

4-1-1996

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### Recommended Citation

Samuel M. Leaf, *How Voluntary Is the Voluntary Commitment of Minors? Disparities in the Treatment of Children and Adults Under New York's Civil Commitment Law*, 62 Brook. L. Rev. 1687 (1996).

Available at: <https://brooklynworks.brooklaw.edu/blr/vol62/iss4/13>

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# HOW VOLUNTARY IS THE VOLUNTARY COMMITMENT OF MINORS? DISPARITIES IN THE TREATMENT OF CHILDREN AND ADULTS UNDER NEW YORK'S CIVIL COMMITMENT LAW

## INTRODUCTION

Between 1980 and 1984 the admission rate of adolescents to private psychiatric hospitals increased more than four-fold despite a general decline in admissions of adolescents to state and county mental hospitals.<sup>1</sup> This increase may be due, in part, to the movement away from placing children in the juvenile criminal justice system and toward viewing troublesome children as needing psychiatric care rather than punishment.<sup>2</sup> Private mental hospitals have reacted to this increase—and at the same time have contributed to it—by creating a lucrative market for their services that often targets youth who are not in need of inpatient psychiatric treatment.<sup>3</sup> Media accounts and congressional testimony depict an industry that will go to extreme lengths—including aggressive advertising campaigns, infiltration of schools and Alcoholics Anonymous meetings, and questionable (if not fraudulent) diagnoses—to attract and keep new adolescent patients.<sup>4</sup>

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<sup>1</sup> Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773 (1988). In her seminal article on civil commitment of youth, Weithorn suggests that "trans-institutionalization," the movement of youth in need of care from one type of institution to another, accounts in part for the increase in admissions of minors to mental health facilities. *Id.* at 805.

<sup>2</sup> See *id.* at 799.

<sup>3</sup> See *The Profits of Misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays Our Trust*, Hearings Before the House Select Comm. on Children, Youth and Families, 102d Cong., 2d Sess. 310-12 (1991) [hereinafter *Profits of Misery*] (letter of Richard L. Cohen, M.D., President of the Academy of Child and Adolescent Psychiatry recognizing that insurance fraud and abuse, including patient "bounty hunting," exists in the adolescent health care industry); see also *infra* notes 206-219 and accompanying text.

<sup>4</sup> See Alex Beasley, *Private Hospitals—Few Rules But Many Patients*, ORLANDO SENTINEL, May 22, 1990, at A1; Geoffrey Cowley et al., *Money Madness*, NEWS-

Whatever the cause, committing teenagers to private mental hospitals has become increasingly popular in recent years, and is frequently used to manage troublesome adolescent behavior rather than to treat serious mental illness.<sup>5</sup> Some parents appear willing to take the extreme step of committing their children to psychiatric institutions due to behavior that clearly does not require such treatment,<sup>6</sup> and these children are often powerless to prevent it.<sup>7</sup>

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WEEK, Nov. 4, 1991, at 50; Nina Darnton, *Committed Youth*, NEWSWEEK, July 31, 1989, at 66; Susan Moffat, *Healing Patients, or Profits; Pressures on Private Psychiatric Hospitals Have Led to Aggressive Recruiting of Patients*, L.A. TIMES, Feb. 2, 1992, at A1.

<sup>5</sup> Weithorn, *supra* note 1, at 774; see, e.g., Patti Jones, "Don't Put Me Away, Mom, Please!" *Committing Teens to Private Mental Hospitals*, REDBOOK, Oct. 1990, at 140 ("Statistics from the National Institute of Mental Health . . . show that in 1980 there were 128 kids under 18 undergoing inpatient psychiatric care for every 100,000. By 1985, it was 440 per 100,000—or 112,000 kids nationally . . . an increase of 343 percent.").

<sup>6</sup> See Darnton, *supra* note 4; Ruth Padawer, *Coming Out, Coming Home for Some Parents of Gay Children, Shock Has Given Way to Support*, THE RECORD (Northern New Jersey ed.), July 2, 1995, at L1 (director of gay support group noting that "it's not even unusual" for parents to institutionalize their gay children solely because of their sexual orientation).

<sup>7</sup> See *Profits of Misery*, *supra* note 3, at 343-48 (letter of Barbara Demming Lurie, Program Director, Patients' Rights and Advocacy Services, County of Los Angeles, Department of Mental Health, stating that adolescents may be deemed voluntary patients even if they are "dragged kicking and screaming" into the hospital). The commitment of Stephanie Hobbs, a sixteen-year old from Minneapolis, is in many ways representative of the type of hospitalization that constitutes this increase. Stephanie's parents committed her to the Golden Valley Health Center, a private hospital outside of Minneapolis, when her mother suspected that Stephanie was abusing drugs or alcohol and became concerned over her rebellious behavior. The day Stephanie was committed to Golden Valley, her parents told her only that she was going to the hospital to see a doctor. Her stay, which was initially scheduled to last one month to treat her alleged chemical dependency, lasted six months. Despite the initial diagnosis of chemical dependency and a recommended treatment of group and family therapy, Stephanie's behavior worsened while at Golden Valley. She was eventually re-diagnosed as a borderline personality, was considered a suicide threat and was given a powerful, antipsychotic drug, Haldol.

Upon learning of both the Haldol treatment and Stephanie's transfer from the chemical dependency unit to the "psyche" unit, Stephanie's parents immediately attempted to remove her from Golden Valley. Although her doctors threatened to petition the court to have Stephanie committed to a state institution if her parents attempted to remove her, they eventually obtained her release. At the end of the six-month contract for Stephanie's commitment, she was admitted to the Mayo Clinic in Rochester, Minnesota, for evaluation. There she was diagnosed as having normal teenage adjustment problems with no sign of a borderline personality disorder. Doctors at the Mayo Clinic found that rather than treating her adjustment problems, Stephanie's stay at Golden Valley had aggravated these problems to the

While the Supreme Court has extended due process protections to minors who face incarceration through juvenile delinquency hearings,<sup>8</sup> it has not extended the same protections to juveniles who face an equal loss of liberty through civil commitment. Frequently the only procedural protections minors can rely on are those contained in state voluntary commitment statutes, many of which allow commitment at the parent's request so long as the admitting physician, often a financially interested party in the private hospital context, agrees.<sup>9</sup>

This Note examines New York's voluntary and involuntary commitment statutes as applied to children. Part I sets forth the history and development of civil commitment laws in general, as well as federal case law establishing the minimum due process protections that commitment statutes must contain. Part II examines the New York Mental Hygiene Law, particularly section 9.13 governing voluntary civil commitment, and section 9.27 governing involuntary civil commitment, and its application to minors. This Part also analyzes the problems and abuses associated with the application of these and similar state commitment statutes. Part III proposes changes to New York Mental Hygiene Law section 9.13 to address the problem of unnecessary and wrongful commitment and retention of children that may result from the standard for voluntary commitment mandated by this statute, and proposes a new voluntary commitment statute that affords children the due process protections required for involuntary admission.

## I. HISTORY OF CIVIL COMMITMENT AND THE EVOLUTION OF THE DUE PROCESS STANDARDS

### A. *Historical Development*

Prior to the 1830s, few hospitals existed in the United States for treatment of either the physically or mentally ill.<sup>10</sup>

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extent that further treatment was required. Jones, *supra* note 5, at 140.

<sup>8</sup> See *In re Winship*, 397 U.S. 358 (1970); *In re Gault*, 387 U.S. 1 (1967); see also *infra* notes 53-66 and accompanying text.

<sup>9</sup> See *infra* notes 91-105 and accompanying text.

<sup>10</sup> PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 18 (1994). "In May 1751 . . . the Pennsylvania Assembly au-

Existing hospitals generally made no distinction between admissions of mentally and physically ill patients.<sup>11</sup> Private hospitals were not regulated by the state and were free to formulate their own admission policies, which often consisted merely of certification for admission by an attending physician and a guarantee of payment by a relative or friend.<sup>12</sup> Due to the scarcity of hospitals, many mentally ill patients were confined to prisons or almshouses under deplorable conditions.<sup>13</sup>

Toward the middle of the nineteenth century, reformers campaigned for more humane treatment of the mentally ill.<sup>14</sup> Largely as a result of this era of reform, "states began to assume responsibility for the care of the indigent mentally ill" and established state-run asylums.<sup>15</sup> However, from the middle of the eighteenth century until the 1950s, commitment of patients to these hospitals often was achieved with little formality. "The request of a friend or relative—or perhaps even an enemy—to a member of the hospital staff for an order of admission would often suffice. The staff member might then hastily scribble a few words on a scrap of paper, and sign his name, and the procedure would be completed."<sup>16</sup>

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thorized the establishment of a general hospital to cure the mentally disabled as well as the sick poor. Certification by one physician was required for commitment. In 1773, Virginia established its first hospital devoted exclusively to the [treatment of] the mentally disabled. It remained the only one of its kind until 1824 . . . ." EDWARD B. BEIS, *MENTAL HEALTH AND THE LAW* 4 (1984).

<sup>11</sup> APPELBAUM, *supra* note 10, at 18.

<sup>12</sup> APPELBAUM, *supra* note 10, at 18-19.

<sup>13</sup> APPELBAUM, *supra* note 10, at 19.

<sup>14</sup> APPELBAUM, *supra* note 10, at 19. Dorathea Lynde Dix and Mrs. E.P.W. Packard were two such advocates who were instrumental in the reform movement. BEIS, *supra* note 10, at 15. Dix spent much of the 1840s and 1850s documenting the deplorable conditions under which the mentally ill were kept. APPELBAUM, *supra* note 10, at 19. As a result of her work, 32 mental hospitals were established in the U.S. and abroad. BEIS, *supra* note 10, at 15. Packard was committed to a hospital by her husband under a statute that allowed "married women and infants to be admitted [as mental patients] involuntarily upon the request of a husband or guardian without presentation of evidence that the statutory standard [for commitment] had been met." She was hospitalized for three years. BEIS, *supra* note 10, at 5.

<sup>15</sup> APPELBAUM, *supra* note 10, at 19.

<sup>16</sup> SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 22 (1985) (citing A. DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* 419-20 (1949)) (noting that a commitment standard proposed in a 1952 model statute for the hospitalization of the mentally ill suggested commitment for those "in need of care or treatment and

Although state care of the mentally ill imposed some external control on commitment procedures, the sole requirement for commitment was that the person sought to be admitted "be in need of or likely to benefit from treatment."<sup>17</sup> This requirement formed the basis for some states' admission standards well into this century.<sup>18</sup> It was assumed that all patients were involuntarily committed because their faculties were so impaired that they could not request care for themselves.<sup>19</sup>

The state's power to commit a person involuntarily may be based on either of two doctrines: the state's *parens patriae* power, or its police power. The former, literally translated "the father of the country," allows and obligates the state to protect those who are unable to protect themselves: the mentally infirm, elderly or unsupervised minority.<sup>20</sup> As a threshold matter, a person's decisional incompetence is required to invoke the *parens patriae* authority since "a competent individual's refusal to seek treatment is 'strictly a private concern and beyond reach of *all* governmental power.'<sup>21</sup> The exercise of the *parens patriae* power must be in the best interest of the ward, consisting of what he or she would have done if they could choose for themselves.<sup>22</sup> Invocation of this power requires a balance between "the basic liberty interest of the ward, his expressed wishes, and the level of care and treatment the state is able to provide through its institutions, counting also the considerable deprivations that may be part of the institutional treatment regimen."<sup>23</sup>

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[who] lack sufficient capacity to evaluate such need responsibly").

<sup>17</sup> APPELBAUM, *supra* note 10, at 20; see BEIS, *supra* note 10, at 6 (quoting NICHOLAS N. KITTRIE, *THE RIGHT TO BE DIFFERENT* 70 (1971)).

<sup>18</sup> APPELBAUM, *supra* note 10, at 20.

<sup>19</sup> APPELBAUM, *supra* note 10, at 20.

<sup>20</sup> See BRAKEL ET AL., *supra* note 16, at 24; BARRY NURCOMBE & DAVID F. PARTLETT, *CHILD MENTAL HEALTH AND THE LAW* 133 (1994); BARBARA A. WEINER & ROBERT M. WETTSTEIN, *LEGAL ISSUES IN MENTAL HEALTH CARE* 47 (1993).

<sup>21</sup> BRAKEL ET AL., *supra* note 16, at 24 (quoting *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1010, 1016 (D.C. Cir. 1964)). As noted above, decisional incompetence was assumed for the involuntary patient, making commitment a foregone conclusion. BRAKEL, ET AL., *supra* note 16, at 24.

<sup>22</sup> WEINER & WETTSTEIN, *supra* note 20, at 47.

<sup>23</sup> BRAKEL ET AL., *supra* note 16, at 24. In *In re Gault*, 387 U.S. 1, 17-18 (1967), the Supreme Court recognized that the *parens patriae* power has failed to fulfill its mandate of acting in the best interests of its wards in the context of the juvenile justice system. See *infra* notes 56-73 and accompanying text.

