

# An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's "Time-Consuming Procedural Minuets" Theory in *Parham v. J.R.*

MICHAEL L. PERLIN, Esq.

The legal system prides itself on rigorous issues analysis, logical thought processes and comprehensive use of factual data in cases involving the social sciences. Since the famed "Brandeis brief" was filed with the United States Supreme Court in *Lochner v. New York*<sup>1</sup> some 50 years ago, the employment of social science data in public policy cases has been a benchmark of the appellate court process. In cases as disparate as *Brown v. Board of Education*,<sup>2</sup> *Baker v. Carr*<sup>3</sup> and *Regents of University of California v. Bakke*,<sup>4</sup> factual and scientific data has been molded by the US Supreme Court to shape and buttress opinions involving virtually every controversial facet of American life. Seemingly-unresolvable issues of race, religion and politics have been decided through the use of such data.

To what extent, however, has this model been carried over to the field of mental health law on the Supreme Court level? While State and lower Federal courts have regularly used statistical data in mental disability litigation in such areas as predictivity of dangerousness,<sup>5</sup> right to treatment<sup>6</sup> and the right to refuse treatment,<sup>7</sup> to what extent has this trend been followed by the US Supreme Court? Perhaps not surprisingly, a review of the literature fails to reveal a single article on this topic; after all, the Supreme Court has decided more mental health constitutional law cases in the past 15 months (three) than it had in the prior 193 years (two). In spite of this (or, perhaps, because of it) it is still an issue worthy of some consideration.

Specifically, how did the Supreme Court choose to deal with empirical data in the cases of *Parham v. J.R.*<sup>8</sup> and *Secretary of Public Welfare v. Institutionalized Juveniles*<sup>9</sup> (hereinafter sometimes jointly referred to as *Parham*) on the question of the extent to which due process protections apply to the "voluntary" commitment of juveniles to psychiatric institutions? Unlike *Addington v. Texas*<sup>10</sup> and *Vitek v. Jones*<sup>11</sup>—the court's other two recent forays into mental health law—*Parham* and *Institutionalized Juveniles* were class actions with extensive factual records developed below after lengthy, adversarial trials; both had been argued and reargued before

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Mr. Perlin is Director of the Division of Mental Health Advocacy in the Department of the Public Advocate, PO Box 141, Trenton, NJ. Prepared for the Annual AAPL Meeting, Chicago, IL, October, 1980. The author wishes to acknowledge gratefully the work of Laura M. LeWinn, Esq., Deputy Director of the Division of Mental Health Advocacy, and Suzette Bonfiglio, Esq., Assistant Deputy Public Advocate in the Division, on the *amicus curiae* brief upon which much of this paper is based.

the Supreme Court in an earlier term, and both had been watched carefully by mental health professionals, other service providers, patients and attorneys. It could be expected that the court's treatment of empirical data in the **Parham** pair of decisions would likely be a harbinger of its future ventures in this area.

**Parham**, of course, reversed a three-judge district court decision<sup>12</sup> which had declared Georgia's juvenile commitment statutes unconstitutional, holding that that state's procedures were both reasonable and consistent with constitutional guarantees.<sup>12,1</sup> It did, however, go on to rule that (a) the risk of error inherent in parental decision-making on the question of institutionalizing a child was sufficiently great to mandate an independent inquiry by a "neutral factfinder" to determine whether statutory admission requirements were met,<sup>13</sup> (b) although the hearing need not be formal nor conducted by a judicial officer, the inquiry must "Carefully probe the child's background using all available services, including, but not limited to, parents, schools and other social agencies,"<sup>14</sup> (c) that the decision-maker has the authority to refuse to admit a child who does not meet the medical standards for admission<sup>15</sup> and (d) the need for continued commitment must be periodically reviewed by a similarly independent procedure.<sup>16</sup>

As an aside, it should be noted that, while **Parham** is usually seen as a defeat for the "patients' bar,"<sup>17</sup> it contains much language which has been subsequently cited to support pro-plaintiff decisions. Thus, its holding that commitment constituted a deprivation of a protected "substantial liberty interest"<sup>18</sup> and that the protectible interest extended to the question of "being labeled erroneously . . . because of an improper decision by the state hospital superintendent"<sup>19</sup> was subsequently cited by Judge Brotman in **Rennie v. Klein II**<sup>20</sup> as "strengthen[ing]" the due process of holding of **Rennie I**<sup>21</sup> (decided pre-**Parham**) that due process be provided prior to the forced administration of drugs and by the Third Circuit in **Halderman v. Pennhurst State School and Hospital**<sup>22</sup> for the proposition that "Constitutional law developments incline in [the] direction of [deinstitutionalization as the favored approach to habilitation]."

