing.

In addition, the court's requirement of a postadmission procedure that would comport with the requirements of due process seems flexible and broad enough for the legislature to have fashioned statutes that made clinical sense. Unfortunately, the legislature quickly enacted legislation essentially following the involuntary admission procedure,⁵⁸ which not only had an initial hearing,⁵⁹ but a continuing series of rehearings as well.⁶⁰ It should be emphasized, however, that the *Long* court never mentioned rehearings and there certainly was no mandate for them. By engrafting the already existing involuntary admission procedure onto the procedure for hospitalization of minors, the State set up an easy way to accommodate the holding in *Long*, but also created barriers to treatment that need not have existed. North Carolina, therefore, is currently left with a statute that went further than it needed even at the time of enactment. With the Supreme Court's holding in *Parham*, it is clear that the State has the authority to fashion commitment procedures for minors that are more sensitive to clinical considerations.

are certain minimum requirements to procedural due process, "the interpretation and application of the Due Process Clause are intensely practical matters and . . . 'the very nature of due process negates the concept of inflexible procedures universally applicable to every imaginable situation.'"

Id. at 708-09, 214 S.E.2d at 630 (citation omitted).

58. Law of June 25, 1975, ch. 839, § 1, 1975 N.C. Sess. Laws (current version at N.C. GEN. STAT. § 122-56.7 (e)(Cum. Supp. 1979)).

59. *Id.*

60. N.C. Gen Stat. § 122-58.11 (Cum. Supp. 1979).

CLINICAL VIEW

Even if a youth is rightfully admitted to a hospital, some will argue that the loss of liberty, stigma of long hospitalization, and the need for the least restrictive alternative still leaves an important role for the legal system after admission. Since the Supreme Court's opinion left open the question of what form of later review is required to justify continuing commitment, it is important to assess the impact of a judicial review at every stage of hospitalization.⁶¹

While postadmission review may be heartening to some, it is an unappealing and disturbing prospect for most clinicians working with minors. These professionals view work with children or adolescents and their families as difficult enough under the best of circumstances without the intrusion of lay persons attempting to evaluate programs and procedures for which they have little or no training.⁶² Civil libertarians and mental health lawyers counter this argument by challenging the assumption that commitment decisions are really medical questions. They suggest instead that the hard moral questions raised by mental disorder should not be avoided by relying on the mental health field and allowing essentially social, moral, and legal questions to be "medicalized."⁶³ The real issue then may be one of control or territoriality. From a clinical standpoint, it is precisely this struggle and tension surrounding control of the system that may be harmful to treatment, because regardless of the merits of the concern over legal safeguards, the type of procedures advocated to monitor the system do little to correct any real problems and instead create new, more deleterious ones.

In examining from a clinical vantage point the nature of the problems created by legal intervention, it is helpful to present a clinical view⁶⁴ of the types of children and adolescents who end up in residen-

61. This is especially true in North Carolina given the current statutory scheme in the state and the possibility that other states might wish to adopt similar procedures.

62. For an overall picture of adolescent residential treatment see J. MASTERTSON, *TREATMENT OF THE BORDERLINE ADOLESCENT: A DEVELOPMENTAL APPROACH* (1972); W. EASSON, *THE SEVERELY DISTURBED ADOLESCENT* (1969); D. HOLMES, *THE ADOLESCENT IN PSYCHOTHERAPY* (1964). For an account of the difficulties in designing a treatment program for severely disturbed children, see F. REDL & D. WINEMAN, *THE AGGRESSIVE CHILD* (1957).

