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"VOLUNTARY" COMMITMENT OF MENTALLY ILL OR RETARDED CHILDREN: CHILD ABUSE BY THE SUPREME COURT

*Allen Edward Shoenberger**

Paternalistic decisions are to be guided by the individual's own settled preferences and interests insofar as they are not irrational, or failing a knowledge of these, by the theory of primary goods. As we know less and less about a person, we act for him as we would act for ourselves. . . . We try to get for him the things he presumably wants whatever else he wants.[1]

Recent Supreme Court decisions concerning institutional care to mentally ill or retarded children are both contradictory and surprising. For example, the Court has recently permitted the "sterilization of a minor female on ex parte judicial authorization because her mother alleged she was 'somewhat retarded,' 'associating with elder youth and young men,' stayed out overnight with them on several occasions, in order 'to prevent unfortunate circumstances' . . . ."[2]

The Court has also permitted the "commitment of a juvenile to a mental institution by his family or guardian without a hearing before commitment."[3] On the other hand, the Supreme Court has ruled that the Constitution mandates that "a state may not permit a parent to veto an abortion by a minor child,"[4] and "[A]n individual can only be confined in a mental institution after a hearing at which the standard of proof is 'greater than the preponderance of the evidence standard' but less than proof beyond a reasonable doubt."[5]

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1. J. RAWLS, A THEORY OF JUSTICE 249 (1971). For Rawls, primary goods are things which every rational man is presumed to want, whatever his rational plan of life. *Id.* at 62. They include self-respect, health and vigor, intelligence and imagination, rights and liberties, powers and opportunities, income and wealth. Obviously some of these are not readily alterable by societal intervention. Rawls argues that self-respect is "perhaps the most important primary good." *Id.* at 440.
2. Stump v. Sparkman, 435 U.S. 349, 351 (1978).
3. Parham v. J.R., 442 U.S. 584, 597 (1979).
4. Planned Parenthood of Mo. v. Danforth, 428 U.S. 52 (1976).
5. Addington v. Texas, 441 U.S. 418 (1979).

It seems incongruous to require a high degree of proof for involuntary hospitalization of the mentally ill, but then to require no hearing on that issue for children.[6] Although the commitment of children is considered voluntary, the Court has recently decided that they can be committed summarily because often they were too young.[7]

In cases involving the voluntary commitment of children, the Court purports to serve certain interests and purposes. This article will focus on two recent cases, *Parham v. J.R.*[8] and *Secretary of Pub. Welfare of Pennsylvania v. Institutionalized Juveniles*,[9] dealing with the voluntary confinement of children to state mental institutions. In these decisions, first, the Court was insensitive to the underlying facts of the cases by failing to recognize the divergence of mental capacities or problems suffered by the patients. A significant proportion of voluntarily commited children (25% by one study),[10] remain institutionalized for very long periods of time. Second, the Supreme Court failed in its primary and appropriate task of monitoring the constitutional compliance of the states' schemes for institutionalizing children with supposed mental problems. Third, the proper role for courts is supervisory and administrative, rather than scrutinizing individual medical decisions. In its zest to deliver medical care to needy juveniles, the Court failed to fulfill its primary role of ascertaining that the "need" determination is made as accurately as possible, or at least within a reasonable range of accuracy.

I. THE *PARHAM* AND *INSTITUTIONALIZED JUVENILES* DECISIONS

The *Parham* case, a certified class action, challenged Georgia's voluntary commitment procedures for children under the age of eighteen.[11] The named class member, J.R., a child being treated in a

6. *See In re* Gault, 387 U.S. 1 (1967) (the court recognized the due process rights of children in Juvenile proceedings).

7. Parham v. J.R., 442 U.S. 584, 589 (1979).

8. 442 U.S. 584 (1979).

9. 442 U.S. 640 (1979).

10. Joint Commission on the Mental Health of Children, Crisis in Child Mental Health Challenge for the 1970's (1979). *See also* Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30, 43 n.45 (E.D. Pa. 1978), *rev'd sub nom.*, 442 U.S. 640 (1979) (referring to L. Glenn deposition).

11. 442 U.S. 584, 587; Section 88-503.1 provides:

(a) The Chief Medical Officer of any facility may receive for observation and diagnosis . . . any patient under 18 years of age for whom such application is made by his parent or guardian. . . . If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility until discharged pursuant to sections 88-503.2 or 88.503.3: Provided, however, that the parents or

Georgia state mental hospital, represented a class as large as 200 at one point and as small as 140 at other times.[12] The plaintiffs sought a declaratory judgment that the voluntary commitment procedures for children violated the due process clause of the fourteenth amendment, and requested an injunction against future enforcement.

A three-judge district court[13] conducted extensive hearings including visits to two of the State's regional mental hospitals. They concluded that the Georgia statutory scheme was unconstitutional because it failed to adequately protect the children due process rights.[14]

The *Institutionalized Juveniles* decision, also a class action suit, challenged Pennsylvania's voluntary commitment statutes and their attendant regulations.[15] The class in this case contained two subclasses of plaintiffs[16] consisting of "all juveniles under the age of fourteen who [were] subject to in-patient treatment under Article II of the 1976 Act," and "mentally retarded juveniles who [were] 18 or younger."[17] The three-judge district court reached a result similar to *Parham*, holding that these children had a constitutionally protected liberty interest that could not be "waived" by their parents.[18] Given the "perceived fallibility of psychiatric diagnosis," the court posited that

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guardian of a minor child must be given written consent to such treatment. . . . Section 88-503.2 provides: "The chief medical officer of the facility shall discharge any voluntary patient who has recovered from his mental illness or who has sufficiently improved that the Chief Medical Officer determines that hospitalizaiton of the patient is no longer necessary. . . ."

12. 442 U.S. at 587 n.2.

13. 28 U.S.C. § 2284 (1976).

14. J.L. v. Parham, 412 F. Supp. 112, 138 (M.D. Ga. 1976), *rev'd sub nom.* Parham v. J.R., 442 U.S. 584 (1979).

15. A declaration was sought that the admission procedures embodied in § 201 of the Pennsylvania Mental Health Procedures Act of 1976, PA. STAT. ANN. tit. 50, § 7201 (Purdon Supp. 1980), which had been expanded by regulations promulgated by the Secretary of Public Welfare, 8 Pennsylvania Bulletin 2433 (1978), violated procedural due process rights. Section 201 provides in part: "parent, guardian or person standing in loco parentis to a child less than 14 years of age may subject such child to examination and treatment under this act, and in so doing shall be deemed to be acting for the child. . . ." *See* Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640, 644 n.5 (1979). (in which the Supreme Court sets out the regulations in part).

16. *Id.* at 644.

17. *Id.* at 644 n.6. Section 201 of the Act allowed a parent or guardian to apply for voluntary examination and treatment. The class consisted of approximately 360 mentally ill members at one point. Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30, 41 (E.D. Pa. 1978), *rev'd sub nom.*, 442 U.S. 640 (1979). On July 5, 1978, there were 382 allegedly mentally ill and 3603 allegedly mentally retarded. 459 F. Supp. at 55.

18. Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640, 645 (1979).

only a formal adversary hearing could protect the children in the class from needless hospitalization.[19]

The Supreme Court opinion by Chief Justice Burger states that the following procedures were established by the district court as necessary before any child could be admitted voluntarily to a mental hospital:

1. 48-hour notice prior to any hearing;
2. legal counsel "during all significant stages of the commitment process;"
3. the child's presence at all commitment hearings;
4. a finding by an impartial tribunal based on clear and convincing evidence that the child required institutional treatment;
5. a probable cause determination within 72 hours after admission to a hospital;
6. a full hearing, including the right to confront and cross-examine witnesses, within two weeks from the date of the initial admission.[20]

That interpretation of the district court's decision is confusing and inaccurate. First, the district court did not require these rights to be provided *before* institutionalization.[21] For example, notice was not absolutely required before every institutionalization,[22] nor was a lawyer's counsel mandated.[23] These misstatements might not be so critically suspect if the facts were otherwise fairly treated. The Supreme Court, however, ignored the specific facts and circumstances surrounding any of the juveniles involved in the case. For example, of the three named plaintiffs who were "mentally retarded," two were only moderately retarded; one of these was abandoned by his parents and institutionalized only after a foster mother became ill and a second foster home became

19. *Id.*

20. *Id.* That is not exactly the holding of the district court. Legal counsel is not required, the wording was "Counsel or other trained representative." Appendix to Jurisdictional Statement at 1097a in *Institutionalized Juveniles*. There are other minor variations between the statement of the holding by Chief Justice Burger; however, the most significant misstatement is that the impression is left that the district court required prior hearings before commitment. That was not required.

21. Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30, 43-44 (E.D. Pa. 1978).

22. Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979). Temporary detention by parents is authorized. Appendix to Jurisdictional Statement at 1092a. A probable cause hearing within three days after commitment is also authorized. *Id.* at 1094a. Finally, notice within 48 hours before hearing is required. *Id.* at 1093a.

23. The reference cited by the Supreme Court reads, "counsel or other trained representative" or counsel or other representative, attorney or other representative. Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979); Statement at 1097a; *but see* 459 F. Supp. at 44 n.47.

too crowded.[24] Furthermore, nothing in the medical records of these plaintiffs indicated that they needed institutional care or that the non-institutional care they had been receiving prior to commitment was somehow inadequate for their needs.[25] Similarly, none of the facts and circumstances of the mentally ill plaintiffs were recounted. The district court, however, described the admission of one of the plaintiffs as follows:

> Hospital records show that Edward was not informed that he was to be admitted to a mental facility prior to his admission date, but rather was told that his parents were taking him to a new school. He was extremely upset by the admission process, expressing fears about being in a hospital with "crazies" and being confined "like a prisoner."[26]

Furthermore, the Supreme Court did not refer to any of the procedural irregularities under Pennsylvania law. These include signing an admission form in blank[27] and holding one of the juveniles committed under a law invalidated by federal court in 1971.[28] Between 1971 and 1975, no commitment papers were prepared for one of the plaintiffs.[29] Another patient was admitted under the Mental Health Act of 1951 rather than the 1966 Act in effect in 1968.[30]

The Supreme Court did not mention the kind of treatment received by patients at some of the facilities involved in the Pennsylvania program. For example, Pennhurst, one facility used for the mentally retarded in Pennsylvania, was described by a federal district judge as an institution where the patients "have been physically abused. Lack of adequate supervision has produced an atmosphere of danger to the residents. Occasionally, there have been incidents of staff abuse of residents, including rape and beatings. Hundreds of injuries, both major and minor, are reported every month."[31] The misuse of restraints[32]

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24. Brief for Appellees at 58, Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979).

25. *Id.* at 18 (brief for appellees).

26. Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979), Appendix to Jurisdictional Statement 1064a.

27. Brief for Appellees at 11, Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979).

28. The statute was declared unconstitutional in Dixon v. Attorney General, 325 F. Supp. 966, 972 (E.D. Pa. 1971).

29. Brief for Appellees at 18, Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979).

30. Appendix to Jurisdictional Statement at 1065a, n.16 in *Institutionalized Juveniles*.

31. Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1320 (E.D. Pa. 1977).

32. *Id.* at 1307. These included the use of restraints for one patient for 651 hours,

and seclusion rooms,[33] as well as the lack of rehabilitation treatment for the retarded,[34] are described elsewhere in that opinion. At the time the Supreme Court decided *Institutionalized Juveniles*, Pennhurst was still unaccredited by the Joint Commission of the Accreditation of Hospitals.[35]

Similarly, the Supreme Court understated many specific facts of the plaintiff's case in *Institutionalized Juveniles*. The Court focused on the procedural requirements of the Pennsylvania statute, concluding that the *Parham* decision controlled *Institutionalized Juveniles*:

> We conclude that the 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]

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5 minutes in June 1976, 720 hours in August 1976, 674 hours, 20 minutes in September 1976, 647 hours, 5 minutes in October 1976. After enrolling the patient in occupational therapy in early 1977, for the first time it became possible to release the patient from restraints for up to four hours per day.

33. *Id.* at 1306.

34. *Id.* at 1304-06.

35. Brief for Appellees at 17, in *Institutionalized Juveniles*.

36. Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640, 646 (1979) (quoting Parham v. J.R., 442 U.S. 584, 606-07 (1979)). The Court only dealt cursorily with the issue of institutional pressures to commit in *Parham*. The opinion asserts that such pressures are not supported or documented in the record for these cases, and relegates consideration of such problems to individual law suits rather than to class actions. 442 U.S. at 616. It is unclear, however, when the court must consider various risks and factors in determining the level of process due, or why such a risk should be excluded from the calculus. These are serious risks and were recognized as such by the district court in Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30, 46 (E.D. Pa. 1978). The court noted the testimony of one witness:

> [P]sychiatrists are people too and we are influenced by considerations other than those that are strictly clinical. For example, if I, as director of a state hospital get a letter from a colleague in a community facility, saying that John Doe really needs psychiatric hospitalization and is severly disturbed, even if I felt otherwise from a direct discussion with the patient, I would be in an awkward position if I said, "No, this patient does not require hospitalization". What do I then say to my colleague whose opinion I disagree with? Secondly, professionals—psychiatrists who work for institutions—are influenced by the needs of the institutions, as well as the needs of the individual patient. If I am the director of an adolescent

After a brief discussion of the requisite Pennsylvania statutory and regulatory procedures, the Supreme Court reversed and remanded the district court's decision.[37] The Court intended to reverse and remand the decision below only insofar as it dealt with the "process . . . due at the initial admission"[38] and not with post-admission procedures.[39] It is distressing to note that the Court perceived no difference in the treatment of the admissions of mentally retarded and the mentally ill.[40] Rather, *Institutionalized Juveniles* clearly turned upon the same justifications and basis cited by the *Parham* decision. Examining the basis of that decision is therefore appropriate.

II. *PARHAM*: PRECOMMITMENT HEARINGS WHEN PARENTS OR THE STATE AS *PARENS PATRIAE* REQUESTS COMMITMENT

Because the *Parham* decision dealt only with the issue of committing mentally ill juveniles, the issue of mentally retarded individuals was

service and the funding of my unit depends on how fully utilized the unit is, I might be on the side of admitting the adolescent. I am not saying this is done deliberately, but I think a decision as complex as hospitalization is influenced by factors within the psychiatrists at a number of different levels and such considerations as bed utilization will play some role.

459 F. Supp. at 46 n.58. This latter consideration can be with the best of motives. In some hospitals, the number of free or low cost beds may depend on utilization rates for the other beds. Cost is seldom discussed, but one of the major constraints is bed cost.

37. 442 U.S. 640, 650 (1979).

38. *Id.* at 650 n.9.

39. *Id.* By failing to discuss individual facts in the light of the statutes, the Supreme Court avoided noting that one of the named plaintiffs, Kevin S., was committed after physical abuse at home by his mother, who herself had a history of serious mental illness and that his psychosocial history concluded, "It is felt that much of Kevin's problems come from living with a schizophrenic mother and having a very unstable and abused early life." Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30, 37 (E.D. Pa. 1978), *rev'd sub nom.*, 442 U.S. 640 (1979). Of the nine class members at Haverford Hospital, a third had been abused by parents, a third had parents with drinking problems, two had mothers with visible mental problems. (One of the admissions notes included the reaction to allegations that the juvenile was hyperactive. "I cannot describe him as hyperactive. In the first interview his mother seemed more hyperactive than he did." Brief for Appellants at 11-16 in *Institutionalized Juveniles*.) Much of this material is incorporated in the district court decision. 459 F. Supp. 30, 36-38.

40. Secretary of Pub. Welfare v. Institutionalized Juveniles, 442 U.S. 640, 650-52 (1979). A separate opinion by Justice Brennan, with Marshall and Stevens concurring in part and dissenting in part, found the post admission procedures provided by Pennsylvania inadequate. Justice Brennan condemned placing the burden to initiate challenges on the juvenile, and described the recitation of rights required by current regulations as "hollow ritual." His opinion would require appointment of an authorized representative to ensure that each child's rights are fully protected.

not presented. *Parham* also differs from *Institutionalized Juveniles* because some of the specific facts of the named plaintiff class representatives are recounted in *Parham*. Chief Justice Burger described the plaintiff, J.L., as initially having been admitted to a psychiatric institution in 1970 at age six after having received out-patient treatment for two months. J.L.'s mother then requested that the hospital admit him indefinitely. The admitting physician interviewed both J.L. and his parents. His natural parents had been divorced and his mother remarried. J.L. had been expelled from school because he was uncontrollable. The physician, accepting the parents' representation that the boy was extremely aggressive, diagnosed the child as having a "hyperkinetic reaction to childhood."[41] At first J.L.'s mother and stepfather participated in family therapy during J.L.'s hospitalization. J.L. was then permitted to go home for short stays, but apparently his behavior during these visits was erratic, so the parents requested termination of that program after several months. In 1972 the child was returned to the parents on a furlough basis, whereby he would live at home but go to school at the hospital. Because the parents found that they were unable to control J.L. to their satisfaction, which created family stress, within two months they requested readmission to the hospital. J.L.'s parents relinquished their parental rights to the county in 1974. Although several hospital employees recommended that J.L. should be placed in a special foster home with "a warm, supportive, truly involved couple," the Department of Family and Children Services was unable to place him in such a setting.[42]

The other plaintiff, J.R., was declared a neglected child and removed from his natural parents at age three months. He was then placed in seven different foster homes in succession prior to his admission to Central State Hospital at age seven. Prior to hospitalization, J.R. received out-patient treatment at a county mental health center for several months. When he began attending school he was so disruptive and incorrigible that he could not conform to normal behavior patterns. His seventh set of foster parents, and eighth set of parents in seven years, then requested that he be removed from their home. The agency provided the hospital with a complete sociomedical history at the time of the admission. In addition, three separate interviews were conducted with J.R. by the admission team of the hospital. J.R. was

41. Both the district court and the Appendix to the Jurisdictional Statement in the Supreme Court describe this as hyperkinetic reaction *of* childhood, not *to* childhood. *Compare* 412 F. Supp. at 117 *with* Appendix to Jurisdictional Statement at 77, Parham v. J.R., 442 U.S. 584, 589-90 (1979).