While *parens patriae* focuses on the protection of the individual's well being, the focus of a state's police power is on protecting the general public from the incompetent individual.<sup>24</sup> For the mentally disabled person who has committed no crime, the threshold requirement for invocation of the police power to commit him or her is the "individual's diminished capacity to conform his conduct to the requirements of the law or to the limits of social tolerance and his inability to appreciate the deterrent force of the law."<sup>25</sup>

For nearly a century after the initial reforms of the 1800s, changes in the law of civil commitment focused almost exclusively on the commitment procedure itself, rather than on the criteria for hospitalization.<sup>26</sup> Judicial, trial-like procedures were advocated and employed in many states, allowing a mentally ill person to object to confinement and to receive a hearing in which a jury made the ultimate commitment decision.<sup>27</sup> In the past century, changes to commitment procedures have followed a cycle of reform and backlash, depending on what type of abuse caught the public eye.<sup>28</sup> When patients were found to have been wrongfully committed, procedural safeguards were strengthened. When patients deserving treatment were denied admission to hospitals due to procedural obstacles, the procedural protections were removed.<sup>29</sup>

During the Progressive era, and again between the 1930s and 1950s, concern over the difficulty in obtaining prompt treatment resulted in emergency commitment procedures that bypassed judicial review and relaxed procedural safeguards, such as the requirements of notice and the patient's presence at commitment proceedings.<sup>30</sup> States that retained trial-like proceedings deferred to the presiding judge's discretion concerning whether to inform the patient of his or her commitment hearing.<sup>31</sup>

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<sup>24</sup> BRAKEL ET AL., *supra* note 16, at 24; *see* Lessard v. Schmidt, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972).

<sup>25</sup> BRAKEL ET AL., *supra* note 16, at 24.

<sup>26</sup> APPELBAUM, *supra* note 10, at 20.

<sup>27</sup> APPELBAUM, *supra* note 10, at 20.

<sup>28</sup> *See* APPELBAUM, *supra* note 10, at 21; BRAKEL ET AL., *supra* note 16, at 22-23.

<sup>29</sup> APPELBAUM, *supra* note 10, at 21.

<sup>30</sup> APPELBAUM, *supra* note 10, at 21; BRAKEL ET AL., *supra* note 16, at 22.

<sup>31</sup> APPELBAUM, *supra* note 10, at 21.

In the late 1960s and early 1970s, a counter trend developed due to a growing interest in the rights of mental patients and reform efforts of public interest and Legal Aid lawyers.<sup>32</sup> Spurring this movement was the belief that states had gone too far in the exercise of their *parens patriae* and police powers.<sup>33</sup> In response, states revised their commitment laws to afford greater procedural protections and narrowed the criteria for identifying patients as committable.<sup>34</sup> It was also at this time that the Supreme Court began to hear due process challenges to civil commitment laws.

### B. *Due Process for Adult Mental Patients*

While Civil commitment statutes have been in existence since states first became involved in caring for the mentally ill, until recently relatively little Supreme Court case law developed concerning these statutes. In a series of cases beginning in the late 1960s, the Supreme Court began to apply due process protections to civil commitment, as well as to proceedings and contexts analogous to civil commitment.<sup>35</sup> In 1972, the Court characterized civil commitment as "such a massive curtailment of liberty" that due process protections must apply.<sup>35</sup>

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<sup>32</sup> BEIS, *supra* note 10, at 6. Such lawsuits became possible as the result of the Supreme Court's use of procedural due process analysis in individual rights cases such as *Brown v. Board of Education* and the revival of § 1983 as a basis for civil actions. APPELBUAM, *supra* note 10, at 23.

<sup>33</sup> See BRAKEL ET AL., *supra* note 16, at 26; NURCOMBE & PARTLETT, *supra* note 20, at 43.

<sup>34</sup> BRAKEL ET AL., *supra* note 16, at 26. In 1967, the California legislature passed the Lanterman-Petris-Short Act which gave detailed procedural protections to involuntary adult patients, and required a finding of dangerousness to self or others in order for involuntary commitment to be ordered.

<sup>35</sup> See, e.g., *In re Winship*, 397 U.S. 358 (1970) (juvenile delinquency proceedings); *In re Gault*, 387 U.S. 1 (1967) (same).

<sup>36</sup> *Humphrey v. Cady*, 405 U.S. 504, 509 (1972). In *Humphrey*, a sex offender who had been convicted under the Wisconsin Sex Crimes Act challenged the provision of that statute that allowed continued commitment of convicted sex offenders beyond the maximum term of their criminal sentence. The Court analogized such continued commitment to involuntary civil commitment under the Wisconsin Mental Health Act, which required a finding "that the defendant is mentally ill and treatable . . . [and a] legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty." *Id.*



Early federal court cases extended due process protections to prisoners who were found to be mentally ill or sexually deviant and thus requiring transfer to, or confinement in, state mental institutions.<sup>37</sup> In *Sprecht v. Patterson*, Francis Sprecht had been convicted under a Colorado criminal statute, which carried a maximum sentence of ten years, but sentenced under the Colorado Sex Offenders Act, which permitted an indeterminate sentence.<sup>38</sup> The Supreme Court held that the Sex Offenders Act, which allowed for a proceeding to determine if the offender was an habitual offender or mentally ill, did not comport with due process because it did not provide "the full panoply of the relevant protections which due process guarantees in state criminal proceedings."<sup>39</sup>

Subsequent cases have defined the scope of the due process protections afforded involuntary adult patients. In 1972, a Wisconsin district court issued a sweeping and influential opinion on the validity of civil commitment in *Lessard v. Schmidt*.<sup>40</sup> In that case, Alberta Lessard was detained in a Milwaukee mental hospital for nearly a month against her will under the Wisconsin involuntary commitment statute, which provided none of the traditional due process protections.<sup>41</sup> The Wisconsin district court rejected the *parens patriae* justification for the relaxed standards of civil commitment, stating that the power of the state to deprive a person of fundamental liberty must be "tempered with stringent procedural safeguards,"<sup>42</sup> and "unless constitutionally prescribed procedural due process requirements for involuntary commitment are met,

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<sup>37</sup> See, e.g., *Sprecht v. Patterson*, 386 U.S. 605 (1967); *Baxtrom v. Herold*, 383 U.S. 107 (1966) (holding that prisoner nearing end of criminal sentence entitled to same jury review on question of mental illness as others before committed under state statute).

<sup>38</sup> *Sprecht*, 386 U.S. at 609-10.

<sup>39</sup> *Id.* (quoting *Gerchman v. Maroney*, 355 F.2d 302, 312 (3rd Cir. 1966)).

<sup>40</sup> 349 F. Supp. 1078 (E.D. Wis. 1972).

<sup>41</sup> The Wisconsin statute allowed for involuntary civil commitment for up to 145 days without a hearing on the necessity of detention, did not require that notice of hearings be given to involuntary patients, failed to provide for a right to counsel or the appointment of counsel at a meaningful time, and did not allow counsel to be present at psychiatric interviews. Similarly, the statute did not require the exclusion of hearsay evidence or a finding beyond a reasonable doubt that the person be in need of such commitment. In fact, the statute did not describe any burden of proof, reasonable doubt or otherwise. *Id.* at 1090.

<sup>42</sup> *Id.* at 1084.

no person should be subjected to 'treatment' against his will."<sup>43</sup> The court extended the procedural safeguards required in criminal proceedings to civil commitment, since commitment can have "enormous and devastating effects on the civil rights of the individual," even more so than criminal confinement.<sup>44</sup> The court reasoned that since "the interests in avoiding civil commitment are at least as high as those of persons accused of criminal offenses. . . . [t]he resulting burden on the state to justify civil commitment must be correspondingly high."<sup>45</sup> In order to save the statute from unconstitutionality, the *Lessard* court interpreted the statutory standard, that the prospective patient be "mentally ill or infirm or deficient and . . . a proper subject for custody and treatment," as requiring a finding that if the person was not confined, he or she would do immediate harm to self or others.<sup>46</sup>

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<sup>43</sup> *Id.* at 1087.

<sup>44</sup> *Id.* at 1089. One of the effects described by the court, aside from the deprivation of personal liberty, was that under Wisconsin law, involuntary hospitalization raised a rebuttable presumption of incompetence so long as the person is under the jurisdiction of the hospital authorities. This impaired the committed person's right to enter into contracts, to sue or be sued, to obtain certain licenses and engage in certain professions, to vote, drive a car, sit on juries, and to enter into marriage contracts. The court also noted that involuntary hospitalization carried with it a heavy stigma that could impair the patient's functioning outside of the institution and his or her ability to procure employment. Also, the court cited recent studies indicating that mental patients were several times more likely to die in Wisconsin state institutions, possibly because the doctor to patient ratio was so high. In short, the court found that "adjudication of mental illness in Wisconsin carries with it a loss of basic civil rights and loss of future opportunities." *Id.* at 1090.

<sup>45</sup> *Lessard*, 349 F. Supp. at 1090. The court found those sections of the statute that allowed involuntary commitment for up to 145 days without a hearing or notice to the patient facially unconstitutional. Instead, the court required notice consisting of the time, date and place of the commitment hearing, the basis for detention, the name of the examining physicians and those who may testify and the substance of their proposed testimony, as well as notification of the right to a jury trial. *Id.*

<sup>46</sup> *Id.* at 1093. The court also held that the state bore the burden of proving dangerousness beyond a reasonable doubt by evidence of a recent overt act, attempt or threat to do substantial harm to oneself or another. *Id.* at 1093-95. Similarly, the court held that the right to counsel and the fifth amendment protection against self-incrimination applied in the civil commitment context, and that involuntary civil commitment be used only as a last resort. *Id.* at 1095, 1097, 1101. The district court relied on the language of *Shelton v. Tucker*, 364 U.S. 479 (1960), for its conclusion that commitment should only be used as a last resort. In *Shelton*, the Supreme Court stated that "even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly

Although the Supreme Court has declined to require all of the due process protection required by the *Lessard* court, it has repeatedly recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection,<sup>47</sup> and has established a minimum due process requirement in civil commitment proceedings. In *O'Connor v. Donaldson*, the Court held that a finding of mental illness alone is insufficient to justify involuntary civil confinement, and that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving in freedom by himself or with the help of willing and responsible family members or friends."<sup>48</sup>

The scope of the necessary procedural safeguards was defined by the Court in *Vitek v. Jones*.<sup>49</sup> In addressing the issue of what due process procedures are required to transfer a convict from a prison to a mental hospital under a Nebraska state statute, the Court recognized that "[w]ere an ordinary citizen to be subjected to involuntar[y] . . . [commitment], it is undeniable that protected liberty interests would be unconstitutionally infringed upon absent compliance with the procedures required by the Due Process Clause."<sup>50</sup> The plurality agreed that the constitutionally required procedures include: (a) notice given sufficiently in advance of the hearing to give

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stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose." *Id.* at 488.

<sup>47</sup> See, e.g., *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504, 509-10 (1967); *Sprecht v. Patterson*, 386 U.S. 605, 609-11 (1967).

<sup>48</sup> 422 U.S. 563, 575 (1975). O'Connor had been committed indefinitely to a Florida mental hospital by his father. Although he was not dangerous and apparently was capable of gaining employment outside of the institution, he remained in custody for fifteen years. The treatment he received during this period consisted mostly of "milieu therapy," a euphemism for confinement in the "milieu" of the hospital. *Id.* at 568.

<sup>49</sup> 445 U.S. 480 (1980). In *Vitek*, Jones, a convicted felon in a Nebraska state prison, challenged his transfer to a state mental hospital under a statute allowing such transfers upon a finding that the prisoner suffers from a mental illness that cannot be treated appropriately in the prison. The diagnosis of a mental illness was left to either a physician or psychologist designated by the Director of Correctional Services. The Court held that due to the stigma attached to commitment, and the necessary change in treatment such a transfer entailed, the statute created a liberty interest in not being designated mentally ill that could not be abrogated absent procedural due process. *Id.* at 493-94.

<sup>50</sup> *Id.* at 492.

the prisoner time to prepare; (b) notice of the evidence being relied on to effect the transfer; (c) the opportunity to be heard, to present testimony and confront witnesses; and (d) the right to assistance.<sup>51</sup> While the Court held that these due process protections apply in force to adults, later cases indicate that children may be committed under statutes containing significantly less procedural protection.<sup>52</sup>

### C. Due Process for Children

While the Supreme Court has recognized that "[m]inors, as well as adults, are protected by the Constitution and possess constitutional rights,"<sup>53</sup> it has held that these protections do not necessarily apply with equal force to children and adults. The rights of children have been limited by the Court's recognition of the interests of parents and the state in the upbringing and welfare of children.<sup>54</sup> The state's interest has been given force through the application of the *parens patriae* doctrine, which gives the state the power to exercise more control over the conduct of children than that of adults since children are perceived to be more susceptible to harm and less able to make sound judgments.<sup>55</sup> Parents' interests have been given force through the Court's elevation of parental control over children to constitutional status.<sup>56</sup> Underlying the Supreme Court cas-

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<sup>51</sup> *Id.* at 494. The plurality could not agree that the prisoner was constitutionally entitled to the assistance of an attorney, with Justice Powell arguing that "[d]ue process merely requires that the State provide an inmate with qualified and independent assistance." *Id.* at 500. Contrary to the *Lessard* court, the Supreme Court has held that the evidentiary standard to be used in commitment proceedings is proof by clear and convincing evidence. *Addington v. Texas*, 441 U.S. 418, 430-31 (1979).