63. See Morse, *supra* note 25, at 542.

64. To pursue this analysis it is necessary to assert several clinical "truths" that are difficult to demonstrate with the same sort of scientific evidence possible in other fields. What is perhaps most frustrating to legal analysts is that much of clinical work proceeds under the assumption that most people neither say what they mean, nor mean what they say. As a result, clinicians tend not to take much of what is said by an individual at face value. Instead, most look carefully for more subtle forms of communications such as what the individual avoids, the nuances of what the

tial treatment and examine the effect the legal process has on them.⁶⁵ While there are many types of adolescent problems that many mental health professionals feel require hospitalization, the focus of the following analysis will center on the problems associated with "acting out" youngsters.⁶⁶ These youngsters, by the nature of the difficulties

individual says, and the individual's body language. This is often dramatically demonstrated with the "acting out" adolescent who often displays alarmingly disruptive symptoms. *See note 66 infra.*

65. This analysis will not address the problems of the mentally retarded. This is not to say that mental illness and mental retardation are mutually exclusive, but to recognize the important clinical difference between the two groups.

66. The term "acting out" is descriptive of the external results of whatever internal or intrapsychic process is happening within the teenager. Adolescents who have been hospitalized for "acting out" often carry a range of diagnoses reflecting the efforts of mental health professionals to differentiate the underlying motivation for such actions. In AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d Ed. 1968), acting out patterns are seen both in Personality Disorders and Behavior Disorders of Childhood. The Behavior Disorder

is reserved for disorders occurring in childhood and adolescence that are more stable, internalized, and resistant to treatment than [a Situational Disturbance] but less so than [a Personality Disorder]. This intermediate stability is attributed to the greater fluidity of all behavior at this age. Characteristic manifestations include such symptoms as overactivity, inattentiveness, shyness, feeling of rejection, over-aggressiveness, timidity, and delinquency.

Id. at 50. Of the Behavior Disorders, commonly seen diagnoses include: Runaway Reaction of Childhood or Adolescence and Unsocialized Aggressive Reaction of Childhood or Adolescence. The Unsocialized Aggressive Reaction of Childhood or Adolescence is, "characterized by overt or covert hostile disobedience, quarrelsomeness, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying, and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline."

Id. at 51. This diagnosis should be distinguished from the diagnosis of Antisocial Personality which is described as follows:

This term is reserved for individuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behavior.

Id. at 43.

A different classification scheme was advanced by the Group for the Advancement of Psychiatry. COMMITTEE ON CHILD PSYCHIATRY OF THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, PSYCHOPATHOLOGICAL DISORDERS IN CHILDHOOD: THEORETICAL CONSIDERATIONS AND A PROPOSED CLASSIFICATION (1966). This scheme uses Tension Discharge Disorder as the major category for the acting out group of youngsters, with two subcategories consisting of the impulsive or impulse-ridden group and the group of children in whom neurotic conflicts seem to play so large a role. The Impulse-Ridden Personality, one of the two subcategories, is described as follows:

These children show shallow relationships with adults or other children, having very low frustration tolerance. They exhibit great difficulty in control of their impulses, both aggressive and sexual, which are discharged immediately and impulsively, without delay or inhibition and often without regard for the consequences. Little anxiety, internalized conflict, or guilt is experienced by most of these children, as the conflict remains largely external, between society and their impulses. . . . Such children ordinarily exhibit primitive defense mechanisms, with strong denial of dependent or other needs, projection of their hostile feelings onto adults or society, and rationalization of their own behavior.

Children in this category often have a history of extreme emotional deprivation

they present to the community, draw the most obvious attention to themselves. They may also pose the most difficult management and treatment problems once institutionalized and seem to be the ones most affected by the judicial process.⁶⁷ Often the parents of these youngsters, because of their own difficulties, are unable to set firm, consistent, and nonpunitive limits on the child's behavior. The adolescent often comes into the hospital with a history of a curious mixture of indulgence, neglect, and abuse. The parents are often unable to stand up to their child even when the child is a mere toddler. Statements like "I couldn't stand to hear my child cry" lead to a perpetual series of demands from the child without corresponding guidelines or limits. The effect of this on the child is to limit severely his or her self-confidence and autonomous functioning, and to fill this void, the child will con-

during infancy and early childhood marked by frequent and prolonged separations from mothering figures. . . . Some constitutional tendencies toward motoric discharge of tension rather than other avenues of handling tensions may be noted. . . . Stealing, firesetting, vandalism, destruction, aggressive attack, and other antisocial acts may frequently occur, and behavior may shift at times from one form to another or several others; addiction is not infrequent in older children and adolescents. Although their judgment and time concepts are poor, they usually have adequate intelligence and their reality testing in certain areas is quite effective.