42. Parham v. J.R., 442 U.S. 584, 589-90 (1979).

diagnosed as borderline retarded and suffering an "unsocialized, aggressive reaction to childhood." The admission team unanimously recommended that J.R. would "benefit from the structured environment" of the hospital and would "enjoy living and playing with boys of the same age."[43]

The differences between the descriptions of the cases by the Supreme Court and the district court are revealing. The district court opened its opinion by disclosing that both J.R. and J.L. sought release from more than five years of confinement in a mental hospital.[44] The Supreme Court failed, however, to consider the reasons behind the continued hospitalization of both juveniles. On the other hand, the district court recounted a number of significant factors underlying the boys' confinement.[45] For example, J.R. lost his placement in each foster home because "it seemed that he had lost his place to a more favored child."[46] In early 1973, hospital personnel began requesting the Department of Family and Children Services to remove J.R. from hospital confinement and to place him in a long-term foster or adoptive placement because of a feeling that he "will only regress if he does not get a suitable home placement, and as soon as possible."[47] Later that same year, hospital personnel "felt that efforts to obtain a foster home should be primary at this time, lest [J.R.] become a permanently institutionalized child."[48] Nevertheless, a foster home was not obtained, and suit was filed over two years later with J.R. still in confinement. Furthermore, J.R. did quite well in first grade with normal students until his teacher retired and was replaced with a much younger teacher who was unable to control J.R.[49] Not surprisingly, J.L.'s file revealed that his out-patient treatment at the County Mental Health Center prior to his hospitalization consisted of roughly one appointment a month, presumably for forty-five minutes to an hour.[50]

With respect to J.L.'s continued hospitalization, the district court observed that records of the Department of Family and Children's Services indicated that the department could not pay for institutionalized

43. *Id.* at 590.

44. J.L. v. Parham, 412 F. Supp. 112, 114 (M.D. Ga. 1976), *rev'd sub nom.* Parham v. J.R., 442 U.S. 584 (1979) (J.L. died before appeal).

45. 412 F. Supp. at 116.

46. Appendix to Jurisdictional Statement at 146-53, Parham v. J.R., 442 U.S. 584 (1979).

47. 412 F. Supp. at 117.

48. *Id.*

49. Appendix to Jurisdictional Statement at 132, Parham v. J.R., 442 U.S. 584 (1979).

50. Early tests showed I.Q.'s of 77 or 65. A test after hospitalization showed at 61. This is probably not a significant change. *Id.*

(private) foster care unless J.L. was eligible for such care to be paid for by A.F.D.C. or social security funds. "He was not an A.F.D.C. eligible child. . . . Specialized foster care was not obtained for J.L. by the defendants."[51]

Several common, noteworthy factors are evident in the previously recounted facts. First, the services available to the named plaintiffs by the State of Georgia were not overly abundant. In both cases, the state's own hospital staff suggested placement outside the hospital context, but nothing was done. Whether unavailable funding precluded specialized placement for J.L. is unknown, but one suspects so. Second, both J.R. and J.L. suffered rejection from their natural and foster families. J.R. typified a ward of the state because he was bounced from foster home to foster home before ending up in a mental hospital. J.L. experienced similar trauma by his parents' divorce, his mother's remarriage, and then his being shuffled between his home and the hospital for a number of years, after which his parents relinquished their responsibility for J.L. to the state.[52]

A. The Precommitment Hearing Issue.

In *Parham*, the Supreme Court focused upon whether a hearing prior to each child's hospitalization was necessary. The opinion by Chief Justice Burger was rather straightforward, applying the balancing test first clearly announced in *Mathews v. Eldridge*.[53] This test measures the procedures required by due process after determining that the children, like adults, have a substantial liberty interest in not being confined unnecessarily,[54] and also in not being labeled erroneously by an incorrect decision.[55] In applying the threefold *Mathews* test, the Court considered:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substituted procedural requirement would entail.[56]

51. 412 F. Supp. at 117. The diagnostic notes show unsurprisingly that he too suffered feelings of rejection. Appendix to Jurisdictional Statement at 132, Parham v. J.R., 442 U.S. 584 (1979).

52. This factor is also of considerable importance with respect to the mentally retarded. For discussion *see* note 47 and accompanying text *supra*.

53. 424 U.S. 319 (1976).

54. Parham v. J.R., 442 U.S. 584, 600 (1979).

55. *Id.*

56. *Id.* at 599-600 (quoting Matthew v. Eldridge, 424 U.S. 319, 335 (1976)).

1. The Interests of the Child

The Supreme Court first considered the child's interests. Potential "adverse social consequences . . . because of the reaction of some to the discovery that the child had received psychiatric care,"[57] were recognized. However, "the state through its voluntary commitment procedures does not 'label' the child; it provides a diagnosis and treatment that medical specialists conclude the child requires."[58] In the Court's view, citing as authority a number of articles,[59] what is truly stigmatizing is the symptomology of a mental or emotional illness.[60] Taken together, these articles are scant authority.

The first article, *The Stigma of Mental Hospitalization*,[61] hardly stands for the general proposition that stigma does not exist—or is not worth worrying about. The study had a very limited objective and was severely constrained by the design of the project. Only former mental patients who had been in one particular hospital were the target of the study, and except for situations in which a family member responded on behalf of an otherwise unavailable mental patient, the ex-patients were the *only* respondents. There is no indication that the study contained any children as mental patients. Moreover, the study primarily evaluated various objective measures of social activity or "performance" from the viewpoint of the "ex-patient." These included employment of the respondents, performance of housework before and one year after hospitalization, and the financial situation of patients afterwards. By self-rating, a modest improvement is determined to exist in all of these.[62] Such improvement, however, is merely some indication that either in-patient care, other care, or else the passage of time has some tendency to benefit the patient. Moreover, it is assumed by the definition of the subject group of the study that all respondents

57. Parham v. J.R., 442 U.S. 584, 600 (1979).
58. *Id.* at 600-01.
59. *See Id.* at 601 n.12.
60. The full text of footnote 12 provides:

See also Gove & Fain, *The Stigma of Mental Hospitalization*, 28 ARCHIVES OF GENERAL PSYCH. 494, 500 (1973); Phillips, *Rejection of the Mentally Ill: The Influence of Behavior and Sex*, 29 AM. SOC. REV. 679, 686-687 (1964). Research by Schwartz, Meyers & Astrachan and that of Gove and Fain found 'that the stigma of mental hospitalization is not a major problem for the ex-patient.' Schwartz, Meyers & Astrachan, *Psychiatric Labeling and the Rehabilitation of the Mental Patient*, 31 ARCHIVES OF GENERAL PSYCH. 329, 333 (1974).

The Court nowhere mentions that all of this research appears to have involved adults only.

61. Gove & Fain, *The Stigma of Mental Hospitalization*, 28 ARCHIVES OF GENERAL PSYCH. 494 (1973).
62. *Id.*

were in-patients. That is, however, exactly the issue being decided in these cases. Ought the children be in-patients? The data on improvement is not impressive. For example, before hospitalization sixty-one men and seventeen women reported being employed.[63] After hospitalization, sixty-five men and thirty-nine women were employed.[64] Prior to hospitalization, eighty-one men indicated that they were in the labor force but unemployed.[65] After hospitalization, seventy-seven men were apparently still looking for a job. This data does not support the conclusion that there is no stigma involved with hospitalization, but it did specifically mention that having been in a mental hospital made finding a job difficult.[66]

Another area surveyed included social relationships with cohabitants such as spouses and children.[67] Generally, better relationships are reported after the patient has left the hospital. The concept of stigma, however, is not normally associated with such people but rather with strangers. The study confesses that a number of studies show that the public generally regard the mentally ill with "fear, distrust and dislike."[68]

Four other areas of relationships and activities outside the home were also surveyed: 1) the amount of visiting, 2) involvement in conflicts with others, 3) time devoted to recreational activities, and 4) participation in formal organizations. All are obviously very indirect measures of something so subtle as stigma.