<sup>52</sup> *See, e.g., Parham v. J.R.*, 442 U.S. 584 (1979).

<sup>53</sup> *Carey v. Population Serv. Intl.*, 431 U.S. 678, 692 (1977) (citing *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) (contraception)); *see Tinker v. Des Moines Indep. Community Sch. Dist.*, 393 U.S. 503 (1969) (First Amendment rights of minors).

<sup>54</sup> *See, e.g., Carey*, 431 U.S. at 692 (citing *Danforth*, 428 U.S. at 74); *Tinker*, 393 U.S. 503 (1969).

<sup>55</sup> *See, e.g., Parham*, 442 U.S. at 602 (children lack the maturity, experience and capacity to make difficult decisions); *Carey*, 431 U.S. at 692; *Ginsberg v. New York*, 390 U.S. 629, 638-39 (1968) (state has power to adjust definition of obscenity as applied to minors); *Prince v. Massachusetts*, 321 U.S. 158, 168-70 (1944) (state power to control conduct of children is broader than power to control conduct of adults).

<sup>56</sup> *See, e.g., Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Pierce v. Society of Sis-*

es defining parental autonomy and the rights of parents to control the upbringing of their children is a fundamental belief in the sanctity of the family as a unit, with parental control of children as a significant element of the liberty of being a parent.<sup>57</sup> Rather than enunciating a single test for determining the scope of children's constitutional rights, the Court has engaged in a case-by-case balancing of the interests of the parent, child and the state.<sup>58</sup>

While the Supreme Court has given credence to the *parens patriae* role of the state in some contexts, it has also noted the shortcomings of this approach. Where it has perceived that the state has failed in its *parens patriae* role, the Court has extended to minors those due process protections afforded adults. One such context is the juvenile justice system.<sup>59</sup>

In the juvenile justice system, states utilized their *parens patriae* authority to justify treating minors outside of the traditional criminal justice system; acting in *loco parentis* to provide compassionate guidance, rather than to punish their juvenile wards.<sup>60</sup> Because of this fundamental difference in purpose, juvenile court proceedings were viewed as civil, rather than criminal, and therefore the rules of criminal procedure were seen as inapplicable.<sup>61</sup> However, instead of treating juveniles more compassionately, the juvenile justice system often treated children arbitrarily and allowed judges to impose their own brand of justice and to sentence children more harshly than they could adults.<sup>62</sup>

As the Court stated in *In re Gault*, "The powers of the Star Chamber were a trifle in comparison with those of our juvenile courts."<sup>63</sup> In *Gault*, fifteen-year-old Francis Gault was found

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ters, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

<sup>57</sup> See *Yoder*, 406 U.S. at 231-32 ("The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.")

<sup>58</sup> This balancing test has caused varying results, with the child's interests winning out over those of the parent, and vice versa, in different contexts. See, e.g., *Fare v. Michael C.*, 442 U.S. 707 (1979); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *In re Winship*, 397 U.S. 358 (1970); *In re Gault*, 387 U.S. 1 (1967); *Pierce*, 268 U.S. 510 (1925).

<sup>59</sup> *Gault*, 387 U.S. at 17-19.

<sup>60</sup> *Id.* at 15.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at 19.

<sup>63</sup> *Id.* at 18 (quoting DEAN POUND, *YOUNG, SOCIAL TREATMENT IN PROBATION*

guilty of making a lewd phone call under the Arizona Juvenile Code. He was sentenced to a state juvenile institution for the remainder of his minority, six years.<sup>64</sup> Under Arizona law, the maximum sentence for an adult for the same offense was a fifty dollar fine or a sentence of two months in prison.<sup>65</sup>

Because of the potential for such disproportionately harsh treatment and other failures of the state in its *parens patriae* role in the juvenile justice context,<sup>66</sup> the Court held that juvenile delinquency hearings "must measure up to the essentials of due process,"<sup>67</sup> noting that the "observance of due process standards . . . will not compel the States to abandon or displace any of the substantive benefits of the juvenile process."<sup>68</sup> The Court extended to minors those due process protections afforded adults, noting that the history of juvenile court has "demonstrated that unbridled discretion, however benevolently motivated, is frequently a poor substitute for principle and procedure."<sup>69</sup>

#### D. *Due Process for Minors in the Civil Commitment Context*

While the involuntary commitment of adults has been categorized as a "massive curtailment of liberty"<sup>70</sup> implicating

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AND DELINQUENCY at xxvii (1937)).

<sup>64</sup> *Gault*, 387 U.S. at 29.

<sup>65</sup> *Id.* at 8-9, 20.

<sup>66</sup> *See id.* at 21-23 (discussing rising juvenile crime rate, recidivism and failure of juvenile justice system to rehabilitate juvenile offenders).

<sup>67</sup> *Id.* at 30-31 (citing *Kent v. United States*, 383 U.S. 541, 542 (1966)).

<sup>68</sup> *Id.* at 21.

<sup>69</sup> *Gault*, 387 U.S. at 17-18. The *Gault* Court held that due process for juveniles included: adequate notice of the charges against the child; that the notice set forth the charges in writing and with particularity; that notice be given at the earliest practicable time and sufficiently in advance of court proceedings that a reasonable opportunity to prepare is afforded. A right to counsel was also held as essential to any proceeding that could result in a loss of liberty for a term of years, as well as the right to confrontation of witnesses. *Id.* at 55-56. Similarly, the Court held that the availability of the fifth amendment right against self-incrimination does "not turn on the type of proceeding in which its protection is involved, but upon the nature of the statement or admission and the exposure which it invites." *Id.* at 49. Children, unlike hardened adults, are particularly vulnerable in situations where coercion or intimidation is likely, and "the constitutional privilege against self-incrimination is applicable in the case of juveniles as it is with respect to adults." *Id.* at 55; *see In re Winship*, 397 U.S. 358 (1970) (minors entitled to reasonable doubt standard in juvenile delinquency proceedings).

<sup>70</sup> *Humphrey v. Cady*, 405 U.S. 504, 508 (1972).

due process protections, children have not been afforded the same protections. Although the Supreme Court explicitly recognized the failures of the juvenile justice system and the *parens patriae* doctrine it was built on, and consequently extended due process protections to minors in this context, it has failed to accord the same degree of protection to minors committed to mental institutions, even when parents or state custodial agencies may volunteer children for commitment.<sup>71</sup> The reasons for this disparity can be explained by the Court's analysis of children's rights in different contexts. The Court's approach has been to balance the interests of the child against those of both the parents and the state in order to achieve the best public policy solution, which has lead to varying results depending on the interests involved.<sup>72</sup>

### 1. Lower Courts

Before the Supreme Court addressed the issue, several state and lower federal courts heard due process challenges to voluntary admission statutes, many of them passed in the late 1950s and 1960s, that permitted parents to commit their children without a court hearing.<sup>73</sup> Typically these statutes allowed parents to commit their children simply by petition or application for admission with none of the legal formalities afforded adults, such as notice, counsel, witnesses or burden of proof.<sup>74</sup> The justification for the passage of such procedurally lax laws was the pro-family rationale that parents are best able to judge that their child is mentally ill.<sup>75</sup> Additionally, these laws were based on the therapeutic rationales that adversarial proceedings, with the parent on one side and the child on the other, would be detrimental to the family and the

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<sup>71</sup> See *Parham v. J.R.*, 442 U.S. 584 (1979); *Secretary of Public Welfare of Pa. v. Institutionalized Juveniles*, 442 U.S. 640 (1979); see also *infra* notes 88-114 and accompanying text.

<sup>72</sup> Compare *Parham*, 442 U.S. 584 (1979) (finding parental interests paramount in civil commitment context) with *Tinker v. Des Moines Indep. Community Sch. Dist.*, 393 U.S. 503 (1969) (upholding high school student's first amendment rights) and *Carey v. Population Serv. Int'l*, 431 U.S. 678 (1977) (upholding minors' right to contraception).

<sup>73</sup> BRAKEL ET AL., *supra* note 16, at 43-44.

<sup>74</sup> BRAKEL ET AL., *supra* note 16, at 44.

<sup>75</sup> BRAKEL ET AL., *supra* note 16, at 44.

parent-child relationship, and that voluntary admissions are preferred because they evidence a desire on the part of the patient to get better.<sup>76</sup>

Many of the lower courts that addressed challenges on behalf of minors to such voluntary admission statutes found unconstitutional those statutes that did not afford minors all—or nearly all—of the due process protections.<sup>77</sup> In one such challenge, *Melville v. Sabbatino*,<sup>78</sup> a Connecticut state court analogized civil commitment of minors to juvenile delinquency hearings. The court struck down Connecticut's voluntary commitment statute under the same reasoning employed by the Supreme Court in *Gault*,<sup>79</sup> that deprivation of liberty—even that of a minor—requires due process.<sup>80</sup>

Similarly, in *Saville v. Treadway*,<sup>81</sup> a case involving the commitment of mentally retarded minors, a federal district court found it "absolutely essential that such confinement be preceded by adequate procedural safeguards" and not left wholly to the discretion of parents.<sup>82</sup> In *Bartley v. Kremens*,<sup>83</sup> a class action brought in a Pennsylvania district court on behalf of voluntarily committed minors, the few procedural protections afforded by the state voluntary commitment statute were found inadequate. While the court noted that parents

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<sup>76</sup> BRAKEL ET AL., *supra* note 16, at 44. Admission under such statutes is rarely completely voluntary. Rather, "the hallmark of voluntary admission is that generally the hospital staff has the authority to decide when actual release will occur within legislatively mandated time frames." WEINER & WETTSTEIN, *supra* note 20, at 44; see John P. Panneton, *Children Commitment and Consent: A Constitutional Crisis*, 10 FAMILY L.Q., 295, 303-04 (1977) (noting that the therapeutic rationale makes no sense when the patient is coerced into a facility and that such a "voluntary" admission does not evidence a desire on the part of the patient to seek help).

<sup>77</sup> See, e.g., *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. 119 (1977); *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974) (mentally retarded minors); *Dixon v. Attorney General of the Commonwealth of Pa.*, 325 F. Supp. 966 (M.D. Pa. 1971); *Melville v. Sabbatino*, 313 A.2d 886, 888 (Conn. Super. Ct. 1973).

<sup>78</sup> *Melville*, 313 A.2d at 888.

<sup>79</sup> 387 U.S. 1 (1967).

<sup>80</sup> *Melville*, 313 A.2d at 888.

<sup>81</sup> 404 F. Supp. 430 (M.D. Tenn. 1974).

<sup>82</sup> *Id.* at 432. Although *Saville* was a case involving mentally retarded minors, the court's analysis is equally applicable to the commitment of minors to mental institutions.

<sup>83</sup> 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. 119 (1977).



have traditionally been afforded autonomy in making decisions for their children, it also recognized that the interests of parents (and those standing in loco parentis) may be in conflict with the interests of the child, thus increasing the risk of wrongful commitment.<sup>84</sup> Due to this risk, the court found that procedural safeguards, including a probable cause hearing, postcommitment hearings, notice, counsel and a finding of need for treatment by a standard of clear and convincing proof, were necessary for such a statute to pass constitutional muster.<sup>85</sup>

## 2. Supreme Court

In 1979, a divided Supreme Court finally addressed the issue of voluntary commitment statutes in *Parham v. J.R.*, a class action suit challenging the constitutionality of Georgia's procedures for voluntary commitment of children.<sup>86</sup> *Parham* established the minimum due process protections required for the voluntary admission of minors to state mental institutions, both for children committed by their parents or guardians and for those committed as wards of the state.<sup>87</sup> As with many voluntary commitment statutes, the challenged state law allowed children to be committed upon application of a parent or guardian, regardless of the child's wishes, and request for discharge could be made only by the admitting adult or the superintendent of the facility.<sup>88</sup> Children found by the super-

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<sup>84</sup> *Id.* at 1047-48.

<sup>85</sup> *Id.* at 1053. The district court found Justice Harlan's concurrence in *In re Winship* controlling on the issue of standard of proof. Justice Harlan argued that the standard of proof is determined by the comparative social costs of an erroneous finding of fact. *In re Winship*, 397 U.S. 358, 370-71 (1969). Since the social cost of erroneously committing a child is high, and the cost of wrongly finding commitment unnecessary is low, a higher standard is appropriate. *Bartley*, 402 F. Supp. at 1051-52.

<sup>86</sup> *Parham v. J.R.*, 442 U.S. 584 (1979). *Parham* was consolidated with a second case, *Secretary of Public Welfare v. Institutionalized Juveniles*, 442 U.S. 640 (1979), which was decided on the same bases as *Parham* and handed down the same day.