Its holding, then, should not give much succor to those who see it as a major judicial retrenchment. Even more significantly, its holding is limited to cases involving juveniles: of the roughly 20 states which — via court rule, legislation or State constitutional decision — provide greater than **Parham**-level due process protections for juveniles in peril of commitment,<sup>23</sup> none has abrogated or significantly altered its procedures in the 14 months since the **Parham** decision was issued.

That **Parham** has had such a minimal effect appears, on the surface, at least, to be surprising. Generally, even when a Supreme Court decision is not binding, its moral weight is taken seriously by State legislatures and State courts. The studied indifference to **Parham** — although not the central focus of this paper — is, in and of itself, worthy of notice and greater attention.

Perhaps, however, some of the “non-impact” of **Parham** can be explained away by the way in which the Court chose to treat the empirical issue of what actually happens at a “contested” commitment hearing. For it is here that Chief Justice Warren Burger sets out — for a five-member majority of the court — his philosophy on the issue at hand, and it is here where it could be expected that pertinent data would play a major role in shaping the Court’s ultimate decision.

First, the Chief Justice discussed the state’s interest “in not imposing unnecessary procedural obstacles that may discourage the mentally ill or their families from seeking needed psychiatric assistance,”<sup>24</sup> an observation which simultaneously assumes (1) the persons at risk are genuinely mentally ill, (2) they are in need of psychiatric assistance and (3) such psychiatric assistance is available at the institutions to which the juveniles are being committed. Interestingly, although the lower court opinions in **both Parham**<sup>25</sup> and **Institutionalized Juveniles**<sup>26</sup> discussed many individual cases at length (some of which fit none of the Court’s three assumptions on this point), the Court makes no reference to any case history, supporting data or scientific research on this point.<sup>27</sup>

It continued in the same vein:

The **parens patriae** interest in helping parents care for the mental health of their children cannot be fulfilled if the parents are unwilling to take advantage of the opportunities because the admission process is too onerous, too embarrassing or too contentious. It is surely not idle to speculate as to how many parents who believe they are acting in good faith would forego State-provided hospital care if such care is contingent on participation in an adversary proceeding designed to probe their motives and other private family matters in seeking the voluntary admission.<sup>28</sup>



Again, the Chief Justice does not explain **how** the admission process is “Too onerous, too embarrassing or too contentious,” and although he “Speculate[s] as to how many parents . . . would forego State-provided hospital care” if it were contingent on an adversarial trial, he nowhere indicates the basis for his speculation.

Immediately thereafter, the opinion continues similarly:

The State also has a genuine interest in allocating priority to the diagnosis and treatment of patients as soon as they are admitted to a hospital rather than to **time-consuming procedural minuets before the admission**. One factor that must be considered is the utilization of the time of psychiatrists, psychologists and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them. Behavioral experts in courtrooms and hearings are of little help to patients.<sup>29</sup>



Although the Court cites a study provided by *amicus curiae* American Psychiatric Association that the average hospital staff psychiatrist spends only 47% of his time on direct patient care,<sup>30</sup> it offers neither data nor theory to explain **why** such hearings would be "time-consuming procedural minuets." In fact, the only footnote in the quoted paragraph is to an oft-cited law review article by Second Circuit Judge Henry Friendly which notes "That, at some point, the benefit to individuals from an additional safeguard is substantially outweighed by the cost of providing such protection, and that the expense in protecting those likely to be found undeserving will probably come out of the pockets of the deserving."<sup>31</sup>

The court continued by analyzing "What process is constitutionally due,"<sup>32</sup> stressing that "The questions are essentially medical in character: whether the child is mentally or emotionally ill and whether he can benefit from the treatment provided by the State."<sup>33</sup> Although the Court acknowledged "The fallibility of medical and psychiatric diagnosis,"<sup>34</sup> citing to the Chief Justice's concurring opinion in *O'Connor v. Donaldson*,<sup>35</sup> it added, again, without supporting reference:

[W]e do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing.<sup>36</sup>



In this vein, the opinion observed further:

Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real. See Albers, Pasewark and Meyer, **Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception**, 6 *Cap. U.L. Rev.* 11, 15 (1976).<sup>37</sup>