Id. at 247-48. The Neurotic Personality Disorder is described as follows:

These children may show behavior superficially similar to that of the impulse-ridden personality as they act out or discharge tension arising from conflict. They appear, however, to have reached a higher level of personality development, revealing strong influence from earlier repressed neurotic conflicts. Their behavior often assumes a repetitive character, with unconscious symbolic significance to their acts, rather than the predominance of discharge phenomena. Evidence of some conscience formation is manifest from the presence of conflict, accompanied by some apparent anxiety and guilt, the latter leading them at times unconsciously to invite limits or punishments. Impulse controls appear to operate to some extent in the absence of exacerbations of conflict. . . . Relationships are warmer and more meaningful, although often highly ambivalent.

Id. at 249. While there is often overlap between the Impulse-Ridden Personality and the Neurotic Personality Disorder, the differentiation in this diagnostic category is often a very meaningful clinical distinction. Unfortunately, the criteria for making such distinctions, especially at the time of admission are often "soft" and contribute to general criticisms of the diagnostic categories. For an excellent symposium on the various aspects of acting out, see *A DEVELOPMENTAL APPROACH TO PROBLEMS OF ACTING OUT* (E. REXFORD ed. rev. ed. 1978).

67. This section is not intended to be dispositive about the variety of treatment approaches that are possible. For an understanding of a psychoanalytic developmental approach, the interested reader is encouraged to read C. BRENNER, *AN ELEMENTARY TEXTBOOK OF PSYCHOANALYSIS* (1955). This should provide background knowledge of the terminology. See generally P. BLOS, *ON ADOLESCENCE* (1962); P. BLOS, *THE ADOLESCENT PASSAGE* (1979); E. ERICKSON, *CHILDHOOD AND SOCIETY* (2d ed. 1963); A. FREUD, *THE EGO AND THE MECHANISMS OF DEFENSE* (rev. ed. 1966); A. FREUD, *NORMALITY AND PATHOLOGY IN CHILDHOOD: ASSESSMENTS OF DEVELOPMENT* (1965); F. FROMM-REICHMANN, *PRINCIPLES OF INTENSIVE PSYCHOTHERAPY* (1950); O. KERNBERG, *BORDERLINE CONDITIONS AND PATHOLOGICAL NARCISSISM* (1975); O. KERNBERG, *OBJECT-RELATIONS THEORY AND CLINICAL PSYCHOANALYSIS* (1976); M. MAHLER, F. PINE & A. BERGMAN, *THE PSYCHOLOGICAL BIRTH OF THE HUMAN INFANT* (1975); J. MASTERSON, *supra* note 62; J. MASTERSON, *PSYCHOTHERAPY OF THE BORDERLINE ADULT: A DEVELOPMENTAL APPROACH* (1976).

tinue to escalate demand after demand. This continual demanding may lead the parent into battering the child or being too punitive over a very small matter. This type of parental overreaction further limits the child's ability to see the world as a predictable place in which appropriate consequences follow specific events. In fact, the world is not such a place for these children, because rewards sometimes follow misbehavior and punishment is often unrelated to the child's actions.

These children deal with such a world by developing both maladaptive means of fleeing from the unpredictable nature of the parenting and a distrust of the value of talking rather than acting. In addition, the avoidance of feelings becomes a major *modus operandi* for such teenagers, as the years only increase the variety of ways in which they can use action to deal with anxiety and frustration or any dysphoric feelings. They seek solutions to problems in quick or magical ways, solutions that are usually unplanned and often detrimental to themselves or others. The emphasis is always on external change, because in the past internal change had been too difficult or frightening and often led to a series of failed endeavors that further alienated the youth from society and, ultimately, his own feelings.