<sup>87</sup> *Parham*, 442 U.S. 584 (1979).

<sup>88</sup> See, e.g., N.Y. MENTAL HYG. LAW § 9.13 (McKinney 1996) (allowing voluntary admission of children by parents, but, unlike the Georgia statute at issue in *Parham*, also allowing children to request their own release). Voluntary admissions were initially seen as beneficial since they did not put the patient in an adversary relationship with his or her family. Also, it was thought that voluntary patients

intendent to show signs of mental illness and to be suitable for treatment could be admitted.<sup>89</sup> The statute required that retention of the child be subject to periodic review, and that the superintendent release any child found to have sufficiently recovered.<sup>90</sup>

To determine what procedures minors are constitutionally entitled to when facing commitment, the Court employed the balancing test articulated in *Matthews v. Eldridge*,<sup>91</sup> weighing the private interest affected; the risk of erroneous deprivation through the procedures used and the probable value of additional safeguards; as well as the government's interests, including fiscal and administrative burdens, that additional or substitute procedures would entail.<sup>92</sup> The Court recognized that children, like adults, have undisputed and "substan-

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are better candidates for recovery since they have shown a desire to "get better," and voluntary admissions allow treatment in the early stages of a disease before the statutory requirements for involuntary admission have been met. However, some have questioned the voluntariness of such commitments for children as well as adults. Patients may be pressured into voluntary commitment with the threat of involuntary proceedings, or through their lack of information. Charles W. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CAL. L. REV. 840, 846-48 (1974); see BRAKEL ET AL., *supra* note 16, at 179, stating in reference to adult admission:

A study of voluntary admissions . . . found that the majority of persons admitted under the [Illinois] procedure were already in some form of official custody when they "decided" to enter the mental hospital and that many were pressured by the threat of less advantageous alternatives to agree to the suggestion to sign themselves in. In some 40% of the cases, the admittees were reportedly brought to the hospital by the police, a circumstance that suggests that the alternative to voluntary admission would have been involuntary emergency commitment or placement in jail on a disorderly conduct charge or the like.

<sup>89</sup> *Parham*, 442 U.S. at 588 n.3. The trend in recent years has been toward lowering the age at which patients may voluntarily commit themselves, rather than being voluntarily committed by their parents or guardians. Many states allow children as young as 16 to voluntarily commit themselves. See BRAKEL ET AL., *supra* note 16, at 190-201 (comparing state voluntary admission statutes); ILL. ANN. STAT. ch. 91-1/2, ¶¶ 3-401 (Smith-Hurd Supp. 1983). However, children under the statutorily defined age may still be voluntarily committed upon the application of a parent or guardian.

<sup>90</sup> *Parham*, 442 U.S. at 591. An affirmative duty also existed under the Georgia statute to release, at the parent or guardian's request, any child hospitalized for more than five days.

<sup>91</sup> 424 U.S. 319, 321 (1976).

<sup>92</sup> *Parham*, 442 U.S. at 599-600. While the Court stated that it conducted a balancing test, its analysis did not explore any procedural safeguard other than those already required by the Georgia statute. *Id.*

tial . . . liberty interest[s] in not being confined unnecessarily for medical treatment,"<sup>93</sup> and that commitment to a mental health facility is a "massive curtailment of liberty" that triggers constitutional due process protection.<sup>94</sup> Despite these considerations, the Court held the state procedures constitutionally sufficient,<sup>95</sup> finding that the minimum statutory protections must include an inquiry by a neutral factfinder into the child's background and a determination that the child meets the statutory conditions for commitment.<sup>96</sup> Similarly, in order for a commitment statute to be constitutionally sound, it must provide the doctor or mental health professional making the decision to admit a child with the authority to refuse admission,<sup>97</sup> and must require periodic review of the need for continuing commitment of the child by a neutral factfinder.<sup>98</sup> In short, the Court concluded that sufficient due process protections inhere in any statutory scheme that allows commitment where the parents have requested commitment of the child and a single doctor or mental health professional agrees with the parent's request.<sup>99</sup>

The Court found that an adversarial proceeding, in which an advocate for the child can challenge the proposed commitment, was undesirable and not constitutionally required since such proceedings would impose severe costs on the state and on other mental patients whose care would be degraded by the need for doctors to attend commitment proceedings rather than devoting themselves to patient care.<sup>100</sup> Adversarial admission

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<sup>93</sup> *Id.* at 600.

<sup>94</sup> *Id.* (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

<sup>95</sup> *Id.* at 606-07.

<sup>96</sup> *Id.*

<sup>97</sup> *Parham*, 442 U.S. at 607.

<sup>98</sup> *Id.* at 585, 607.

<sup>99</sup> Some commentators have noted that where "the only limitation on parental discretion [to commit a child] is the concurrence by the committing authority . . . these officials frequently fail to exercise independent judgment . . . [and] generally defer to the wishes of the parent." Ellis, *supra* note 88, at 850. Also, the environment in which a child is interviewed by a mental health professional and the prospect of commitment may elicit abnormal behavior from the child that is misinterpreted as grounds for admission to a hospital. BRAKEL ET AL., *supra* note 16, at 178.

<sup>100</sup> *Parham*, 442 U.S. at 605-06. However, some scholars and mental health professionals have noted that admission interviews are often perfunctory, with few institutions capable of expending the resources to conduct extensive background checks and investigations. Ellis, *supra* note 88, at 865-66. Similarly, experiments

hearings were also found by the Court not to reduce sufficiently the risk of erroneous commitment to justify their costs.<sup>101</sup> Additionally, adversarial hearings could put medical decisions in the hands of judges and judicial factfinders who are ill equipped to make such decisions, could possibly exacerbate a child's emotional problems by pitting the child against the family he or she may have to return to in the near future, or discourage families from seeking treatment altogether.<sup>102</sup>

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have been conducted to test the efficacy and accuracy of such admission procedures. In one such experiment healthy individuals who presented themselves at various psychiatric hospitals complaining of hearing a voice saying "empty" or "thud" were admitted to these hospitals and diagnosed as schizophrenic or manic depressive. Ellis, *supra* note 88, at 865-66. Conversely, an experiment in which hospital staffs were warned to watch out for such "pseudo-patients" identified 41 such patients out of 193 patients evaluated although no such pseudo-patients were presented for admission. Ellis, *supra* note 88, at 865-66. Also, hospital personnel may not easily recognize when a child has been improperly committed or may be reluctant to release a child when there is no viable option for placement in the community. Institutionalization itself may induce abnormal behavior or cause the patient to take on the role of "patient." Similarly, "the impersonal nature of the day-to-day hospital operation makes immediate identification [of a patient as improperly committed] unlikely." Ellis, *supra* note 88, at 868. Even vigorous protests against commitment may be viewed as a sign of illness. For those children admitted and later discovered to be healthy, or not warranting in-patient treatment, it cannot be said that no emotional damage has been done to them as a result of their incarceration. Ellis, *supra* note 88, at 868-69.

<sup>101</sup> *Parham*, 442 U.S. at 605.

<sup>102</sup> *Id.* at 606-13. The Court's reasoning regarding the need for adversarial hearings and their effect on children has been strongly criticized. See Michael L. Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's "time consuming procedural minuet" Theory in Parham v. J.R.*, 9 BULLETIN OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, 149 (1981). Perlin criticizes Justice Burger's argument that adversarial proceedings and other procedural safeguards constitute "time consuming procedural minuets" and are unnecessary. Perlin, a mental health professional, noted that the argument against imposing procedural obstacles to admission "simultaneously assumes that (1) persons at risk are genuinely mentally ill, (2) they are in need of psychiatric assistance, (3) such psychiatric assistance is available at the institution to which the juveniles are being committed." *Id.* at 151. Perlin also points out that the authority cited by the Court to support its argument that adversarial proceedings are unnecessary, Dale A. Albers et al., *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U. L. REV. 11 (1976), actually discusses the inadequate job counsel usually perform at commitment hearings and advocates a more active role on the part of counsel. Perlin, *supra*, at 152. Similarly, the Court relied heavily on the American Psychiatric Association's amicus curiae brief for the proposition that adversarial hearings will be harmful to the child. However, the articles cited in that brief only speak to the effect of hospitalization on the parent, while other amicus briefs, which the Court disregarded, found such hearings to be beneficial to the therapeutic process. Perlin, *supra*, at

The fear that without an adversarial proceeding children could be "railroaded" into institutions was discounted since any such "charade" by parents would eventually be discovered by mental health professionals trained to evaluate human behavior.<sup>103</sup> Similarly, the *Parham* Court found that state health professionals have no vested interest in committing a healthy child who will only take up resources that could be better used on truly mentally ill patients.<sup>104</sup>

Underlying the *Parham* Court's analysis is the premise articulated in such cases as *Wisconsin v. Yoder*<sup>105</sup> and *Meyer v. Nebraska*,<sup>106</sup> that the autonomy of parents in making decisions for their children is such an integral part of western history and tradition that the interests of parents are paramount.<sup>107</sup> Although the Court acknowledged, as lower courts had previously, that the interests of parents and children do not necessarily coincide and that parents may at times act contrary to the best interests of the child,<sup>108</sup> it nevertheless found the risk of erroneous commitment at the hands of parents insufficient to require additional procedural safeguards.<sup>109</sup> Rather, the Court reasoned that the historical conception of the family as "a unit with broad parental authority over minor children"<sup>110</sup> allowed parents to retain the dominant role in the decision to commit a child, particularly since children are, in the Court's view, "simply . . . not able to make sound judgments concerning [such] decisions."<sup>111</sup>

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154-56.<sup>103</sup> *Parham*, 442 U.S. at 611.<sup>104</sup> *Id.* at 604-05.<sup>105</sup> 406 U.S. 205 (1972).<sup>106</sup> 262 U.S. 390 (1923).<sup>107</sup> *See Parham*, 442 U.S. at 602.<sup>108</sup> *Id.* at 603-04; *see Saville v. Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974) (finding it essential that due process protections be applied to commitment hearings for retarded children given the potential for conflict between interests of parent and child); *New York State Ass'n. for Retarded Children v. Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973) (recognizing the possibility of a fundamental conflict between interests of parent and child).<sup>109</sup> *Parham*, 442 U.S. at 603-04.<sup>110</sup> *Id.* at 602.<sup>111</sup> *Id.* at 604. *But see In re Long*, 214 S.E.2d 626 (N.C. 1975) (holding that tradition of parental autonomy and concerns about ability of minors to make decisions cannot override child's liberty interest in not being committed to a state institution).

By emphasizing the interests of parents and the western cultural tradition of parental autonomy in making decisions regarding children, the Court collapsed the interests of the child into those of the parent, rather than independently assessing whether the child has a protectable interest in being free from bodily restraint. The Court's analysis led it to conclude that the "natural bonds of affection" will cause parents to act in the best interests of the child, despite acknowledging that some parents do, in fact, act contrary to these interests.<sup>112</sup> The assumption that parents will act in the best interests of the child is also evident in state civil commitment statutes that rely on the involvement of family and friends to prevent wrongful commitments.

## II. NEW YORK'S MENTAL HYGIENE LAW

### A. *Voluntary Admission Procedures*

New York's civil commitment statutes are among those that rely on familial involvement to prevent wrongful commitments. Under New York Mental Hygiene Law section 9.13, any suitable person in need of care and treatment may be voluntarily admitted to any mental hospital upon written application.<sup>113</sup>

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<sup>112</sup> *Parham*, 442 U.S. at 602. In *Parham*, Justice Brennan concurred in part and dissented in part, noting that "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors as well as adults are protected by the Constitution and possess constitutional rights." *Id.* at 627 (quoting *Planned Parenthood of Mo. v. Danforth*, 428 U.S. 52, 74 (1976)). Brennan argued that these due process rights confer on the minor a right to an adversarial proceeding equal to that of an adult, complete with the right to representation, confrontation, cross examination and the right to offer evidence. Children may even be entitled to more protection than adults since they are often committed for longer than adults, are possibly more scarred by the experience, and are often denied adequate treatment and conditions. *Id.* at 628 (Brennan, J., dissenting). Brennan argued that the case should be governed by the rule of *Danforth*, prohibiting an absolute parental veto over a minor's exercise of a constitutional right, stating that "parental authority and family autonomy cannot stand as absolute and invariable barriers to the assertion of constitutional rights by children." *Id.*

<sup>113</sup> N.Y. MENTAL HYG. LAW § 9.13 (McKinney 1996). A person "in need of care and treatment" is defined as "a person who has a mental illness for which inpatient care and treatment in a hospital is appropriate." *Id.* § 9.01. To be found "suitable," a patient must be aware he or she is entering a mental hospital and must understand the consequences of voluntary commitment, including the possibility that his or her status as a voluntary patient may be converted to involuntary,

Children under the age of sixteen may be voluntarily admitted upon the application of a parent, legal guardian, next of kin or a person or agency that has care and custody of the child.<sup>114</sup> Admission of children upon the application of parents or custodians are uniformly considered voluntary, even if the child objects to the admission.<sup>115</sup> Children over sixteen years old, but younger than eighteen, may be voluntarily admitted either upon their own application or by those persons and entities that may voluntarily admit a younger child.<sup>116</sup> In short, children may be committed on the basis of the application of a parent, guardian or state agency and the examination of a single doctor.<sup>117</sup>

Upon admission, all voluntary patients, regardless of age, must immediately be informed of their admission status and of their rights, including the availability of the Mental Hygiene Legal Service ("MHLS").<sup>118</sup> The MHLS is a statutorily created

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and the rules governing his or her release. *Id.* § 9.17. This provision seeks to ensure that the admission is, in fact, voluntary. However, this protection can easily be undermined since the voluntary patient "may have agreed to hospitalization because of the threat of involuntary proceedings, family pressure, or exploitation of his or her lack of information." Ellis, *supra* note 88, at 846. Some commentators believe that "truly voluntary hospitalization is virtually nonexistent in public mental institutions in the United States." Ellis, *supra* note 88, at 846.