A modest change in favor of more visiting of parents, friends, siblings, children, other relatives, in-laws, and neighbors was observed.[69] On the whole, 56% indicated little change, 25.1% indicated more visits, and 18.1% indicated fewer visits. What this says about stigma is unclear.

Serious conflicts between the ex-patients and others were reported to be relatively rare.[70] Most (67.6%) said there were some either before or after hospitalization.[71] However, 20.9% reported both pre- and post-hospitalization conflicts.[72] Although 10% reported pre-admission conflicts, only 1.5% reported post-admission conflicts.[73] If stigma im-

63. *Id.* at 496.
64. *Id.*
65. *Id.*
66. *Id.* at 496-97.
67. *Id.* at 497-98.
68. *Id.* at 494.
69. *Id.* at 498.
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.*

plies shunning, this data may support its existence, but not self-awareness of the stigma by the former patients in the panel. Conflicts are only possible if some relationships with people exist. These may be unusually isolated respondents. In any case, a very weak positive case is made.

Recreational activities changed little. Most respondents reported no change.[74] More persons reported no increase in time than reported a decrease.[75] There was, however, no measure of the absolute time devoted to recreation, nor is there any measure of the quality of the recreational time by comparison with persons other than former in-patients. Once again the implications are unclear.

Of the 206 patients from one group of 215 who responded, 78.6% indicated no change in attendance of meetings of voluntary organizations.[76] But "[t]his figure is primarily a product of the fact that two thirds [sic] of the patients indicated they simply had never attended such meetings."[77] There was an increase for 12.6% of the patients and a decrease for 8.7%.[78]

Finally, in a general evaluation section the researcher asked two questions: "Do you think your stay in the hospital harmed you in any way?"[79] Most patients reported hospitalization as beneficial and no more than 16% viewed the hospitalization as harmful.[80] The generality of such questions obviates any serious conclusions about a stigma. A skillfully drawn set of follow up questions about the reactions of other people to the ex-patients might have adequately explored this area. This apparently was not done.

The question asked that was most directly relevant to stigma is itself far from direct: "Since returning from the hospital do you think you have, in any way, presented a problem at home?"[81] It is possible, although unlikely, to interpret this question as requesting information about stigma of the family unit, and one respondent may have indicated such a problem.

In short, the data suggest that the majority benefited from

74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.*
80. *Id.* at 498-99. Of patients interviewed, 84.2% of those living in an open community one year after hospitalization said they had been helped; of those living in an institution a year later 74.1% said they had been helped; of other persons interviewed, when the patient was residing in an open community, 71.4% said hospitalization helped, and 92.3% said the same for a patient residing in an institution a year later.
81. *Id.* at 499.

hospitalization; however, any conclusions about stigma perceived by the former patients becomes problematic.

The next article cited, *Rejection of the Mentally Ill: The Influence of Behavior and Sex*, is even less helpful; indeed, one might say that it is contra to the major proposition.[82] Moreover, the article also presents serious experimental design problems. First, all of the respondents were women. Second, data were gathered by displaying a series of cards to the women and by ranking their responses in a social distance scale. The data are simply overwhelming that seeking help through hospitalization strongly increases the rank of social distance.[83]

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82. Phillips, *Rejection of the Mentally Ill: The Influence of Behavior and Sex*, 29 AM. SOC. REV. 679 (1964).

83. *Id.* at 684. For example, a partial reprint of the rejection scores is as follows:

Help source utilized and sex	Normal Individual	Phobic Compulsive	Simple Schizophrenic	Depressed Neurotic	Paranoid Schizophrenic
No Help					
Male	.00*	.70	1.60	1.77	3.77
Female	.03	.37	.60	1.13	3.53
Psychiatrist					
Male	1.53	2.07	2.97	2.83	4.40
Female	.97	1.67	2.73	2.57	3.83
Mental Hospital					
Male	1.77	2.57	4.07	3.83	4.73
Female	1.50	1.97	3.30	2.73	3.93

*Number values are rejection scores based on the mean number of items rejected by the females on the social distance scale.

Although the collection of data is fairly standard, it must be emphasized that such studies greatly depend upon the verbal content and nuances of the cards displayed to the respondents. Each of the descriptions contained the sentence, "Imagine that he (she) is a respectable person living in your neighborhood." The survey included this statement deliberately to suggest that the individuals in the case abstracts were similar to the respondents. *Id.* at 681 n.14. For example, the description of a "normal" person was as follows:

> Here is a description of a man. Imagine that he is a respectable person living in your neighborhood. He is happy and cheerful, has a good job and is fairly well satisfied with it. He is always busy and has quite a few friends who think he is easy to get along with most of the time. Within the next few months he plans to marry a nice young woman he is engaged to.

Id. at 681. It isn't hard to imagine rejection of such an ideal type because of the personal interpretation given this description by the respondents. Indeed, the rejection score for such a "normal" person who has consulted a psychiatrist exceeds the rejection scores for the descriptons of behavior of all of "phobic compulsives," and "simple schizophrenics," and a "depressed neurotic" when none of these has sought more help than a clergyman. *Id.* at 684. Similarly, such a man who seeks the help of a physician, not a psychiatrist, is rejected by the same score as a woman "simple schizophrenic" who has sought no help. *Id.* at 684. That description is as follows: [altered to insert woman for man as the researchers did].

> Here is a description of a woman. Imagine that she is a respectable person living in your neighborhood. She has never had a job and doesn't seem to want to go out

In every case the perceived distance increased, often by substantial amounts, with the addition of hospitalization as a factor. The authors of that study concluded that individuals are rejected in accordance with how much their behavior deviates from socially prescribed norms, and not on the basis of how pathological their behavior is from a mental-hygiene point of view.[84] But what is meant by behavior in this context is the seeking of particular forms of help, not just the objective behavior of people as set out in verbal descriptions provided to respondents.

The best of the studies upon which Chief Justice Burger relied, in terms of experimental design and administration, was *Psychiatric Labeling and the Rehabilitation of the Mental Patient*.[85] Even that study contained a significant limitation, however. The data collected dealt with 132 schizophrenics who were so diagnosed, treated, and interviewed two years after in-patient treatment.[86] One hundred twenty-four relatives of the former patients were also interviewed.[87] Thus people with prolonged exposure to one of the most serious forms of mental illness were respondents in this study. Therefore, the subjects of this study were probably quite well informed about mental illness. They may have been unusually predisposed to recognize the need for hospitalization. Even though stigma is perceived in one area of the study, among lower-class whites,[88] the authors assert, "[t]he finding of a relationship between social class and social distance is clarified by keeping in mind that the social distance scale used here deals with labeled mental illness. Once defined as mentally ill, the lower the social class, the greater the social distance."[89] Moreover, "[fifty-one] percent of the family members expressed social distance reactions to the mentally ill . . ., in-

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and look for one. She is very quiet. She doesn't talk much to anyone—even in her own family. And she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

Id. at 684. Yet the rejection score of a "normal man" consulting a doctor is identical! The closing paragraph to the study confesses hope that the disadvantages of using verbal descriptions such as these are balanced by illumination of the factors involved in rejection of the mentally ill. *Id.* at 687. There is, however, no question that rejection does occur.

84. *Id.* at 686-87.

85. Schwartz, Myers, & Astrachan, *Psychiatric Labeling and the Rehabilitation of the Mental Patient*, 31 ARCHIVES OF GENERAL PSYCH. 329 (1974).

86. *Id.* at 330.

87. *Id.*

88. *Id.* at 333.

89. *Id.*

dicating that negative attitudes are still a factor in rehabilitation for a substantial number of former patients."[90]

The study reports that social class and membership in the white race explains 13.7% of the variance in social distance scores.[91] The next two most significant variables, both measuring impairment of mental status, together represented only 7.6% of the variation in social distance.[92] Symptomology is not as important as preconceptions about status in society, for the authors of the study report "a lower-class nonwhite mental patient is not as likely to meet with as much disapproval as if he were white."[93] They conclude that social attitudes towards mental illness are determined in large part by group affiliation, and are deeply engrained and not easily changed.[94] That conclusion is well supported by their study, whereas significant conclusions on the levels of stigma and impact are not.