Nevertheless, these teenagers may not be alienated from their families even though they may be running away, constantly in trouble in school, and perhaps even in trouble with the law. Many parents, although constantly angry at and frustrated by their children, are also the most tenacious in their avoidance of dealing with something that is obvious to neighbors, schools, and society at large—these are severely troubled youngsters. The same sort of externalizations about the nature of the child's problems are exhibited by the parents. Bad school teachers, a poor choice of friends, drugs, and related external excuses are given as reasons for these problems. Often parents have no explanation for their teenager's problems or tend to minimize dramatic symptoms while emphasizing an event or character trait that seems objectively minor in the over-all picture.

While entrance into the mental health system varies, it rarely is openly embraced as a panacea. Many families have, or feel they have, something to be ashamed of and would prefer to have their problems remain private. In addition, while the youth's repetitive problems may be uncomfortable for the family, they are at least uncomfortable in a familiar way. The prospect of treatment, however, introduces the possibility of change in an unknown manner and is, therefore, somewhat frightening. As a result, while to objective observers these families may

appear as chaotic or fragmented, often as a result of divorce or separation, they tend to show a remarkable tendency to unite in confronting an outsider who threatens to change the family dynamics. In addition, in the subculture of many of the families involved, the identification of the teenager as "mentally ill" is a stigma to the whole family. Moreover, entrance into the system is usually through low fee clinics, community mental health centers, or state institutions. The state institutions are often large, multi-serviced, and perhaps substandard, and are often joked about in the local community as the last place anyone would willingly want to be, or send a relative. The decision to seek hospitalization, therefore, is often an excruciatingly painful process. Some families are never able to see any merit in this type of solution, and as a result the teenager usually only surfaces as a referral from a social service agency or a juvenile court after custody has been removed from the parents or extended family.

The teenager is also likely to be uncertain about the need for hospitalization and treatment. Even individuals who enter therapy voluntarily are ambivalent about the process, so it is only reasonable to expect a disturbed teenager to be at least as wary or ambivalent. In fact, the nature and extent of ambivalence or conflict is an essential clinical diagnostic and therapeutic issue.⁶⁸ An immediate clinical concern is not only whether someone needs treatment, but whether he or she is treatable. Many teenagers grow up in homes with the dynamics described earlier, but few enter mental hospitals. Some seem to do reasonably well for themselves, others seem to be more delinquent, and others are felt to be more "mentally ill." The vicissitudes of normal teenage development often preclude the ready identification of certain actions as *per se* indications of mental illness. Therefore, careful consideration of all the factors leading to the alarming actions, a detailed social history, including school adjustment, and psychological and psychiatric evaluations, are all important in assessing an adolescent's needs and likelihood to benefit from certain interventions. While these considerations are obviously important in assessing a minor's needs in other legal settings, such as a juvenile court, clinicians argue that they are better able, by virtue of their training and experience, to sift through the data and reach conclusions on issues surrounding emotional care or hospitalization.

When a teenager is at a point where hospitalization is recom-

68. See note 66 *supra*.

mended, there is, no matter what his or her surface reaction to hospitalization, a more subtle testing of the new environment—what are the expectations, what are the limits, what are the consequences, how do the staff respond, and how are the personal interactions different from those to which the youth has become accustomed.⁶⁹ For many teenagers, the hospital is perceived merely as another place to fail. By definition, when hospitalization occurs there has been a rift or separation in the family. Many adolescents have never experienced what it is like to work through any problem within a system. Often any desire on the part of the child to succeed, or even to entertain hopes for the future, has been layered over by failure, self-doubt, and actions leading to guilt or pain to others. One key element of successful hospitalization, therefore, is to establish or reconstruct a sense of being able to succeed within a system and thus reduce the need to flee from one to another.