<sup>114</sup> N.Y. MENTAL HYG. LAW § 9.13. Children may be admitted by agencies under a court order executed pursuant to § 384(a) of the Social Services Law, by a social service official or agency authorized with care and custody of the child under the Social Services Law, by the director of the division for youth under § 509 of the Executive Law, or by a person having custody of the child under the Family Court Act. *Id.*

<sup>115</sup> *Id.* § 9.13; Telephone Interview with Ramon Perez, Mental Hygiene Legal Services Attorney, Brooklyn, N.Y. (Jan. 18, 1996) [hereinafter Perez Telephone Interview].

<sup>116</sup> N.Y. MENTAL HYG. LAW § 9.13. The director of the hospital has the discretion to determine whether children over 16 may be admitted upon their own application. *Id.*

<sup>117</sup> Such voluntary admissions of minors can be constitutionally effected only after an examination by a doctor or mental health care professional. *Parham v. J.R.*, 442 U.S. 584, 604 (1979). At least one commentator has noted that where "the only limitation on parental discretion [to commit a child] is the concurrence by the committing authority . . . these officials frequently fail to exercise independent judgment . . . [and] generally defer to the wishes of the parent." Ellis, *supra* note 88, at 850.

<sup>118</sup> N.Y. MENTAL HYG. LAW § 9.07. Voluntary patients must be periodically informed of their rights throughout their in-patient care. *Id.* § 9.19. Similarly, MHLS must be informed of any change in a minor patient's admission status and the patient may seek review of the change in status prior to its effect. *Id.* § 9.09.

legal service which is obligated to review the status of patients and act as a legal advocate for them.<sup>119</sup> The MHLS must be informed of the admission of all patients under the age of eighteen, and MHLS attorneys routinely interview adolescent patients shortly after admission.<sup>120</sup>

All voluntary patients may request to be discharged by giving written notice to the institution's director, and must be promptly released upon such a request unless there are grounds to believe that the patient is suitable for involuntary treatment.<sup>121</sup> If such grounds exist, the hospital may hold the patient for up to seventy-two hours, during which time the hospital director must apply for court authorization for involuntary retention of the patient.<sup>122</sup> As a practical matter, children admitted on a voluntary basis are never immediately released. Rather, they must file a "seventy-two hour letter" requesting a hearing to determine if they may be involuntarily held.<sup>123</sup> If such an application is made by the director, then the patient, MHLS and certain persons designated by the patient must receive notice of the application and may demand a court hearing, to be held within three days of the demand.<sup>124</sup> Patients under the age of eighteen may request their own release, or such a request may be made by the admitting agency or person, or by a person of equally close relation to the child as the person who applied for admission initially.<sup>125</sup>

If a patient remains hospitalized on a voluntary basis, MHLS must conduct a yearly review of the patient's status to determine if there is reason to doubt the patient's suitability and willingness for continued voluntary commitment.<sup>126</sup> If such doubt exists, MHLS must apply for a court order to resolve the patient's status.<sup>127</sup> A court hearing must be held on this issue upon the request of the patient, MHLS or a person acting on behalf of the patient.<sup>128</sup>

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<sup>119</sup> *Id.* § 47.01; *see id.* §§ 9.25(a), 9.29, 9.31(a).

<sup>120</sup> *Id.* § 9.09; Perez Telephone Interview, *supra* note 116.

<sup>121</sup> N.Y. MENTAL HYG. LAW § 9.13(b).

<sup>122</sup> *Id.*

<sup>123</sup> Perez Telephone Interview, *supra* note 116.

<sup>124</sup> N.Y. MENTAL HYG. LAW § 9.13.

<sup>125</sup> *Id.*

<sup>126</sup> *Id.* § 9.25.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* A person may also apply for admission to a mental hospital on an infor-



## B. *Involuntary Admission Procedures*

The statutorily mandated procedure for involuntary admissions, contained in New York Mental Hygiene Law section 9.27, is substantially more rigorous than for voluntary patients. As with voluntary admissions, application for involuntary admission is required and may be made by a number of persons and agencies, including relatives of the patient, persons with whom the patient lives, or agencies that are in some way responsible for the care or welfare of the patient.<sup>129</sup> A person "alleged to be mentally ill and in need of involuntary care and treatment" may be admitted as an involuntary patient.<sup>130</sup>

Applications for involuntary admission must include a statement of facts, executed under penalty of perjury, "upon which the allegation of mental illness and need for care and treatment are based."<sup>131</sup> Unlike voluntary admissions, the application must be accompanied by separate certificates of two examining physicians.<sup>132</sup> Before completing the certificate of

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mal basis. Although the standards for informal admissions are the same as voluntary admissions, an informal patient may leave the hospital at any time without filing a written application for release. *Id.* § 9.15.

<sup>129</sup> N.Y. MENTAL HYG. LAW § 9.27. The need for immediate hospitalization must be confirmed by a staff physician, and within 72 hours a third physician must certify that the patient is in need of involuntary care. *Id.* Involuntary admissions can also be made on the application of a director of community services, or the director's designee, upon certification that the person "has an illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others." *Id.* § 9.37.

<sup>130</sup> *Id.* § 9.27(a). A person "in need of involuntary care and treatment" is someone who "has a mental illness for which care and treatment in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." *Id.* § 9.01.

Likelihood to result in serious harm" is defined as "(a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

*Id.*

<sup>131</sup> *Id.* § 9.27(c). The procedures for involuntary admission based on the certificate of the director of community services and on an emergency basis vary slightly from the admission on medical certification. *See id.* §§ 9.37, 9.39. However, many of the procedural safeguards afforded by § 9.27 apply to these types of admissions.

<sup>132</sup> *Id.* § 9.27(a). The examining physicians may conduct the examination of the

examination, alternative, less restrictive forms of care and treatment short of involuntary admission must be considered to determine if they would adequately provide for the person's needs.<sup>133</sup> Prior to admission a third physician, who must be a member of the hospital staff to which the patient is brought and may not be one of the original examining physicians, must then examine the person.<sup>134</sup> Only if this third physician finds the person in need of involuntary commitment may the patient be admitted.<sup>135</sup> MHLS must immediately receive notice of a patient's involuntary admission and must inform the patient of his or her statutory rights.<sup>136</sup>

An involuntary patient may be held for up to sixty days without court authorization, but if no authorization is obtained, the patient must be released within this period of time.<sup>137</sup> The patient, or a relative or friend, may contest his or her involuntary admission and request a hearing.<sup>138</sup> The request for a hearing must be forwarded to the appropriate court in the county designated by the patient, a copy of the notice and record must be sent to MHLS, and a hearing must be held.<sup>139</sup> If after examining the patient and hearing testimony the court determines that the patient is in need of involuntary care, the patient will be retained.<sup>140</sup> However, if it is determined that relatives of the patient, "or a committee of his person," are willing and able to care for the patient, he may be released to such person's care.<sup>141</sup>

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person jointly, but each must complete a certificate of admission. *Id.*

<sup>133</sup> *Id.* § 9.27(d). If the person is known to have been under prior treatment, the examining physician must, insofar as possible, contact the physician furnishing prior treatment before completing the certificate of admission. *Id.*

<sup>134</sup> N.Y. MENTAL HYG. LAW § 9.27(e).

<sup>135</sup> *Id.* Written notice of the person's admission must promptly be given to MHLS as well as the nearest relative of the patient or as many as three designated persons. *Id.* §§ 9.27(f), 9.27(b)(2).

<sup>136</sup> *Id.* § 9.29(a)-(b).

<sup>137</sup> *Id.* § 9.33(a).

<sup>138</sup> *Id.* § 9.31(a). The patient may designate the jurisdiction in which the hearing will be held, subject to a request for change of venue by any interested party. The court must then fix the date of the hearing within five days of receiving notice, and the patient, as well as MHLS, must be advised of this date. *Id.* § 9.31(a), (c).

<sup>139</sup> N.Y. MENTAL HYG. LAW § 9.31(b).

<sup>140</sup> *Id.* § 9.31(c).

<sup>141</sup> *Id.*

Review of a court authorization for retention of an involuntary patient provides an additional safeguard.<sup>142</sup> Patients may challenge a denial of release within thirty days of a retention order and receive a jury trial on the question of mental illness and the need to be retained.<sup>143</sup> If the jury or court in bench trials determines that the patient is not in need of involuntary commitment, the patient must be released immediately.<sup>144</sup>

Additionally, each patient, regardless of admission status, has a statutory right to care and treatment "that is suited to his needs and skillfully, safely, and humanely administered with full respect for his dignity and personal integrity."<sup>145</sup> This treatment must include full medical and psychological reexaminations and evaluations of the patient at least once a year.<sup>146</sup> Similarly, each patient must be provided with an individual service plan that is "commensurate with each patient's needs and well-being, the well-being of others, and [is] least restrictive to the patient's rights."<sup>147</sup>

### C. *The Shortcomings of New York's Commitment Statutes*

#### 1. Constitutionality of New York's Mental Hygiene Law

New York's civil commitment laws were found constitutionally sound in *Project Release v. Provost*.<sup>148</sup> While these statutes do provide some protection against wrongful commit-

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<sup>142</sup> *Id.* § 9.35.

<sup>143</sup> *Id.*

<sup>144</sup> N.Y. MENTAL HYG. LAW § 9.35

<sup>145</sup> *Id.* § 33.03(a).

<sup>146</sup> *Id.* § 33.03(b).

<sup>147</sup> [1995] 14 N.Y.C.C.R.R. § 27.3(a). The content of patient service plans must be established by the appropriate staff members and must include a comprehensive statement of the patient's "physical, psychological, social, economic, educational and vocational assets and disabilities," as well as the goals of service to be provided based on the statement of assets and disabilities, and must "relat[e] to plans for [the patient's] return to the larger community." *Id.* § 27.3(c)(1)-(2). A statement of the methods and procedures to be used in attaining these goals must also be included, and the staff members who will be involved in carrying out the plan must be identified. *Id.* § 27.3(c)(3); see *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1965) (holding that the state bears the burden of exploring less drastic alternatives than inpatient care), *cert. denied*, 382 U.S. 863 (1966).

<sup>148</sup> 551 F. Supp. 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983).

ment and meet the constitutional due process standards articulated in *Parham* and other Supreme Court cases, gaps in these procedural protections still exist, particularly as they are applied to minors.

In *Project Release*, a New York district court held that both the voluntary and involuntary admission procedures are facially constitutional because they contain several procedural safeguards that minimize the chances of wrongful commitment.<sup>149</sup> These statutes were challenged as overbroad and unconstitutional because, inter alia, they failed to require that: (a) the person to be admitted have a serious mental disorder that is susceptible to treatment by existing medical and psychological techniques; (b) that adequate personnel and resources be provided to afford a realistic opportunity for the patient to improve; and (c) that a person receive the necessary help through any less restrictive means.<sup>150</sup>

In granting summary judgment for the defense on all of the issues, the district court found that each of the elements, the absence of which the plaintiff claimed rendered the statute unconstitutional, was either already contained in the statute or not constitutionally required.<sup>151</sup> That the statute required a finding of substantial mental illness for all types of admissions was seen by the court as "not seriously in dispute," since only patients in need of voluntary or involuntary mental health care could be admitted under the statute.<sup>152</sup> Similarly, the court found that a right to treatment is also present in the Mental Hygiene Law, and while "medical science . . . may not assure eventual improvement or freedom, the State may still constitutionally confine for 'care and treatment' dangerous mentally ill patients."<sup>153</sup> While the court recognized that the state may not constitutionally confine the mentally ill merely to ensure a better living standard for them,<sup>154</sup> it reasoned that the Mental Hygiene Law requires that more than custodial care be given since individual treatment plans for all patients are

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<sup>149</sup> *Project Release*, 551 F. Supp. 1298 (E.D.N.Y. 1982).

<sup>150</sup> *Id.* at 1303.

<sup>151</sup> *Id.* at 1310.

<sup>152</sup> *Id.* See *supra* notes 114-115 and accompanying text.