Edmond Cahn's trenchant comment about the social science footnote in *Brown v. Board of Education*[95] seems appropriate: "I would not have the constitutional rights of Negroes—or of other Americans—rest on any such flimsy foundation as some of the scientific demonstrations in these records."[96]

After citing the aforementioned articles as authorities, the Chief Justice next turned to the interests of the parents who have decided "on the basis of their observations and independent professional recommendations, that their child needs institutional care."[97]

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90. *Id.* at 331. The authors report that:

> The multiple regression analysis, performed to isolate the correlates of social distance, yielded 18 independent variables that explain slightly less than one third of the variance in social distance scores. . . . In terms of the direction of the relationships, a strong social distance reaction is associated with being of a lower social class; white; highly impaired on [several] mental status factors . . .; alone in terms of living arrangements; downwardly mobile; of an older age; a married head of a household; married or single; male; rehospitalized; and Catholic. A more favorable social distance reaction, indicating less rejection, is associated with being Jewish or Protestant, and unimpaired on [another] mental status factor [representing halucinations].

Id.

91. *Id.* at 333.

92. *Id.*

93. *Id.*

94. *Id.* at 334.

95. 347 U.S. 483, 494 n.11 (1954).

96. Cahn, *Jurisprudence*, 20 N.Y.U.L. REV. 150, 157-58 (1955). *Compare* Clark, *The Desegregation Cases: Criticism of the Social Scientist's Role*, 5 VILL. L. REV. 224 (1959) *with* Stell v. Savannah-Chatham County Bd. of Educ., 220 F. Supp. 667 (S.D. Ga. 1963), *rev'd*, 333 F.2d 55 (5th Cir.), *cert. denied sub nom.* Roberts v. Stell, 379 U.S. 933 (1964).

97. Parham v. J.R., 442 U.S. 584, 602-03 (1979).

Although the Court recognized that child neglect and abuse cases indicate some degree of tension between reality and the presumption that parents act in the best interest of the child, the Court basically discounted such risks. Such situations are "hardly a reason to disregard wholesale those pages of human experience that teach that parents generally do act in the child's best interests."[98]

Rolfe and MacClintock did not propose rejecting the legal system as a protective device for juveniles, but rather recognizing the importance of using the skills "available only through the medical profession."[99] They proposed creating a statewide review board, rather like an adminstrative agency, to review every admission routinely and to hold hearings if deemed necessary.[100] Review then might be taken in the courts just as review of any administrative agency determination. Chief Justice Burger, however, pontificated that "[t]he statist notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition."[101] Unfortunately, however, the cases in which children are committed to mental hospitals involve a high risk of intrafamily conflict and/or parental problems such as alcoholism and mental illness.[102]

Despite this, the Chief Justice distinguished earlier decisions restricting the deference due parental decision-making because in *Parham* the state statute required the superintendent of each regional hospital to exercise independent judgment about the need for confinement. Although the parents do not retain "absolute and unreviewable discretion to decide whether to have a child institutionalized,"[103] they do retain plenary authority to seek such care, "subject to a physician's independent examination and medical judgment."[104] The Court's decision to prohibit a parent's veto of his child's abortion in *Planned Parenthood of Central Missouri v. Danforth*[105] is therefore different from a parental role of committing a child to a mental hospital.[106] The difference is the agreement of a doctor. That difference, however, is not particularly persuasive in this context. If the question was whether

98. *Id.* at 602-03. *See* Rolfe & MacClintock, *The Due Process Rights of Minors "Voluntarily Admitted" to Mental Institutions*, 4 J. OF PSYCHE. & L. 333 (1976).
99. *Id.* at 349.
100. *Id.* at 357-61.
101. 442 U.S. at 603 (emphasis in original).
102. *See, e.g.*, the facts recited in notes 39-41 and accompanying text *supra*.
103. 442 U.S. at 604.
104. *Id.*
105. 428 U.S. 52 (1976).
106. 442 U.S. at 604.

the parents and doctor could force a child to undergo sterilization, the Supreme Court would probably not view suits after the fact as an adequate remedy.[107] The Court apparently overvalued parental interests *vis-a-vis* the child's interests. Nevertheless, as will be discussed below, a reasonable argument may be made that the ultimate result is proper in a limited context.[108]

2. The Interests of the State

Another important element of the *Mathews v. Eldridge* balancing calculus concerns state interests which are threefold: 1) confining the use of costly mental health facilities to cases of genuine need; 2) not imposing unnecessary procedural obstacles so as to discourage seeking needed mental help; and 3) maximizing the resources devoted to diagnosis and treatment and minimizing resource allocation devoted to "time-consuming procedural minuets."[109] Chief Justice Burger referred to the amicus brief of the American Psychiatric Association for authority that the average staff psychiatrist in a hospital is able to devote only 47% of his time to direct patient care.[110] The Chief Justice, however, did not mention that the same brief advocates exemption from due process requirements only in instances in which: (1) parents in an intact family wish to admit a (2) preadolescent child to (3) an accredited institution (4) for a short-term period; e.g., less than forty-five days.[111]

Chief Justice Burger then turned to the issue of the process required to adequately protect the constitutional rights of juveniles. The complete holding, that judicial precommitment scrutiny is not required and that only a neutral factfinding process of some form (e.g., screening by the hospital) is required, has been previously reported.[112] To some degree that holding turns upon the Court's perception that there is little utility of court hearings in such situations. Once again, as in the

107. *But see* Stump v. Sparkman, 435 U.S. 349 (1978) (showing approval of judicially ordered sterilization) *and* note 2 and accompanying text *supra*.

108. *See* notes 151-60 and accompanying text *infra*.

109. Parham v. J.R., 442 U.S. at 604-05 (footnote omitted).

110. *Id.* at 606.

111. Amicus Curiae at 25 et seq. by the American Psychiatric Association, American Society for Adolescent Psychiatry, American Academy of Child Psychiatry, and American Association of Psychiatric Services for Children, Parham v. J.R., 442 U.S. 584 (1979) (hereinafter cited as Amicus Brief by the American Psychiatric Association et. al.) (none of the *Parham* admittees met more than two of these conditions).

112. *See* text accompanying note 36 *supra*.

area of stigma, an empirical footnote was made, reporting the mean hearing time from various studies,[113] which went from 3.8 minutes to 9.2 minutes. Once again the empirical basis is less than overwhelming, particularly when one of the citations is completely incorrect. Rather than a citation to the time spent in court, one of the citations of 9.2 minutes is to the time spent by a physician interviewing a patient upon his admission to the hospital.[114] Another similar study reported on the same page determined a time of 10.2 minutes, with the longest interview by a physician lasting seventeen minutes.[115] The correct citation of time in that study for judicial hearings would be 1.6 minutes.[116] Neither figure stands for the proposition that there exists an adequate check on parental decision-making by an adequate impartial fact-finder.

The Supreme Court was on more solid ground when it recognized that the decision to be made is essentially medical.[117] After acknowledging the "fallibility of medical and psychiatric diagnosis,"[118] the Court raised an argument about the danger of exacerbating tension within the household as a result of a formal hearing requirement:

> Since the parents can and usually do play a significant role in the treatment while the child is hospitalized and even more so after release, there is a serious risk that an adversary confrontation will adversely affect the ability of the parents to assist the child while in the hospital. Moreover, it will make his subsequent return home more difficult. These unfortunate results are especially critical with an emotionally disturbed child; they seem likely to occur in the context of an adversary hearing in which the parents testify. A confrontation over such intimate family relationships would distress the normal adult parents, and the impact of a disturbed child almost certainly would be significantly greater.[119]

None of the statements in this section of the opinion are documented. Instead, they seem to represent conjecture by the Court. Furthermore, not all of these propositions stand unchallenged. Without denying the seriousness of the issues raised by Chief Justice Burger, an amicus brief reported the essentially beneficial results when courts intervene as

113. 442 U.S. at 609 n.17.
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.* at 608.
118. *See id.* at 609 (citations omitted).
119. *Id.* at 610 (footnotes omitted).

a matter of course in committing children.[120] That brief focused on the major issue—the appropriateness of inpatient treatment of children. The New Jersey system for committing children as revised in 1975 requires a hearing after notice no more than twenty days after either temporary commitment, filing a commitment application, or the child's admission date to a facility.[121] At that hearing, attorneys from the Division of Mental Advocacy often serve as guardians ad litem for the juveniles. The amicus brief reported a study of the "approximately 213" closed cases handled by the Division over a two-year period.[122] Commitment was approved or continued in the institution in which the juvenile was placed in only 42% of the cases.[123] An error rate of nearly 50% suggests little reason for submitting to the medical decision-making process. Contrasted, however, with the spectre of long-term commitment (such as five years for the named plaintiffs in *Parham*), nearly 16% were discharged prior to the hearing,[124] and 15% were discharged at the hearing (usually to parents or a guardian).[125] The remainder were discharged to various specialized programs or ordered transferred or admitted to specialized treatment programs.[126] Moreover, parental reaction to the intervention by the guardian ad litem appears to have been generally favorable.[127]

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120. Brief and Appendix of Amicus Curiae, Department of the Public Advocate, Division of Mental Health Advocacy, State of New Jersey [hereinafter cited as N.J. Amicus Brief].