Significantly, the cited authority — and the other four articles discussed in the accompanying footnote 17<sup>37A</sup> — all discuss the **inadequate job** counsel usually performs at commitment hearings, and urge a more vigorous role for counsel; **none** suggests that counsel should not be appointed or is unnecessary.<sup>38</sup>

The opinion continues by stating its philosophical premise: that hearings would intrude into the parent-child relationship. Without any supporting

citation, reference to the court record or analysis of behavioral research, it sets out its rationale:

Another problem with requiring a formalized, factfinding hearing lies in the danger it poses for significant intrusion into the parent-child relationship. Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their child. It is one thing to require a neutral physician to make a careful review of the parents' decision in order to make sure it is proper from a medical standpoint; it is a wholly different matter to employ an adversary contest to ascertain whether the parents' motivation is consistent with the child's interests.

Moreover, it is appropriate to inquire into how such a hearing would contribute to the long-range successful treatment of the patient. Surely, there is a risk that it would exacerbate whatever tensions already existed between the child and the parents. Since the parents can and usually do play a significant role in the treatment while the child is hospitalized and even more so after release, there is a serious risk that an adversary confrontation will adversely affect the ability of the parents to assist the child while in the hospital. Moreover, it will make his subsequent return home more difficult. These unfortunate results are especially critical with an emotionally disturbed child; they seem likely to occur in the context of an adversary hearing in which the parents testify. A confrontation over such intimate family relationships would distress the normal adult parents and the impact on a disturbed child almost certainly would be significantly greater.<sup>39</sup>



The majority opinion was sharply criticized by Mr. Justice William Brennan, writing for himself, and Justices Thurgood Marshall and John Stevens in a three-judge dissent. According to the dissent, the Chief Justice's opinion "Ignores reality [when it] assumes[s] blindly that parents act in their children's best interests when making commitment decisions."<sup>40</sup> Although the minority felt that a pre-admission adversarial hearing "Might traumatize both parent and child and make the child's eventual return to his family more difficult,"<sup>41</sup> it recommended the institution of post-admission commitment hearings. It noted:

[T]he interest in avoiding family discord would be less significant at this stage, since the family autonomy already will have been fractured by the institutionalization of the child. In any event, post-admission hearings are unlikely to disrupt family relationships.<sup>42</sup>



Finally, the dissent concluded:

Children incarcerated in public mental institutions are constitutionally entitled to a fair opportunity to contest the legitimacy of their confinement. They are entitled to some champion who can speak on their behalf and who stands ready to oppose a wrongful commitment. Georgia should not be permitted to deny that opportunity and that champion simply because the children's parents or guardians wish them to be confined without a hearing. The risk of erroneous commitment is simply too great unless there is some form of adversarial review, and fairness demands that children abandoned by their supposed protectors to the rigors of institutional confinement be given the help of some separate voice.<sup>43</sup>



In a sharply-worded critique of the **Parham** opinion, the counsel for plaintiffs in **Institutionalized Juveniles** has written:

The decisions by the Supreme Court in **Institutionalized Juveniles** and **Parham** ignore the facts, distort the law and condemn children to second-class citizenship. The physical conditions, isolation and dangers of day-to-day life in institutions are ignored. Inevitable bias and conflict of interest of institutional professional staff are dangerously and incorrectly underplayed. Also overlooked and undiscussed is the critical necessity of a hearing and a children's advocate to assure noninstitutional care whenever possible. Those children most in need of protection, the youngest and most disabled, are denied any protection at all. Children who are already under the State's control and without the limited protection parents can provide are denied hearings as well.<sup>44</sup>



It may be too early to speculate as to whether or not, in reality, children actually have been "condemn[ed]" to "second-class citizenship," as David Ferleger suggests. It is **not** speculative, however, to ponder **how** and **why** the Supreme Court reached its decision without even discussing data that was presented to it about what actually happens in such hearings, and what the results of such hearings are.