<sup>153</sup> *Project Release*, 551 F. Supp. at 1306 (noting that N.Y. MENTAL HYG. LAW § 33.03(a) requires individual treatment plans for all mental patients).

<sup>154</sup> *Id.* at n.4 (quoting *O'Connor v. Donaldson*, 442 U.S. 563, 575-76 (1975)).

required, and so concluded that "New York does not purport to provide only custodial care."<sup>155</sup> Similarly, the individual treatment programs must afford the patient "a realistic opportunity to be cured or to improve," thereby meeting the plaintiff's challenge to the adequacy of treatment.<sup>156</sup>

The *Project Release* court further reasoned that several procedural safeguards exist to ensure that only mentally ill individuals are committed, noting that a person may be voluntarily committed only if inpatient care is "appropriate" for the individual, and involuntarily committed only if such care and treatment is "essential" to the person's welfare.<sup>157</sup> Also persuasive to the court were the requirements that three physicians and a psychiatrist examine involuntary patients and concur in the assessment that such care is essential;<sup>158</sup> that the examining medical experts consider alternative, less restrictive means of treatment before completing the involuntary admission certificate; and that each of these experts have the opportunity to disapprove the confinement.<sup>159</sup>

The Eastern District court also noted that MHLS is under a statutory duty to review all commitments, and a judicial hearing on the need for commitment could be demanded by

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<sup>155</sup> *Id.* at 1306; see N.Y. MENTAL HYG. LAW § 33.03(a).

<sup>156</sup> *Project Release*, 551 F. Supp. at 1306. Although the court recognized that a non-dangerous individual could not be involuntarily admitted constitutionally without a finding of dangerousness, it declined to accept the recent overt act standard. Instead, "dangerousness" was more generously interpreted as including individuals who could not properly care for themselves without such treatment. *Id.* at 1304-05; see generally *Rodriguez v. City of New York*, 861 F. Supp. 1173 (S.D.N.Y. 1994) (discussing dangerousness standard), *vacated*, 72 F.3d 1051 (2d Cir. 1995); *Renelli v. Department of Mental Hygiene*, 73 Misc. 2d 261, 263, 340 N.Y.S.2d 498, 500 (Sup. Ct. Richmond County 1973) (finding that Department of Mental Hygiene has the statutory responsibility to develop comprehensive programs for care, treatment and rehabilitation of mentally ill and retarded).

<sup>157</sup> *Project Release*, 551 F. Supp. at 1305; see *Torsney v. Gold*, 47 N.Y.2d 667, 394 N.E.2d 262, 420 N.Y.S.2d 192 (1979), *overruled in part*, *People v. Escobar*, 61 N.Y.2d 431, 462 N.E.2d 1171, 471 N.Y.S.2d 453 (1984). *Torsney*, a police officer, was found not guilty of second degree murder by reason of mental disease or defect and was committed to a psychiatric hospital. After less than one year, the hospital petitioned for his release because he was found not to be dangerous to himself or others. *Torsney* was ordered released two years after entering the hospital upon being found not to be mentally ill and in need of immediate treatment. *Id.* at 682-84.

<sup>158</sup> *Project Release*, 551 F. Supp. at 1305; see *supra* notes 133-135 and accompanying text.

<sup>159</sup> *Project Release*, 551 F. Supp. at 1307; see N.Y. MENTAL HYG. LAW § 9.27.

several different parties, including MHLS and the patients themselves.<sup>160</sup> Noting these procedural safeguards, the court characterized New York's commitment laws as being permeated by a dedication to patient's rights,<sup>161</sup> and as "invit[ing] the involvement of the patient, his family and friends" to safeguard against wrongful commitment.<sup>162</sup>

The *Project Release* court paid little attention to voluntary admission procedures. Rather, the court found these admission procedures constitutional for the same reasons it upheld the involuntary and emergency procedures: The commitment process contained sufficient opportunity for medical and judicial review to prevent wrongful admissions.<sup>163</sup> At no time did the court address how the procedural safeguards contained in the voluntary admission statute might uniquely affect children who are presented for voluntary commitment by their parents, guardians or agencies responsible for their care and custody. In omitting this consideration from its analysis, the court failed to recognize that many of the protections it relied on to find the statute constitutionally sufficient may not apply to children, particularly those "volunteered" for commitment.<sup>164</sup>

While the *Project Release* court's characterization of the Mental Hygiene Law as being permeated by a dedication to patient's rights may be accurate for the adult involuntary patient, serious questions exist as to whether this is so for children. Several of the procedural protections relied on by the court to find the Mental Hygiene Law to comport with due process, such as multiple examinations and certificates of admission, statements of fact—signed under penalty of perjury—and consideration of alternative treatment, do not apply to children.<sup>165</sup> Similarly, the court's emphasis on the statute's

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<sup>160</sup> *Project Release*, 551 F. Supp. at 1307; see N.Y. MENTAL HYG. LAW §§ 9.13, 9.31, 9.33, 9.35.

<sup>161</sup> *Project Release*, 551 F. Supp. at 1310.

<sup>162</sup> *Id.* at 1307.

<sup>163</sup> *Id.* at 1309.

<sup>164</sup> See *infra* notes 183-203 and accompanying text.

<sup>165</sup> Compare N.Y. MENTAL HYG. LAW § 9.13 (allowing admission upon certification and a single examination) with N.Y. MENTAL HYG. LAW § 9.27 (requiring multiple examinations, certificates of admission filled out by each examining physician, a statement of facts signed under penalty of perjury by the party seeking admission of the patient, and consideration of alternative forms of treatment prior to allowing admission).

encouragement of the active involvement of family and friends of the patient in the commitment process, and the additional safeguard this caring involvement can afford, may be significantly less applicable to children committed by parents who cannot—or will not—care for the child, and for children volunteered for commitment by custodial agencies.

Significantly, the New York's voluntary admission statute fails to specify the number and type of medical and psychological examinations required, or who must conduct them, in order for voluntary commitment to occur.<sup>166</sup> Presumably, the constitutional standard articulated by the *Parham* Court must apply. Accordingly, a child can be admitted voluntarily upon the application of a parent, guardian or custodial agency after an examination by a single doctor or mental health care professional.<sup>167</sup> This is in contrast to the more stringent standard governing involuntary commitment, requiring examination of the patient by no less than three physicians who must individually certify that the patient is suitable for involuntary inpatient care.<sup>168</sup> Similarly, while application for involuntary admission must include "a statement of the facts upon which the allegation of mental illness and need for care and treatment are based [which] shall be executed under penalty of perjury,"<sup>169</sup> no such requirement is contained in the voluntary admission statute.<sup>170</sup>

Under lax standards of the current voluntary admission statute, parents who are unwilling or unable to care for their children may volunteer them for admission to a mental hospital, with little to stand in the way of the child's commitment.<sup>171</sup> That such abandonment does occur,<sup>172</sup> and that many children are committed while in the custody of state agencies and persons who are not the child's parents, argues

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<sup>166</sup> *Id.* § 9.13. In 1952, only 20% of the states had voluntary commitment statutes for children. Currently most states have such statutes. Ellis, *supra* note 88, at 844.

<sup>167</sup> *Parham v. J.R.*, 442 U.S. 584, 602-06 (1979); see *supra* notes 86-103 and accompanying text.

<sup>168</sup> N.Y. MENTAL HYG. LAW § 9.27(a), (e).

<sup>169</sup> *Id.* § 9.27(c).

<sup>170</sup> *Id.* § 9.13.

<sup>171</sup> *Id.*

<sup>172</sup> Perez Telephone Interview, *supra* note 116. Mr. Perez noted that abandonment by parents is not uncommon.

against the *Project Release* court's reliance on the involvement of the patient's family and friends to prevent wrongful commitment.<sup>173</sup> Where the "natural bonds of affection"<sup>174</sup> relied upon by the *Parham* Court are no longer present, the additional safeguard of familial involvement is similarly absent.

In *Project Release*, the court repeatedly emphasized that the Mental Hygiene Law requires that only persons who are suffering from a mental illness and are suitable for commitment can be considered for hospitalization.<sup>175</sup> An assumption implicit in the statute is that a voluntary patient recognizes his or her own need for treatment and therefore has volunteered him or herself for commitment. For children, this recognition of a need for treatment may not exist because the child may believe—often correctly—that he or she is not in need of inpatient mental health care. As much of the literature concerning the dynamics of committing children suggests, parents often commit children who are not suffering from mental illness—or from illnesses requiring inpatient treatment—for reasons other than concern for the child's mental health and well being.<sup>176</sup>

## 2. The Best Interests of the Child

The decision to seek hospitalization is most often made by parents who are rarely mental health professionals and whose concerns may not be solely for the child, but for the "well-being of the family as a whole."<sup>177</sup> This concern may cause parents to commit a child who is not in need of inpatient treatment when this course of action is seen as being in the best interests of the entire family.<sup>178</sup> Moreover, the decision to commit a

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<sup>173</sup> See *Panneton*, *supra* note 76, at 305 (noting that in *New York State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752 (1973), a case involving the care and treatment of retarded patients in a state institution, "[d]uring the course of the litigation approximately ten percent of the parents of those minors involved in the case could not be found.").

<sup>174</sup> *Parham v. J.R.* 442 U.S. 584, 602 (1979).

<sup>175</sup> *Project Release v. Provost*, 551 F. Supp. 1298, 1300-01, 1303, 1305 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983).

<sup>176</sup> See *infra* notes 194-216 and accompanying text.

<sup>177</sup> RICHARD REDDING, *DUE PROCESS PROTECTIONS FOR JUVENILES IN CIVIL COMMITMENT PROCEEDINGS* 5 (1991).

<sup>178</sup> REDDING, *supra* note 178, at 5.



child may also be made as the result of an internal family dynamic that has caused the child to be scapegoated for the family's dysfunctions.<sup>179</sup> Similarly, parents who are themselves dysfunctional or disturbed may not be able to assess their own role in the child's or the family's problems.<sup>180</sup> The result may be inappropriate admission of a child, initiated by a less than objective parent who may, in fact, be mentally ill.<sup>181</sup> Regardless of the mental health of a parent, the decision to commit a child may come at a time of great family stress when the parent is not thinking clearly or not willing to explore other mental health options.<sup>182</sup> Perhaps more disturbing, the decision to commit a child may be the result of factors having little, if anything at all, to do with the well-being and interests of the child.<sup>183</sup>

No formal, commonly accepted criteria for the admission of children to mental hospitals have been adopted to determine when inpatient treatment is appropriate.<sup>184</sup> In the absence of such standards, "rather vague and overly broad criteria have been promulgated," often by organizations that have a vested financial interest in high admission rates.<sup>185</sup> These criteria are often vague enough to be used to justify the admission of children who behave in ways that their parents or the community disapprove of, but who do not need inpatient treatment.<sup>186</sup> In fact, many children have been admitted to psychi-

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<sup>179</sup> *Id.* at 6; see Ellis, *supra* note 88, at 852 (also noting that parents may make the decision to commit a child at a time of great emotional stress and without careful consideration of alternatives to commitment). Also, what alternatives are available may be a function of the family's socio-economic status, making a decision to commit a child more attractive to a family lacking the resources to choose alternative methods of treatment. Ellis, *supra* note 88, at 852.

<sup>180</sup> Ellis, *supra* note 88, at 862.

<sup>181</sup> Ellis, *supra* note 88, at 859-62.

<sup>182</sup> REDDING, *supra* note 178, at 6.

<sup>183</sup> See *infra* notes 204-221 and accompanying text.

<sup>184</sup> See *Profits of Misery*, *supra* note 3, at 312-16 (policy statement of American Academy of Child and Adolescent Psychiatry, suggesting that hospitals adopt a standard for admissions of adolescents for inpatient care that includes that: "[t]he psychiatric disorder should be of such severity as to cause significant impairment of daily functioning in at least two important areas of the child or adolescent's life, such as school performance, social interaction, or family relationships"); Weithorn, *supra* note 1, at 785-86 (noting that no such criteria have been offered by the American Psychiatric Association or American Psychological Association).

<sup>185</sup> Weithorn, *supra* note 1, at 785-86.

<sup>186</sup> Weithorn, *supra* note 1, at 786. Weithorn notes that "fewer than one third of

atric facilities for such illnesses characterized as personality, conduct or transitional disorders.<sup>187</sup> The symptoms of these disorders may include behavior such as truancy, promiscuity, drug abuse, aggression, running away, persistent lying, or stealing.<sup>188</sup> In short, disorders that are viewed by many mental health professionals as manifestations of normal childhood developmental changes with transitory symptoms<sup>189</sup> often serve as the basis for commitment of children to mental institutions.<sup>190</sup> Private mental health care facilities have taken

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juveniles admitted for inpatient mental health treatment in recent years were diagnosed as having severe or acute mental disorders of the type typically associated with such admissions (such as psychotic, serious depressive, or organic disorders)." Weithorn, *supra* note 1, at 788; see REDDING, *supra* note 178, at 5; Ellis, *supra* note 88, at 865 (noting that overdiagnosis commonly occurs, perhaps as a result of the value judgment of the medical profession that it is better to err on the side of caution).