121. *Id.* at 11-14.

122. N.J. Amicus Brief, *supra* note 120 at 18.

123. *Id.* at 20-21. Voluntary applications for admission were accepted in 38 cases, while commitment was ordered in 38 cases and confinement continued in 30 cases.

124. Discharge prior to final hearing occurred in 34 cases after involvement of amicus. *Id.* at 19.

125. *Id.*

126. Fourteen were "discharged pending placement;" six were "discharged pending placement" to a facility administered by New Jersey's Division of Mental Retardation. Fifteen were "discharged pending placement to a residential school, one was discharged pending placement" to a drug rehabilitation facility, one was discharged to the custody of Division of Mental Retardation officials. Four were discharged subject to certain conditions (for example that the juvenile participate in a specific after-care program). Two were transferred to out-of-state hospitals, three were ordered admitted to a specific education program while institutionalized, five were remanded to local jails or youth detention facilities to await trial on criminal offenses or hearings on juvenile delinquency petitions, or to a facility for "juveniles in need of supervision," and one was discharged to a foster home. In two cases adjournments were entered to facilitate residential school placement and to avert the potentially stigmatic effect of a commitment label. *Id.* at 19-20 (footnotes omitted).

127. In four cases in which the parents were initially "negative or uncooperative," radical shifts towards cooperation occurred. *Id.* at 23. In most cases parents were pleased with the involvement of amicus attorneys. Only in a handful of cases [number unspecified] were parents hostile.

Considering the dynamics involved in committing a child to a mental institution, these findings are not surprising,[128] because the decision to commit a child clearly requires a most painful decision for any parent. Even if a parent is convinced that the professional advice of the medical physicians and other specialists is appropriate, another professional's concurrence in the determination offers reassurance to the parent, because invoking either a guardian ad litem or a court hearing partially shifts the decision-making burden from the parents. Indeed, the New Jersey study suggests that intervention by outsiders is beneficial rather than detrimental. Determining where the balance lies in intervening is most difficult, however, for any court or parent. Arguably, however, it appears possible to shift the balance in the direction of the Supreme Court's determination as far as children with involved parents. Summarily requiring a precommitment hearing may deter some parents from seeking any help or delay their obtaining assistance so as to be seriously detrimental to the child.[129] Although no empirical data exist to prove this risk, it may be so grievous that ignoring the lack of data is permissible. Hopefully, the result is proper, but even that ought to be tested by prompt postcommitment review.

B. The Courts as Monitors of the Commitment Process.

In *Parham v. J.R.*, the Supreme Court concluded that "the risk of error inherent in the parental decision to have a child institutionalized for mental health care was such that some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied."[130] In addition, 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 under a similarly independent procedure.[131]

The Court thus recognized the necessity of another party's intervening in the admission process; indeed, the Court apparently

128. Although they too could stand a great deal of further examination and replication.

129. Chief Justice Burger in *Parham* refers to undue inhibition of parents seeking help. 442 U.S. at 605-07.

130. Parham v. J.R., 442 U.S. 584, 606 (1979).

131. *Id.* at 606-07 (footnote omitted).

designated that party as a "constitutional actor" for admission purposes. The Court adopted this approach because "in general, we are satisfied that an independent medical decisionmaking process, which includes the thorough psychiatric investigation described earlier followed by additional periodic review of a child's condition, will protect children who should not be admitted . . . ."[132] The Court reached this decision by evaluating the admissions process at the six state hospitals involved in the *Parham* case. The Court described one of these as follows:

> Augusta Regional Hospital was opened in 1969 and is affiliated with 10 community mental health clinics. Its children and adolescent unit housed 14 children in December 1975.
>
> Approximately 90% of the children admitted to the hospital have first received treatment in the community, but not all of them were admitted based on a specific referral from a clinic. The admission criterion is whether the child needs hospitalization and that decision must be approved by two psychiatrists. There is also an informal practice of not admitting a child if his parents refuse to participate in a family therapy program. The admission decision is reviewed within 10 days by a team of staff physicians and mental health professionals; thereafter each child is reviewed each week. In addition, every child's condition is reviewed by a team of clinic staff members every 100 days. The average stay for the children at Augusta in December 1975 was 92 days.[133]

The issue, however, involves not merely the proper diagnosis of mental illness, but also the appropriate care for that illness. The *Parham* amicus brief for the American Psychiatric Association emphasized this point.

> While Amici agree with appellant that psychiatric diagnosis, *i.e.*, identification of specific mental illnesses—are medically reliable, we recognize that this fact is not dispositive of the issue of when a hearing is constitutionally required. Even if a child is properly diagnosed, it does not follow that hospitalization is necessary or desirable: Rather, Amici believe that in appropriate circumstances a due process hearing may pro-

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132. *Id.* at 613.

133. *Id.* at 593-94. It is interesting to note the wide variation in average length of stay at the various hospitals in Georgia. They are: 100 days (Southwestern Hospital); 161 days (Atlanta Regional Hospital); 346 days (Georgia Mental Health Institute); 92 days (Augusta Regional Hospital); 464 days (West Central Hospital). The Court notes the unusual length of stay at the last hospital is unexplained. Since the Georgia Mental Health system is regionalized, J.L. v. Parham, 412 F. Supp. 112, 119 (M.D. Ga. 1976), such disparities ought not to exist. Nor is it untroubling that 10% of the admittees were not previously treated outside the hospital.

> vide a reasonable forum for deciding what care should be provided to a properly diagnosed child.[134]

Therefore, the American Psychiatric Association would require that pre-commitment hearings be held for any child being committed to a hospital not accredited by the Joint Commission on Hospital Accreditation.[135] Five of the eight regional hospitals in Georgia to which children are confined have not been so accredited by the Joint Commission.[136] In some cases, poor treatment may be worse than no treatment. A study commission on Mental Health Services for Children and Youth, formed in Georgia in 1973, reported that improvement was urgently needed. The study disclosed that:

> [in] many cases, youth are housed on geographic units with disturbed adults. Staff were concerned that in these units adolescents are continuously confronted with pathological adult behavior patterns at a time in their psychological development when healthy role models are needed to help them develop an individual sense of identity.[137]

Nevertheless, as the district court found in *Parham*, the situation is basically unchanged since this report.[138] Moreover, as of January 19, 1976, the State indicated that forty-six children in mental institutions could be cared for in a less restrictive, nonhospital setting.[139] However, "these 46 children are not eligible for . . . federal money, and for them the state affords nothing other than hospitalization."[140] The State thus concedes that for roughly one-fourth to one-third of the in-patient population, less restrictive care is preferable. Children eligible for A.F.D.C. or social security federal money are placed in privately operated, less restrictive facilities.[141]

The core question ought to be how to provide the most suitable care for those children needing mental health care. It is that decision that may be most appropriately examined, according to the American

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134. Amicus Brief for the American Psychiatric Association et. al., *supra* note 111 at 24.

135. Note 116 and accompanying text *supra*.

136. Amicus Brief at 26 by the American Orthopsychiatric Association, Children's Defense Fund of the Washington Research Project, Inc., Federation of Parents Organizations for N.Y. State Mental Institutions, Mental Association, National Association of Social Workers, National Center for Law and the Handicapped, and the National Juvenile Law Center, Parham v. J.R., 442 U.S. 584 (1979) (hereinafter cited as Amicus Brief by the Am. Orthopsychiatric Association).

137. *Id.* at 25, extract of Georgia Commission Report at 9 (A. 904).

138. Amicus Brief by the Am. Orthopsychiatric Association at 26, J.L. v. Parham, 412 F. Supp. 112, 138 (M.D. Ga. 1976).

139. 412 F. Supp. at 124-25.

140. *Id.* at 125.

141. *Id.*

Psychiatric Association amicus brief, in the context of a court hearing. Yet the Supreme Court's decision deals only with the issue of whether treatment ought to be provided at all rather than with what treatment would be appropriate. The State's scandalous confession that forty-six children confined in in-patient units do not need such treatment, when the maximum number of confined children never passed two-hundred and dropped as low as one hundred and forty,[142] strongly emphasizes the need for monitoring the quality and nature of the care provided. The courts need not delve very deeply into the medical issues in such cases to properly monitor confinement and treatment. After all, the states have employees who recommended alternate treatment for these 46 children, including both of the named plaintiffs.