First, as indicated above, the American Psychiatric Association had filed an **amicus curiae** brief, arguing that due process hearings "May in certain cases inflict psychological harm on children because of the unique emotion-laden nature of the parent-child conflicts that will be aired in those hearings."<sup>45</sup> In support of this argument, **amicus** APA cited several articles

as to why hospitalization may be traumatic to the **parent**, but **none** as to its possible effect on the child.<sup>46</sup> The brief cited James Ellis' seminal article on why counsel **should** be provided at such hearings,<sup>47</sup> arguing that the scenario Ellis envisions — at which lawyers could “Examine the parents as witnesses in order to explore their reasons for seeking the child's commitment, their perceptions of the child's problems and their relationship to the family's problems”<sup>48</sup> — “Could have significant negative consequences.”<sup>49</sup>

Such hearings “Can severely strain the relationship between the parent and the child,”<sup>50</sup> **amicus** APA alleged, because it is “Most distressing to children [to hear] ‘Negative remarks made about them by the parents.’”<sup>51</sup> Importantly, its citations in support of this argument refer to studies of juvenile delinquency hearing,<sup>52</sup> juveniles in need of supervision” hearings<sup>53</sup> and child abuse hearings<sup>54</sup> which show that “judicial proceedings are ‘damaging to an **already-strained** family situation.’”<sup>55</sup>

Similar studies — **not** involving the specific fact situation before the court — are cited for the proposition that “**In certain instances**, court hearings create a considerable feeling of uneasiness, if not anger in the child,”<sup>56</sup> and that such hearings may “intimidate and confuse” younger children,<sup>57</sup> even going so far as to possibly harm “the course of the child's therapy” because the hearing could be viewed “As an attack on the competence and judgment of the child's therapist.”<sup>58</sup> For this proposition, the brief cites one paper on “Children's Rights and the Juvenile Court”<sup>59</sup> for the proposition that the adversarial role of lawyers is antithetical to good child care because (1) the “Disturbed child . . . abandons the right to confidentiality,” and (2) “A perceived attack on a therapist **may** negate the value of therapy.”<sup>60</sup>

Finally, the **amicus** APA brief suggests that the benefits of hearings are “often overstated” because they are frequently “perfunctory, ritualistic, impersonal, superficial **and presumptive of mental illness**,”<sup>61</sup> citing to two studies (one of which was adopted by the court<sup>62</sup>) which criticize the court for, in **amicus**' own words, “Most often accepting uncritically the psychiatric recommendation.”<sup>63</sup>

The meretriciousness of the proposition is obvious: while arguing strongly elsewhere that commitment proceedings are not and should not be considered criminal or quasi-criminal,<sup>64</sup> the APA urges the Supreme Court to reject due process protections based on experiences in those supposedly **dissimilar** proceedings; the authorities it relies on on the issue of the harmfulness of hearings presuppose the preexistence of a therapeutic relationship between a disturbed child and his/her treater, a dyad not commonly found in many state hospitals (officials at the Georgia hospital that was at the center of the **Parham** controversy, for instance, acknowledged that at least 46 children at that facility “Needed to be in a non-institutional setting and were being harmed by continued incarceration”).<sup>65</sup> The “Children's Rights” paper cited in the brief—which **appears** to deal with juvenile delinquents — actually opposes “The current generally unsatisfactory way of

treating children in residential care.’’<sup>65.4</sup> a proposition supportive of plaintiffs’ position, not defendants’.

Finally, the brief stands the line of authorities cited on the issue of the perfunctoriness of commitment hearings on its head by suggesting that their brevity and inadequacy is a reason to not have them; all of the authorities in question urge an expanded role of counsel to make such hearings more meaningful.<sup>66</sup>

Nevertheless, the Supreme Court readily embraced the basic propositions proffered by *amicus* APA without much consideration of its supporting data. On the other hand, it totally failed to acknowledge, consider, deal with or rebut the data presented by another *amicus*, the Division of Mental Health Advocacy of the New Jersey Department of the Public Advocate.<sup>66.1</sup>

Since September, 1975, the Division of Mental Health Advocacy, a statutory agency,<sup>67</sup> has provided independent legal representation to juveniles facing involuntary civil commitment proceedings in six of New Jersey’s 21 counties, pursuant to court rule,<sup>68</sup> in a format comporting with the full range of procedural due process protections.<sup>69</sup> Its experiences — and the experiences of its clients — have been totally opposite the scenario sketched by the Supreme Court and suggested by *amicus* APA. Its statistics and dispositions reveal that individual (often creative) determinations are made by the assigned judges on individual basis. Dispositions are not limited to a finite commit/release paradigm (as feared); parents have been generally pleased with the counsel’s involvement (in spite of the ostensible “adversariness” of the proceedings); in fact, counsel has served to alleviate familial tension and strengthen inter-familial bonds; representation has led to exceptional judicial creativity in an area not known for such developments.