Unfortunately, the legal system's monitoring of the mental health system, and the implicit distrust this conveys, fits into the teenager's maladaptive pattern. At the point of hospitalization, many adults have already repeatedly failed the youth in their actions and have been unable to control the youth's actions. One of the implicit promises the treatment team offers is to control the behavior of the adolescent if he or she cannot. The legal system's involvement immediately undermines this promise. On some level the adolescent must realize that it is a great deal easier to attempt to manipulate a lawyer or judge than to work toward internal change. The legal process, especially an adversary court hearing, is often a recapitulation of the same events that occurred earlier, in that it causes discord, confusion, and arguments among adults, with the possibility that someone eventually may relent. Even if the court finally does give the youth a strong and therapeutic message, it cannot seriously be argued that hearing a painful rehash of one's failures and problems aired in an adversarial setting is beneficial. Furthermore, if the therapist is forced by the youth's actions to testify against him or her, the youth's belief that the hospital can be a safe place is further eroded.

Legal intervention creates other problems as well. For example, one of the immediate issues arising in the treatment of acting out adolescents is whether the treatment facility is strong enough to provide the protection so obviously lacking in the past. The presence of court pro-

69. Planauskas, Ritchie, & Silverstein, *Intensive Residential Treatment for Adolescents in North Carolina and the Present Legal System: A Review and Proposed Changes*, 8 N.C.J. OF MENTAL HEALTH 1, 4 (Winter 1978).

cedures can do much to erode the hospital's therapeutic effectiveness in this regard. The existence of procedures that allow the teenagers to capriciously set in motion the mechanism for discharge must on some level be very threatening. The teenager can of course do that anyway by violent or destructive acts that may indicate that hospitalization is not the proper course of action. The teenager is, however, clearly violating a taboo in such cases and will often face criminal sanctions as a result. With a courtroom fight, however, the teenager is pursuing legitimate means and may only be mirroring the distrust for the hospital that the legal procedures imply. As such, these procedures may serve to foster in the teenager the negative feelings about the treatment process, thus making trust that much more difficult to achieve.

While the potential damage to treatment by legal procedures is immediately present, it is a far greater problem in later hearings. The first court hearing will relate to past events and whether they make sense in the context of how the adolescent appears at the onset of hospitalization. While clinicians may view such legal scrutiny as antithetical to the treatment process, an initial hearing may be just one more obstacle in the initial stage of treatment. Greater clinical concerns, however, arise over the monitoring of the entire treatment process. A certain vulnerability is created as treatment progresses and the adolescent starts to contain the sort of symptoms that led to hospitalization. The symptoms that had previously "defined" the teenager may have diminished, but there will not have been enough time for the establishment of any more permanent identity. The temptation to use the court hearing as a test of whether the old magical solutions to problems will work and whether the hospital is strong enough to vouchsafe treatment is often irresistible.

Even later in treatment, when it is felt that the teenager has internalized a new set of values, the spectre of the legal hearing creates problems. If the teenager is functioning better and appears rather normal, it is often not clear to someone outside the treatment setting why the hospital is still insisting the teenager needs further treatment. In fact, the teenager may need the treatment program at this stage more than ever to move realistically toward autonomy and to solidify the gains made. The teenager, with a backdrop of legal skirmishes, may feel peculiar admitting now to being "mentally ill," especially since he or she feels better than ever. Furthermore, the adolescent may also be covertly supported in seeking discharge by parents who in some ways fear too much change and who prefer to hope the work is over before

all the old painful interactions are rekindled in therapy. Thus, the adolescent may again be tempted to see whether someone outside of his or her daily experience can pronounce treatment finished.