In *Parham* the Supreme Court refused to reach the issue of whether a postadmission hearing is constitutionally required. Considering the submissions of the amicus briefs previously discussed, that decision appears to be unwise. Had the Court viewed its role as monitoring not just the initial diagnosis, but also the treatment, then a postcommitment hearing would have been a likely, logical conclusion. Part of this duty to monitor the treatment accorded such juveniles ought to have included seriously considering the contention by the American Psychiatric Association that a treating hospital should be accredited by the Joint Commission on Hospital Accreditation.[143] The Court declined to respond to this argument. Moreover, the Court also declined to respond to the request that several categories of children be created. The American Psychiatric Association has argued that adolescent children should be treated differently for purposes of assessing the impact of hearing procedures on children.

"The professional literature establishes that when children reach a *developmental age* of approximately 13, they begin to be significantly more capable of rational and analytical evaluation of their own best interests, as well as articulate expression of their views."[144] Indeed, a survey of the states indicates that the age of 13 has generally been adopted as the point at which a juvenile may initiate release procedures

142. *See* note 14 and accompanying text *supra.*

143. The American Psychiatric Association amicus brief states in part, "Amici believe that the risk of psychological injury to children who are placed in such unaccredited institutions is sufficiently great to outweigh the possible harm of hearings." Amicus Brief Am. Psychiatric Association et. al., *supra* note 111, at 28.

144. Amicus Brief American Psychiatric Association et. al., *supra* note 111, at 26-27 (emphasis in original). Several footnotes omitted which suggest that chronological age and developmental age are not identical. Moreover, there is some dispute over the age, but consensus that the age 12-14 is accurate.

from a mental institution.[145] Even Georgia has recognized a line close to this in permitting children 14 and older to volunteer themselves for mental health observation and diagnosis.[146] The group of professionals on whose judgment the Supreme Court so confidently relied would dispense with the requirement of a court hearing only with respect to pre-adolescent children. Moreover, these professionals would also refuse to dispense with a court hearing unless the commitment is for only a short term. They adopt this position partly because they appreciate the shifting interests and risks in the cases. A short term commitment will enable better presentation of a recommended treatment plan to the court, should continued hospitalization be necessary. Moreover, "the basic premise [*sic*] of a rule allowing short-term institutionalization without prior hearing procedures is that the child will return home shortly, the danger of parental abuse, or 'dumping,' is lessened significantly."[147]

Yet the Supreme Court authorized commitment without hearing of both pre- and post-adolescent children to a mental health system described by a national commission in 1969 as operating on a "long abandoned theory," concluding that "instead of being helped, the vast majority [of children] are the worse for the experience."[148] The Georgia system appears to fall into the same pattern.[149]

Such abdication from scrutinizing the treatment provided by the mental health system fails to protect the constitutional rights of the juveniles involved. The Supreme Court ought not to have accepted at face value the descriptions of the admission process at the Georgia hospitals as sufficient guarantees that significant errors were not made, when the State itself reported that many of these juveniles would be better off elsewhere. Surely the Supreme Court would not have accepted voluntary commitment of children by parents to a religious cult that believed in Chinese water torture for eradicating the adolescent rebellion syndrome. When the Court specifically held that an individual's constitutional rights depend upon a third party's scrutinizing the commitment decision, the Court ought to have required some

145. Illinois did this first by a court decision. *In Re* Lee, No. 68 J 15805 (Ill. Cir. Ct. Cook County, County Div., 1972) and then codified it in the new Mental Health and Developmental Disabilities Code, § 3-505. *See also* comments to the Report, Governor's Commission for Revision of the Mental Health Code of Illinois 47 (1976).

146. GA. CODE ANN. § 88-503.1(b) (1980).

147. Amicus Brief, American Psychiatric Association et. al., *supra* note 116, at 32-33.

148. Joint Commission of the Mental Health of Children, established pursuant to Social Security Act, July 20, 1965, PUB. L. 89-97, § 231(a)-(d), 79 STAT. 360. Report at 6.

149. *See* note 137 and accompanying text *supra*.

quality standards for that third party. Moreover, even though the reported commitment procedures in the Georgia state hospitals sound appropriate, one must wonder how so many children slipped through into treatment facilities totally inappropriate for their problems.[150]

C. *Commitment of Wards of the State: The Same Waiver of Pre-Commitment Requirement*

In *Parham v. J.R.*, three Justices, Brennan, Marshall, and Stevens, dissented from the portion of the majority opinion allowing commitment without hearing even for children who are wards of the state.[151] The dissenters also reached the issue of a requirement for a post-admission hearing. Justice Brennan's dissent quite properly noted the irony of describing parental commitment of children to mental institutions as "voluntary commitment.[152] Nevertheless, Justice Brennan was persuaded that parents might be deterred from seeking help, that treatment might be delayed, that the hearing process might traumatize the child-parent relationship; therefore, Justice Brennan concluded that the State may dispense with a pre-commitment hearing for a child who is not a ward of the State. But those considerations merely justify postponing hearings; they do not justify dispensing with all court hearings entirely.[153]

When a state guardian, on the other hand, seeks to commit children, none of the justifications for dispensing with a hearing are present. There is no need to preserve family autonomy or to minimize discord. Furthermore, the prospect of a hearing is unlikely to deter state social workers from obtaining commitment orders to secure psychiatric assistance for their clients. The dissenters explicitly rejected Chief Justice Burger's justification that because social workers are statutorily obliged to act in the children's best interests, no pre-commitment is required.[154] Justice Brennan characterized this as tantamount to arguing "that criminal trials are unnecessary since prosecutors are not supposed to prosecute innocent persons."[155]

As the justifications for not holding hearings become less applicable, the need for such hearings becomes more persuasive. These

150. Or is it that by the time a proper diagnosis was made that the children's condition had already changed?

151. 442 U.S. 584, 625 (Brennan, J., dissenting) (1979).

152. *Id.* at 631-32.

153. *Id.* at 633-34.

154. *Id.* at 637-38.

155. *Id.*

hearings could involve not only scrutiny of the propriety of the decision to treat, but also scrutiny of the care that the State has already provided. One crucial issue is providing inappropriate institutional treatment because of inadequate funding constraints. This issue involves limitations not only upon the total amount of money, but also upon the kind of services provided. In-patient treatment, but not outpatient treatment may be all that is provided, unfortunately, in-patient treatment is the most expensive treatment, hospital care, $40,000 per year; group home care, $7,500 per year; residential treatment, $12,000 per year (1976 prices).[156] In 1980 in-patient psychiatric care at one of the best hospitals in Chicago, Children's Memorial Hospital, cost nearly $100,000 per year.[157] Thus, although both the state and society could save money and improve services in many instances, inpatient care is provided because that is the only service available.[158]

In *Parham*, J.R. all too nearly typifies the tender care rendered wards of the state. At age seven, J.R. was finally committed to a hospital by his seventh set of foster parents.[159] Logic requires a check on the states treatment of such children when there is at least prima facie evidence that the state has already "abused" the child. When the state as surrogate parent sends the child off to a mental institution, confinement can be justified only in rare situations. The risk of stigmatization by other people, such as school teachers and potential foster parents, as well as self-stigmatization, must be considered:

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156. *Id.*

157. Telephone interview with Psychiatric Inpatient Department, Children's Memorial Hospital, Chicago, Jan. 15, 1980. The exact figure for room and board is $270 per day, which is over $98,000 per year.

158. There is often only one alternative available. *See, e.g.*, testimony in Martin M. v. Shephard (D. Conn. No. H-75-130) where a father testified:

"Q. During the year Michael was [in the hospital] did you as his parent feel that it was an appropriate place for him to be?
A. No way, no way.
Q. Why not?
A. The conditions were deplorable.
Q. Why did you sign him in the hospital?
A. We had no other recourse, none."

Testimony reprinted in Amicus Brief, American Orthopsychiatric Association *supra* note 136 at 43.

159. *See* notes 41-43 and accompanying text *supra*. Forty percent of institutionalized juveniles have been in four or more different homes or institutions prior to admission. Less than one-fourth were living in their natural homes at the time of admission. Block and Behrens, "A Study of Children Referred for Residential Treatment in New York State" 16, 17 (Report to the N.Y.S. Interdepartmental Health Resources Board, 1959).