<sup>187</sup> Weithorn, *supra* note 1, at 789. A diagnosis of conduct disorder may result from the observation of the child exhibiting a pattern of antisocial conduct over a period of months. Similarly, a diagnosis of personality disorders, a category that includes "oppositional disorder," "identity disorder," and "avoidant disorder," may consist of the child showing pattern behavior including "stubbornness, violation of minor rules, argumentativeness, and temper tantrums." Weithorn, *supra* note 1, at 786-90.

<sup>188</sup> Weithorn, *supra* note 1, at 788.

<sup>189</sup> REDDING, *supra* note 178, at 5; Weithorn, *supra* note 1, at 791; see *Profits of Misery*, *supra* note 3, at 312-16 (policy statement of the American Academy of Child and Adolescent Psychiatry).

<sup>190</sup> Gay and lesbian youth appear to be particularly vulnerable to being diagnosed as having such disorders since "confusion over sexual orientation" is often considered a key symptom of "borderline personality disorder," one of the frequently invoked justifications for hospitalization of youth. SHANNON MINTER, NATIONAL CENTER FOR LESBIAN RIGHTS, PROJECT TO STOP MENTAL HEALTH CARE ABUSE OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH 4 (1994). "Such confusion is a recognized stage of the typical coming out process." *Id.* at 5 (quoting Richard Troiden, *Homosexual Identity Development*, 9 J. ADOLESCENT HEALTH CARE 105-13 (1988)). For example, Lyn Duff, a teenager, was committed to Rivendell of Utah, a private mental hospital in Salt Lake City, for no other reason than her homosexual orientation. While at Rivendell, Duff was held in physical restraints, was sedated, and underwent "hold therapy" in which she was restrained by staff members, screamed at and forced to admit that her lesbianism was hurting her family. Bruce Mirken, *Setting Them Straight*, 10 PERCENT BREAKING POINT, June 1994, at 54. "Hold therapy" is similar to the "rage reduction therapy" described by Dr. Duard Bok in his congressional testimony on abuses in psychiatric hospitals. This therapy consists of holding the patient down while staff members verbally and physically abuse the patient, often resulting in severe pain and bruising. As Dr. Bok described, children were also confined in restraints for weeks at a time and placed in "body bags." *Profits of Misery*, *supra* note 3, at 110-11 (testimony of Duard Bok, M.D., Psychiatrist, Former Employee of Psychiatric Institute of Fort Worth, Texas).

advantage of these malleable categories of disorders, often tailoring their diagnoses to those covered by the child's insurance policy.<sup>191</sup>

Contrary to the *Parham* Court's finding that parents usually act in the best interest of the child, in many instances a parent's interests may be in direct conflict with those of the child. Such conflicts may exist "where the parent is the complainant against an allegedly disobedient child."<sup>192</sup> Courts have recognized this potential conflict, and in some instances have acted to protect the child's interests.<sup>193</sup> Similarly, in the context where a child is scapegoated for the pathology of the family as a whole, or some of its members, or where parents feel they cannot control the behavior of a rebellious child, commitment may seem an attractive option. Such an option, though, is in direct conflict with the interests of a child who may be exhibiting signs of nothing more than normal childhood developmental changes.<sup>194</sup>

Also adding to the risk of improper admissions of children are overdiagnosis and confusion over whom the admitting health care professional is serving, the parent or the child.<sup>195</sup>

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 interests of the parent. If either of these happens, the doctor would be unable to act effectively as a screening agent at the initial stage of the examination.<sup>196</sup>

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<sup>191</sup> *Profits of Misery*, *supra* note 3, at 44 (statement of Louis' Parisi, Director, Fraud Division, State of New Jersey Department of Insurance). Mr. Parisi also noted that patients without insurance coverage were often referred to nonprofit hospitals. *Profits of Misery*, *supra* note 3, at 51.

<sup>192</sup> Ellis, *supra* note 88, at 857.

<sup>193</sup> See, e.g., *Saville v. Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974) (per curiam) (noting that it is essential that due process protections be applied to commitment hearings for retarded children given potential conflict between interests of parent and child); *In re Sippy*, 97 A.2d 455 (D.C. 1953) (court stripped a mother, who had charged her daughter with incorrigibility, of right to control daughter's legal representation or waive her doctor-patient privilege); *In re Long*, 214 S.E.2d 626, 629 (N.C. Ct. App. 1975); see generally *Addington v. Texas*, 441 U.S. 418 (1979).

<sup>194</sup> See Weithorn, *supra* note 1, at 825-26.

<sup>195</sup> REDDING, *supra* note 178, at 702; see, e.g., *In re Long*, 214 S.E.2d 626, 629 (N.C. Ct. App. 1975).

<sup>196</sup> *Long*, 214 S.E.2d at 629; see Elliot M. Silverstein, *Civil Commitment of Mi-*

The admitting physician may turn to the parents when committing a child since they are closest to the physician in age and social outlook, and may appear to be the most reliable source of information.<sup>197</sup> Where a parent wants to commit a child, "the effect may be that the admitting or certifying psychiatrist becomes—often unwittingly—the agent of the parent in the parent-child confrontation."<sup>198</sup>

### 3. Healing for Profit

In its holding, the *Parham* Court assumed that hospital staff and administrators are sufficiently neutral in their evaluation of a child to make an objective decision regarding the child's need for care, and that only genuinely necessary admissions will be made since the state has no interest in wasting its mental health resources on healthy patients.<sup>199</sup> However, the privatization of the mental health care industry and the dramatic expansion of this market in recent years call into question these fundamental assumptions.<sup>200</sup>

In 1968, for-profit psychiatric hospitals did not exist.<sup>201</sup> By 1982, corporations owned forty-three percent of the psychiatric health market share.<sup>202</sup> In the early 1980s, adolescent psychiatric care was so profitable that many hospitals closed wards used for traditional medical treatment, converting them to adolescent psychiatric units which were not only more lucrative than traditional medical care, but cheaper to set up and

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nors: *Due and Undue Process*, 58 N.C. L. REV. 1133, 1147-48 (1980). While noting that the risk of inappropriate admissions is present, Silverstein argues that imposing more procedural safeguards may degrade the quality of care of minor patients by taking medical decisions out of the hands of mental health care professionals. However, until mental hospitals are able to provide quality care for their patients (which Silverstein, a mental health care practitioner, admits is often not the case), it is disingenuous to argue against stronger due process requirements in the commitment process. *Id.*; see Panneton, *supra* note 76, at 304 (admitting physicians's "overidentification" with parent may cause erroneous admissions).

<sup>197</sup> Ellis, *supra* note 88, at 868.

<sup>198</sup> Ellis, *supra* note 88, at 868.

<sup>199</sup> *Parham v. J.R.*, 442 U.S. 584, 605 (1979).

<sup>200</sup> See generally *Profits of Misery*, *supra* note 3.

<sup>201</sup> Weithorn, *supra* note 1, at 816.

<sup>202</sup> Weithorn, *supra* note 1, at 817.

maintain.<sup>203</sup> With for-profit psychiatric hospitals as the largest mental health care provider, an economic pressure to fill hospital beds was injected into adolescent mental health care.

Certain practices in the private mental health care industry indicate that economic pressures do exist and that profit motives have, in many instances, affected diagnoses and decisions to commit children. Economic incentives have caused many private mental hospitals to employ aggressive advertising and marketing strategies to attract new patients.<sup>204</sup> These strategies have included offering free seminars, given by hospital staff to teachers, parole and probation officers, and church and school counselors, aimed at predisposing these adults to recommend private mental health treatment for children who come to them for help or show signs of mental illness.<sup>205</sup> Some hospitals even have used "bounty hunting" strategies where staff members are given monetary rewards and prizes based on their admission rates or referrals.<sup>206</sup>

Similarly, fear based advertising campaigns have been used to target parents of rebellious teens.<sup>207</sup> One hospital even timed its advertising campaigns to coincide with the issuance of school report cards, implying that hospitalization is warranted for teens who have less than stellar grades.<sup>208</sup> Such practices, although egregious, do not represent the extremes to which hospitals will go in order to attract patients. Some hospitals have billed their services as "Youth Programs," complete with trips to Disney World and the mall, rather than

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<sup>203</sup> See generally Beasley, *supra* note 4, at A1; Darnton, *supra* note 4, at 66; Weithorn, *supra* note 1, at 817 (noting that in 1980 private hospitalization accounted for 61% of inpatient admissions of adolescents).

<sup>204</sup> See *Profits of Misery*, *supra* note 3, at 44 (statement of Louis Parisi, Director, Fraud Division, State of New Jersey Department of Insurance), 61-62 (statement of Curtis L. Decker, Esq., Executive Director, National Association of Protection and Advocacy Systems, Inc.); see also Darnton, *supra* note 4, at 66; Jones, *supra* note 5, at 140; Moffat, *supra* note 4, at A1.

<sup>205</sup> See *Profits of Misery*, *supra* note 3, at 114 (statement of Duard Bok, M.D., Psychiatrist, Former Employee of Psychiatric Institute of Fort Worth, Texas); Weithorn, *supra* note 1, at 820.

<sup>206</sup> *Profits of Misery*, *supra* note 3, at 104 (statement of Russell D. Durrett, Former Employee of Psychiatric Hospital); Darnton, *supra* note 4, at 66.

<sup>207</sup> See *Profits of Misery*, *supra* note 3, at 477-526 for examples of advertisements and marketing strategies used by private psychiatric hospitals.

<sup>208</sup> *Profits of Misery*, *supra* note 3, at 62 (statement of Curtis L. Decker, Esq., Executive Director, National Association of Protection and Advocacy Systems, Inc.).

the inpatient treatment programs they actually are, duping at least one parent into committing his children to a psychiatric ward.<sup>209</sup> Even some adults who have responded to advertisements offering free counseling have been committed allegedly against their will.<sup>210</sup>

With the lax standards of commitment allowed under *Parham*, doctors are able to diagnose children according to the categories of mental illness that are covered by the patient's insurance.<sup>211</sup> Similarly, for-profit hospitals often make liberal use of discretionary treatments, providing unnecessary additional services for which they are reimbursed by the patient's insurer.<sup>212</sup> In some instances the services billed to the insurers are never administered, and patient's charts are retroactively altered to show reimbursable diagnoses and treatments.<sup>213</sup> It is also not unusual for patients to be discharged

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<sup>209</sup> Moffat, *supra* note 4, at A1.

<sup>210</sup> Moffat, *supra* note 4, at A1. One factor contributing to the boom in adolescent mental health care has been the insurance industry practice of providing higher rates of coverage for inpatient psychiatric care than community based treatment. While community based alternatives may provide more effective treatment (particularly for youth who suffer from minor emotional disorders), and such treatment may, in fact, be less expensive than inpatient treatment, any potential savings gained by opting for community based treatment is negated by the often complete insurance coverage for inpatient care. With total coverage for inpatient care, and significantly less coverage for community based services, commitment becomes the cheapest option available to many parents. Insurers may be unwilling to change their current reimbursement structure for fear that allowing coverage for more community based treatments will increase the number of policy holders who seek mental health care since full-time inpatient treatment is no longer the only economically feasible option.

<sup>211</sup> *Profits of Misery*, *supra* note 3, at 111 (statement of Duard Bok, M.D., Psychiatrist, Former Employee of Psychiatric Institute of Fort Worth, Texas).

<sup>212</sup> *Profits of Misery*, *supra* note 3, at 44 (statement of Louis Parisi, Director, Fraud Division, State of New Jersey Department of Insurance).

<sup>213</sup> *Profits of Misery*, *supra* note 3, at 103 (statement of Russell D. Durrett, Former Employee of Psychiatric Hospital, noting that at one hospital, patients were given 23-hour passes: So long as they were in the hospital before midnight, all group therapy sessions held throughout the day were billed to the patients who had taken advantage of the passes although they were not even on the hospital grounds when the therapy sessions took place.). In one instance, computer generated stickers were placed on juvenile patients' charts indicating what therapy and treatment sessions the children had attended. The chart of one girl who was recovering from hepatitis showed several treatments she could not possibly have attended due to her illness. See Beasley, *supra* note 4, at A1; Moffat, *supra* note 4, at A1.

and miraculously "cured" when their insurance coverage is exhausted, irrespective of the state of the child's mental health at the time of release.<sup>214</sup>

In response to these abuses, some insurers have cut the number of days for which they will provide complete coverage for mental health care.<sup>215</sup> Rather than curtailing questionable industry practices, this may have only fueled the fire, making competition for patients even stronger and leading to more aggressive sales and recruitment tactics to fill empty beds.<sup>216</sup> As these abuses come to light, it is evident that there is often a substantial inducement to wrongfully commit children to inpatient care, particularly to private hospitals. However, changes to existing civil commitment statutes may lessen this risk.