These later hearings place everyone in the process in a peculiar position. As time passes, it is more difficult to convey an accurate picture of the teenager's functioning. Much evidence of past and present disturbance is hopefully being channelled into therapy instead of into action. Whatever the merits of an initial court review, the treatment team by now should know far more about the adolescent than the judge is ever likely to discover, especially in an adversary hearing within a courtroom. For a judge, who is so far removed from the daily existence of the teenager, to review a teenager's progress under these circumstances and have the authority to override the treatment team's recommendations must send a confusing message to the teenager.⁷⁰

In essence, then, clinicians are likely to see their jobs made needlessly more complicated by the legal system. Since the system offers one more avenue of escape from the internal changes necessary for these adolescents to have a chance of succeeding in society, it does a great disservice to those it is designed to protect. By questioning and challenging the authority and wisdom of the recommended treatment, the system endangers the legitimacy of the teenager working with the treatment team. The teenager's investment must partly reside outside of treatment, focused instead on what a judge may do or think. The court hearings, if they operate in a true adversary fashion, are hardly benign affairs and are considered by clinicians to be a cruel charade. Instead of protecting the adolescent, the legal system serves as one more institution insensitive to the adolescent's actual needs, and provides one more set of adults to be used and manipulated.

70. The artificiality of this process may explain two phenomena that are observed around the time of court hearings: (1) acting out; and (2) claims of abuse. First, acting out or regressions during the court hearing often reappear, and may guarantee continued hospitalization. Clinicians view this tendency as a lamentable outgrowth of creating a system that ignores clinical reality. Taking seriously a teenager's demand or request to leave the hospital may be frightening enough to force the teenager to prove in action what words cannot. Second, often teenagers will complain during court hearings about abuse of "rights." Since this is a very serious legal concern, lawyers are apt to give these claims a great deal of credence. Clinicians, on the other hand, are more likely to view these complaints as symbolic. The adolescents may indeed be feeling abused, but by (1) the legal system's ignorance of their desire to stay in the hospital; (2) their own inability not to become involved in the process; and (3) the treatment team's inability to protect the teenagers from themselves. Usually, the treatment team will bear the brunt of the adolescents' anger, since the lack of ultimate protection is a painful repetition of what transpired throughout so much of their lives. The inevitable clean-up by the treatment team of the fallout from court hearings may explain much of the resentment felt toward the legal system.

WHO BENEFITS?

The preceding sections focused both on the legal perception of the needs of adolescents facing hospitalization and the clinical concerns about the detrimental effects of legal intervention on treatment. This harm to treatment is predicated on the assumption that there actually is treatment taking place. In many large state institutions, however, it was clear that hospitalization was hardly synonymous with treatment. State legislatures afforded clinicians large latitude in treating the mentally ill but not the financial resources necessary to deliver their services to society. Thus, both legislatures and those charged with providing mental health care helped perpetuate a system of inadequate mental health treatment.⁷¹ Although problems admittedly exist in the mental health system, the judicial solution, which increasingly involves lawyers and judges at all stages of the treatment process, presents other problems. Making entry into the hospital more difficult and perhaps having more individuals released sooner does not squarely address the problem of making conditions satisfactory for those individuals who actually end up in the hospital. Clinicians contend that legal safeguards may make treatment more difficult, if not impossible. The legal system, by ignoring or glossing over these claims, gives credence to clinicians who feel that lawyers are insensitive or misguided about the real needs of the mentally ill. There seems to be an assumption by some that lawyers, who are untrained in clinical matters, are well suited to balance all the competing interests. If the decisions of the courts are being influenced to a large degree by a concern with obvious substandard treatment, does it not make more sense to address this openly rather than provide for lawyers and hearings that merely restrict access to the system? If the legislatures do not concomitantly upgrade services, the same substandard conditions will be perpetuated, albeit on fewer people. The treatment of minors, therefore, may be hurt not only by legal reforms which create a monitoring system inherently detrimental to the treatment process, but also by the societal illusion that the courts are helping to alleviate the problem.