> Frequently a formerly committed individual tends to perceive society's negative response to him as a valid measure of his personal worth. The label becomes a double-edged blade, causing him 'to demean himself and to magnify social ostracism.' In the case of a child who is actually in need of commitment to a mental institution, these detrimental effects are the unfortunate price that must be paid to enable the child to overcome his disability. But, where a child is committed unnecessarily, the profound and long-term harm that results is inexcusable.[160]

III. COMMITMENT OF THE MENTALLY RETARDED: THE WORST CASE

The societal status of the mentally ill is low, but that of mentally retarded persons is lower. The effect of the Supreme Court's decisions involving such persons reflects this societal attitude. Parents of mentally ill individuals at least perceive the possibility of growth and functioning. That possibility, however, may appear remote or nonexistent for a person labeled mentally retarded. When a mentally ill juvenile is briefly taken out of the home, the family receives needed temporary relief while at the same time it can hope for the child's improvement. When, however, the parents have been advised that their child is mentally retarded, that label often voids any hope for the child's recovery. Since the parents perceive no chance for the child to improve, they are usually unwilling to resume the pressure of having the child live in the home. Moreover, expert witnesses for all of the parties in the *Institutionalized Juveniles* case agreed that families seeking commitment of allegedly handicapped children are characterized by severe stress, disharmony, and dislocation.[161] Expressed differently, "one thing that is clear from a variety of statistical data is that both the decision to place a child in an institution and the selection of the type of institution for him are dependent to a great extent on factors other than the needs of the child."[162]

The district court in *Institutionalized Juveniles* found that parents of mentally retarded children are frequently subject to community pressure to institutionalize their children. Other personal pressures,

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160. Amicus brief, Am. Orthopsychiatric Association, *supra* note 136, at 29 (quoting *In Re* Ballay, 482 F. 2d 648, 669 (D.C. Cir. 1973).

161. *See* testimony in appendix to jurisdictional statement in *Institutionalized Juveniles, supra* note 22.

162. Child Caring, Social Policy and the Institution 112 (D. Pappenfort, eds. 1973). *See also* Amicus Brief, American Orthopsychiatric Association, *supra* note 136, at 32. "Children from broken homes, from homes with substandard incomes, from homes with other physically or mentally ill persons present are disproportionally represented in the institutional population."

such as the parents own emotional difficulties in dealing with the mentally retarded child, as well as the financial problems of providing necessary care, may cause a parent to institutionalize a mentally retarded child, although that course is not in the child's best interests.[163]

Society's attitudes towards mentally retarded individuals are aptly expressed by the section headings in a very perceptive article by Wolf Wolfensiberger.[164] They include: The Retarded Person as Sick; The Retarded Person as a Subhuman Organism; The Retarded Person as a Menace; The Retarded Person as an Object of Pity; The Retarded Person as a Burden of Charity; and The Retarded Person as a Holy Innocent.

Testimony in the *Institutionalized Juveniles* case indicated that even doctors are not adequately educated about alternative treatments to institionalization.[165] For example, L. Glenn testified that many doctors wrongly conclude that children with Down's Syndrome (monogoloidism) are automatically mentally retarded.[166] Furthermore, she testified:

> [M]ental retardation is not a medical problem and physicians are not trained in either mental retardation as a rule or [in] service delivery. They are interested in medical aspects or the symptomology or the syndromes that are associated with the mentally retarded, so the service delivery needs of a person are not their bailiwick. Nor can a person, according to her testimony, [r]ely on those social service agencies . . . [for] the large case loads in almost all cases, the attempt is to find as rapid a placement as you can so you don't have to deal with that person on a 24-hour basis because of the problem, try to find somebody else to be responsible for that person in a quck way, administratively."[167]

Another indicator of the inadequate diagnostic skills involved in screening for admission can be found in a study of 616 children identified as mentally retarded.[168] Forty children were found not to be mentally retarded at all and 191 had predominately psychiatric problems. Mental retardation treatment offered no help to the children

163. Institutionalized Juveniles, *supra* note 22 at 39-40.

164. *The Origin and Nature of Our Institutional Models* in *Changing Patterns in Residential Services for the Mentally Retarded*, President's Committee on Mental Retardation 35, 38-44 (1976).

165. Testimony of L. Glenn, Assistant Commissioner for Mental Retardation for the Department of Health, Commonwealth of Massachusets, Appendix to Jurisdictional Statement in Institutionalized Juveniles, *supra* note 22 at 972a *et seq.* [hereinafter cited as Testimony of L. Glenn]

166. *Id.* at 981a.

167. *Id.* at 1009a.

168. *Id.*

with psychiatric problems and eliminated their chances of being treated in a more appropriate way.[169]

Once a family decides to institutionalize a mentally retarded child, however, reopening that emotionally charged decision is very difficult, even in the context of available supportive social services for in-home care that, if previously available, might have prevented institutionalization.[170] Indeed, every time a family member visits the retarded individual, "all the old guilt feelings and indecisiveness surge up about whether or not they made the right decision."[171]

Proper treatment for the mentally retarded is just as crucial as it is for the mentally ill. Institutionalization may shut off the most effective treatment for the mentally retarded—care in the home. As the amicus brief for the American Orthopsychiatric Association reported:

> There has been extensive documentation of the psychological and developmental harms that beset an institutionalized child or adolescent. These include low scores on intelligence tests, poor progess in school, deficiencies in emotional and social development. These harms accelerate with the length of the institutionalization, the age of (first admission) . . . and the improverished conditions in the institution.[172]
>
> "[T]he residential nursery considered as a language laboratory appears to be inferior to a 'good' working-class home."[173] For the mentally retarded, these risks of institutionalization also include "a high rate of mortality," "and an abnormally high prevalence of personality disorders."[174]

IV. CONCLUSION

In *Parham v. J.R.* the Supreme Court, with three Justices dissenting, reversed the district court's well-considered opinion. In reversing the district court's holding, the Supreme Court has, to paraphrase Rawls, accorded little weight to the juveniles' interest in self respect.[175] Indeed, a more accurate description of the process may be that a "greased runway" leading to the incarceration of handicapped

169. Menoloscino, *Emotional Disturbance and Mental Retardation*, 70 AM. J. MEN. DEF. 248, 250 (1965), noted in Amicus Brief, American Bar Association, in Institutionalized Juveniles, *supra* note 22 at 31.

170. Testimony of L. Glenn, *supra* note 165, at 1023a.

171. *Id.* at 1014a.

172. Amicus Brief, Am. Orthopsychiatric Association, *supra* note 136, at 21-22.

173. *Id.* at 22.

174. Appellees brief in *Institutionalized Juveniles* at 36.

175. *See* note 1 *supra*.

children in institutions has been created.[176] Furthermore, once children are institutionalized, the parents frequently resist transfer back to community-based facilities near their home.[177]

Unfortunately all three types of summary commitment approved by the Supreme Court involve hasty institutionalization: Commitment of mentally ill children by their parents, commitment of mentally ill children by the State, and commitment of mentally retarded children. Children deserve more respect than appears to have been accorded by the Court's decisions in *Parham* and *Institutionalized Juveniles*. Judge Wise Polier recently recounted a discourse which took place in 1100 A.D. between St. Anselm, then prior of the monastery of Bec, and an unnamed abbot. The exchanged relates to the conditions of children.

> The unnamed abbot asked:
>
> What, pray, can we do with them? They are perverse and incorrigible; day and night we cease not to chastise them, yet they grow daily worse and worse.
>
> Anselm marvelled and said:
>
> Ye cease not to beat them? And then they are grown to manhood, of what sort are they then?
>
> The abbot said:
>
> They are dull and brutish.
>
> Then said Anselm:
>
> Tell me, I prithee, if thou shouldest plant a sapling in thy garden, and presently shut it in on all sides so that it could nowhere extend its branches; when thou hast liberated it after many years, what manner of tree would come forth? Would it not be wholly unprofitable, with gnarled and tangled branches? And whose fault would it be but thine own, who hast closed it in beyond all reason. Thus without doubt do ye with your children . . . ye hem them in every side with terrors, threats and stripes . . . [so] that they put forth a tangle of evil thoughts like thorns . . . Hence it comes to pass that, perceiving in you no love for themselves, no pity, no kindness, no gentleness, they are unable henceforth to trust in your goodness.[178]

In the future, children could benefit from more of the Anselm approach and less of that of the unnamed abbot being visible in the words and actions of the United States Supreme Court.

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176. Amicus Brief of the National Center for Law and the Handicapped in *Institutionalized Juveniles*, at 57.

177. Kroll, *The Concept of Childhood in 16 Middle Ages*, 13 J. HIST. OF BEHAVIOURAL SCI., 364, 390 (1977).

178. Judge Polier included this extract in a speech delivered in Chicago, April 20, 1979, as the first Matthew H. Schoenbaum Lecture in Law and Social Work.