#### 4. Least Restrictive Means

Arguably, the risk of wrongful commitment of children could be lessened by requiring admitting physicians to consider alternative, less restrictive means of treatment. Although under New York's involuntary commitment law the admitting physician must consider less restrictive forms of treatment prior to admitting involuntary adult patients, no similar requirement is present in the voluntary admission statute.<sup>217</sup> This is so despite the fact that commitment, even for a short

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<sup>214</sup> *Profits of Misery*, *supra* note 3, at 100, 111 (statement of Duard Bok, M.D., Psychiatrist, Former Employee of Psychiatric Institute of Fort Worth, Texas, stating that the hospital held daily "insurance remaining" meetings, and discharge was only discussed for patients whose coverage was running out). In one instance, a child was released one day after being held in solitary confinement for acting out. Coincidentally, the child's insurance coverage expired the day of his release. Beasley, *supra* note 4, at A1.

<sup>215</sup> Cowley et al., *supra* note 4, at 50.

<sup>216</sup> Moffat, *supra* note 4, at A1. The targets of these questionable practices are not confined to the United States. Prior to 1991, a Canadian government program that provided reimbursement for drug and alcohol abuse treatment was targeted by private hospitals in the U.S. The hospitals went so far as to set up recruiting centers in Ontario, paying "patient brokers" for garnering patients and infiltrating Alcoholics Anonymous meetings in search of potential patients. The Canadian government has modified the program to provide \$200 per day in reimbursement, and settled all outstanding debts with American hospitals for 50 cents on the dollar. Cowley et al., *supra* note 4, at 50.

<sup>217</sup> See N.Y. MENTAL HYG. LAW § 9.27, 9.13; *see also* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1965) (requiring consideration of least restrictive means of treatment for involuntary patients), *cert. denied*, 382 U.S. 863 (1966).

time, may have a far more lasting and scarring effect on children than hardened adults.<sup>218</sup> Studies have found that minors committed to mental institutions are susceptible to a lowering of social competence and intelligence, as well as severe stigmatization.<sup>219</sup> New York's voluntary commitment statute currently allows a voluntarily committed minor to be held for at least three days before less restrictive means of treatment must even be considered.<sup>220</sup>

A minor committed "voluntarily" upon the application of a parent, but against his or her wishes, must contact the director of the hospital, usually through MHLS, to give written notice of his or her desire to be released.<sup>221</sup> The child will be retained for up to seventy-two hours, during which time the director may apply to retain him or her involuntarily. If an application for retention is made, the patient may be retained for another three days before receiving a court hearing on the need for commitment.<sup>222</sup> Even if the result of such a hearing is a finding that the child is not in need of inpatient care, it is not certain that he or she will be released.<sup>223</sup> A child whose parents or guardians cannot or will not take them back from an institution is put in the custody of the Child Welfare Agency, which is charged with finding an appropriate placement for the child.<sup>224</sup> However, such placements are not always available.<sup>225</sup> The limited number of beds available in foster care and state run residential treatment facilities may cause the

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<sup>218</sup> *Parham v. J.R.*, 442 U.S. 584, 628 (1979) (Brennan, J., dissenting); see generally Thomas 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).

<sup>219</sup> Robert M. O'Boyle, Note, *Voluntary Minor Mental Patients: A Realistic Balancing of the Competing Interests of Parent, Child and State*, 37 SW. L.J. 1179, 1182 nn.21-27 (1984) (also noting that in many cases minors receive only custodial care during commitment rather than care designed to treat the child).

<sup>220</sup> NEW YORK MENTAL HYG. LAW § 9.13. This is assuming the minor patient immediately apply for his or her release upon commitment. A hearing must be held on the need for involuntary commitment within 72 hours of such application. Only if the court finds involuntary treatment warranted will less restrictive means of treatment be considered in accordance with the involuntary commitment proceedings. See *id.* § 9.13, 9.27(d).

<sup>221</sup> *Id.* § 9.13(b).

<sup>222</sup> *Id.*

<sup>223</sup> Perez Telephone Interview, *supra* note 116.

<sup>224</sup> Perez Telephone Interview, *supra* note 116.

<sup>225</sup> Perez Telephone Interview, *supra* note 116.



child to be returned to the mental institution, despite a judicial finding that inpatient mental care is inappropriate, until a placement becomes available.<sup>226</sup> Although no current figures are available, one MHLS attorney reported that "several" children each year are found to be wrongfully committed, but are returned to mental institutions due to a lack of appropriate placement.<sup>227</sup>

As a result of such commitments, children who have been found not to require inpatient care are confined by the state under the guise of being treated for mental illness while, in fact, the state is merely providing them with custodial care.<sup>228</sup> This is in direct violation of New York's statutory mandate that an individualized treatment plan providing "care and treatment that is suited to [the patient's] needs and [is] skillfully, safely and humanely administered with full respect for his [or her] dignity and personal integrity" be received by every patient.<sup>229</sup> A treatment plan devised for a wrongfully committed child would be a sham, particularly since, by definition, such a plan must include inpatient treatment, which the courts have determined is unnecessary. Similarly, it can hardly be said that such a "plan" is administered "humanely . . . [and] with full respect for [the patient's] dignity and integrity."<sup>230</sup>

### III. A NEW STANDARD FOR VOLUNTARY COMMITMENT OF CHILDREN IN NEW YORK

While New York's Mental Hygiene Law meets the constitutional due process standards articulated in *Parham* and other Supreme Court cases, significant room for improvement still exists, particularly since mental health industry abuses

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<sup>226</sup> Perez Telephone Interview, *supra* note 116.

<sup>227</sup> Perez Telephone Interview, *supra* note 116. Interestingly, the statute governing admission of children to residential treatment facilities spells out a detailed process for determining whether such care is appropriate, which includes review of the patients' records and diagnoses by a committee that has the power to require additional examinations of the child. N.Y. MENTAL HYG. LAW § 9.27, 9.51. No such detailed process is spelled out in the statute governing commitment to a psychiatric hospital, a more restrictive environment than residential treatment facilities. *See id.* § 9.13.

<sup>228</sup> *See* Project Release v. Provost, 551 F. Supp. 1298, 1306 n.4 (1982).

<sup>229</sup> N.Y. MENTAL HYG. LAW § 33.03(a).

<sup>230</sup> *Id.* § 33.03(a).

and the risk of wrongful commitment are prevalent. Ideally, a voluntary commitment statute must address the risks of wrongful commitment, as well as the need for a scheme in which patients truly in need of mental health care are not discouraged or prevented from receiving it due to procedural obstacles.

Due process analysis requires that consideration be given to the private interests affected by official action, the risk of erroneous deprivation through official action, and the probable value, if any, of additional safeguards, as well as the government's interest, including the administrative and fiscal burdens the additional or substitute procedures would entail.<sup>231</sup> With this balancing in mind, it is clear that the private interest involved in civil commitment is of the highest order. Civil commitment has been described by the Supreme Court as "a massive curtailment of personal liberty,"<sup>232</sup> and the Court has recognized that even children have a "substantial liberty interest in not being confined unnecessarily for medical treatment."<sup>233</sup>

The risk of erroneous deprivation of this liberty is substantial for many children, particularly those who are volunteered for commitment by parents who are themselves mentally ill or otherwise unable to care for their children, or by state custodial agencies whose "natural bonds of affection" for the child are necessarily weaker than those of parents. Similarly, the procedural safeguards currently in place do little to discourage wrongful voluntary commitment of children, particularly where there is a financial incentive for parents and institutions to admit the child. Additional safeguards that reduce the risk of wrongful commitment would clearly benefit children by protecting their fundamental interest in personal liberty. Moreover, such safeguards may help to ensure that children receive prompt and appropriate mental health treatment where some treatment short of inpatient care is deemed necessary.<sup>234</sup>

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<sup>231</sup> *Matthews v. Eldridge*, 424 U.S. 319, 335 (1976); *Smith v. Organization of Foster Families for Equality and Reform*, 431 U.S. 816, 848-49 (1977) (citing *Matthews*, 424 U.S. 319 (1976)).

<sup>232</sup> *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

<sup>233</sup> *Parham v. J.R.*, 442 U.S. 584, 600 (1979).

<sup>234</sup> The attitude among many psychiatrists toward procedural safeguards is that they are often incompatible with effective treatment of the patient. See *Ellis*, *supra*

New York's involuntary commitment statutes address the risk of wrongful commitment through several procedural safeguards aimed at reducing this risk.<sup>235</sup> Each of these safeguards could easily be applied to voluntary commitment of juveniles and would reduce the risk of wrongful commitment. The administrative and fiscal burdens associated with these procedures are not so great as to outweigh the liberty interest they would protect, nor would they impose unreasonable barriers to the admission of truly mentally ill patients.

Applications for involuntary commitment must contain a sworn statement of facts "upon which the allegation of mental illness and need for care and treatment are based."<sup>236</sup> By requiring a similar statement for the admission of children, the added formality and threat of legal consequences for perjurious statements may prevent parents from abandoning their children in this way, as well as discourage inappropriate admissions by private hospitals. Requiring such a statement of facts would not discourage parents from applying for admission of a mentally ill child. Rather, a stronger argument can be made that the "natural bonds of affection" would encourage a parent to inform the admitting physicians of all the facts regarding their child's illness so that a more accurate diagnosis and treatment plan could be formulated for the child.

Requiring multiple examinations of juvenile patients, like those mandated for involuntary patients, would also prevent wrongful admissions.<sup>237</sup> Currently, children who are voluntarily admitted need only be examined by a single physician.<sup>238</sup> Obviously, separate examinations conducted by several different physicians are more likely to result in accurate diagnoses of children and findings of the need for inpatient care, thereby helping to weed out those who have been wrongfully volunteered for admission. Also, wrongfully committed

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note 88, at 867. However, one commentator notes that the assumption that procedures harm treatment is predicated on another assumption—that treatment is taking place—and in many instances it is not. Silverstein, *supra* note 196, at 1157.

<sup>235</sup> See *supra* note 132-150 and accompanying text for a discussion of the procedural protections contained in New York's civil commitment statutes.

<sup>236</sup> N.Y. MENTAL HYG. LAW § 9.27(c).

<sup>237</sup> See *id.* § 9.27.

<sup>238</sup> See *supra* notes 167-178 and accompanying text.

children will presumably be the ones most likely to challenge their commitment. To prevent their release, the director of the institution must apply for involuntary retention, and a hearing must be held on the question of the need for commitment.<sup>239</sup> Juvenile patients who have been examined by three physicians, all of whom have come to the same conclusion—that inpatient care is necessary—may be less apt to challenge their commitment, thereby preventing the need for a hearing. Similarly, three concurring diagnoses may weigh heavily with the court if such a hearing is held, thereby limiting its duration and the concomitant administrative and fiscal cost.

Perhaps most notably lacking in the voluntary commitment statute is the consideration of alternative, less restrictive means of care prior to admission. Consideration of alternative means of care is required by the Mental Hygiene Law before a patient may be involuntary committed.<sup>240</sup> However, no similar standard exists in the involuntary commitment statute despite the fact that the negative impact of commitment, even for a short time, on children who are in their formative years has been recognized by the Supreme Court and documented in many studies.<sup>241</sup> By incorporating a least restrictive means requirement into the statute governing juvenile admissions, the state could ensure that children are initially placed in a setting in which they can receive appropriate care, thereby preventing the damage to self-esteem and stigmatization that often afflict children who are institutionalized. This too may cut the state's administrative and fiscal costs since a child who is receiving mental health care in an appropriate environment may be less likely to resort to the courts to change his or her situation.

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<sup>239</sup> N.Y. MENTAL HYG. LAW § 9.13(b).

<sup>240</sup> *Id.* § 9.27. Ironically, patients presented for involuntary admission are, presumably, those who are more obviously in need of such care, but other, less restrictive means of treatment must be considered before they may be admitted. Alternative means of treatment need not be considered for children who are voluntary patients.

<sup>241</sup> See *supra* notes 103, 115.

## CONCLUSION

The drafters of New York's civil commitment laws clearly intended that these statutes prevent patients from being wrongfully committed to inpatient mental institutions. However, the procedures dictated by these statutes do not adequately protect children. The recent privatization of the adolescent mental health care market has created an economic incentive for hospitals to diagnose children as mentally ill and requiring inpatient treatment when, in fact, such treatment is inappropriate. Contrary to the Supreme Court's assumption of nearly two decades ago,<sup>242</sup> empirical and anecdotal evidence indicates that parents, despite the "natural bonds of affection," often do not act in the best interests of their children when committing them to inpatient psychiatric care.

Accordingly, civil commitment statutes should be updated to reflect the fundamental changes to the mental health care market and what we now know about the dynamic of parents committing their children. The significant risk of wrongful commitment present in allowing children to be volunteered for commitment under the New York Mental Hygiene Law may be lessened by importing three of the procedures required for involuntary commitment into the statute governing voluntary commitment: (1) an application for admission containing a statement of facts upon which the allegation of mental illness is based, signed under penalty of perjury; (2) separate examinations by three physicians, rather than the currently required one; and (3) an obligation to consider means of treatment less restrictive than inpatient care before a child may be admitted.

*Samuel M. Leaf*

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<sup>242</sup> See *Parham v. J.R.*, 442 U.S. 584, 602 (1979).