71. In Alabama, for instance, the amount spent for someone institutionalized was so low that it was apparent that adequate and humane treatment was not possible. *See Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971). With minors, as mentioned earlier, *see* note 33 *supra*, the district court in the *Parham* case raised the question of the sufficiency of treatment in Georgia. Georgia's failure to provide a spectrum of services to troubled minors would seem to indicate that even the services provided were suspect. Certainly the few varieties of treatment settings operating within the state would significantly change the dispositional alternatives for clinicians, thereby resulting in longer hospitalizations.

Ironically, the brunt of the suffering will likely be borne by those teenagers with the fewest emotional resources. The adolescents who least misconstrue the court process are most often those individuals with solid parental backing, parental understanding of the need for treatment, and parental comprehension of the legal system.⁷² On the other hand, the teenagers who enter the hospital through agency placements and have no real family to return to are most prey to the harmful side effects of the court process. Even successful hospitalization must inevitably result in one more loss, since the children usually cannot realistically return home nor can they stay in the hospital forever. As noted earlier, it is this group of severely disturbed youngsters that legal reformers are likely to be most vigilant in "protecting" from the mental health system. The reason for this is obvious when viewed in a historical perspective. Since this group of youngsters is most likely to come under the purview of a social service agency, the opportunity to place such youths in a mental hospital may be an easy way to lighten one's case load, especially of the troublesome and often thankless involvement with children who are difficult to place.⁷³ The general reluctance to interfere with family autonomy and parental control over children is removed when custody or guardianship is entrusted to others, and, at that point, it would be more appropriate to question whether a "close, sensitive, and individualized determination" of a minor's needs has truly been made.⁷⁴

Unfortunately, these youngsters are most likely to rely on societal institutions to make appropriate decisions for them and will be most likely to suffer when friction between the institutions occurs. Since the youths are not able to find support and guidance within their own families, they are left with whatever inner resources they have and whatever societal auspices are extended them. If their own inner resources have been damaged by their past experiences, as is likely, their capacity to risk truly investing in others may have diminished substantially by the time they reach the mental health system and hospitalization is recommended. Often these youngsters are considered marginal treatment cases at best and simply cannot weather the detrimental effects of due process procedures on their treatment. No matter what the outcome of the actual court hearings, the youths may have dissipated more energy

72. Planavsky, Ritchie & Silverstein, *supra* note 69, at 13.

73. The district court in *Parham* explicitly expressed this concern. See *J.L. v. Parham*, 412 F. Supp. 112, 134-35 (M.D. Ga. 1976).

74. Bezanson, *supra* note 19, at 578.

than they can afford on these internecine battles. In fact, if treatment goes poorly enough it may be quite easy to keep these youths in the hospital, but for what real purpose?

The plight of these adolescents is symptomatic of the problems with the interface between the legal and mental health systems. Clinicians see the slim chances of these youngsters evaporate with meaningless and destructive legal procedures. The legal system sees one more example of the failure of the mental health system to provide adequate treatment. This increases the push for additional monitoring, which in turn leaves the clinician feeling that true treatment is even less possible to provide. Both blame the other side, while the disturbed teenagers remain caught in the middle of a dispute in which they have much at stake, but little real input.

Except for those unalterably opposed to civil commitment, there are no easy solutions. As long as our society continues to permit civil commitment of juveniles, it makes sense to allow it a real opportunity to work. This will require the legal system to become more sensitive to clinical concerns. Those who insist on the importance of adversary hearings may be attempting to commit the judicial system to a course of action that masks underlying problems with a facade of procedural rather than substantive reforms. The real thrust of legal reform should be directed at legislatures that are unwilling to expend the amount of resources necessary to implement and continue adequate treatment programs. Mental health professionals, in turn, must carefully evaluate and attempt treatment only with those with whom they feel they have a reasonable chance of success. This means working toward a right to treatment of those served by setting up humane treatment programs in decent treatment facilities, as well as working to create a spectrum of services outside of hospitals so that residential treatment will be utilized only when absolutely necessary. These steps by both sides would add moral force to the societal decision to provide such services to troubled teenagers, especially when they are ambivalent or unwilling participants.