Some background as to the Division’s role in commitment cases is necessary. Although conceived of by statute as “law offices,” the regional offices operate, in practical effect, as a partnership among all professionals — attorneys, psychologists, social workers and others — on the staff. The ultimate service provided may be “legal” in nature (i.e., serving as counsel or, in the case of a juvenile, as guardian *ad litem* as well, at a legal proceeding such as a commitment hearing or a periodic review), but input into the final result comes from all staff members. The field representative interviews the patient/client initially and gathers all data pertinent to the type of legal representation called for. In the case of a commitment hearing, the field representative will ascertain (1) The client’s current medical/psychological condition as evidenced both by the hospital records and by the field representative’s assessment of the client at the time of the interview; (2) The client’s background — both social and medical — and current family situation; (3) The availability of alternative care facilities appropriate to the client’s needs; (4) The need for recruiting independent psychiatric testimony to present on behalf of the client at the hearing. For periodic reviews, the field representative will obtain information pertinent to one through four above, and, in addition, will review the patient’s history of



hospitalization to evaluate the nature of the care and treatment rendered in an effort to determine if continued hospitalization is appropriate.

The field representative then confers and works closely with the attorney to develop the appropriate legal strategies in light of the individual patient/client's needs and desires. The attorney appears at the hearing as the patient/client's advocate, to advance that individual's desires to the maximum extent feasible and to give the client a means of reaching outside the system for an examination of situations in which his rights as an individual citizen may have been violated.<sup>70</sup>

What, then, has been the result of those cases in which the Division of Mental Health Advocacy has represented juveniles in accordance with court rule? In partial preparation of its *amicus* brief, the Division reviewed the 213 files of juvenile clients it has represented from September, 1975 (when the rule change mandating counsel was implemented) to August, 1977 (the time of the writing of the brief). Parenthetically, the vast majority of the Division's clients were between 15-17 years old, although one child was as young as seven.

In the 213 juvenile cases closed by *amicus*' field offices, the dispositions reveal a pattern of individualized court determinations. In addition, the dispositions of the cases reveal that counsel — in New Jersey — fulfills those multiple functions urged by respected commentators.<sup>71</sup>

Thus, of the 213 closed files,<sup>72</sup> 34 of the juveniles were discharged following the involvement of *amicus* as counsel, but prior to a formal hearing, 31 were released at such a hearing (in virtually all cases to their parents' or guardian's custody), 14 were "discharged pending placement,"<sup>73</sup> six were "discharged pending placement" to a facility administered by New Jersey's Division of Mental Retardation,<sup>74</sup> 15 were "discharged pending placement," to a residential school,<sup>75</sup> one was "discharged pending placement" to a drug rehabilitation facility,<sup>76</sup> one was discharged to the custody of Division of Mental Retardation officials, four were discharged subject to certain conditions,<sup>77</sup> two were transferred to out-of-state hospitals,<sup>78</sup> three were ordered admitted to a special education program while institutionalized,<sup>79</sup> five were remanded to local jails or youth detention facilities to await trial on criminal offenses or hearings on juvenile delinquency petitions, or to a facility for "juveniles in need of supervision" [JINS]<sup>80</sup> and one was discharged to a foster home. In addition, in two cases, adjournments were entered (so as to facilitate residential school placement and to avert the potentially stigmatic effect of a commitment label),<sup>81</sup> and, in 38 cases, voluntary applications for admission were accepted.<sup>82</sup> Finally, in 22 cases, commitment was ordered, and in 30 cases, confinement was continued.<sup>83</sup>

These statistics reflect, then, individual determinations on individual bases. Dispositions are not limited to a finite commit/release paradigm (a fear often articulated by those who see the involuntary civil commitment process as taking on all of the trappings of the criminal trial). On the other

hand, they are specifically structured so that an individualized determination can be made—following the full participation of counsel at all relevant stages of the proceedings — in the manner contemplated by many of the commentators, including Dr. Alan Stone, who have pondered this issue.<sup>83,4</sup>

Significantly, in a lengthy and thoughtful analysis of this problem, Assistant US Attorney John P. Pannenton has noted:

Both the doctor and the minor's attorney should independently determine whether the child is being coerced into seeking psychiatric help. Then a search should be conducted to ascertain whether possible alternatives to institutionalization exist in the community. Out-patient treatment, special education programs, foster homes and family counseling services, to name only a few, may further the child's interest far better than institutionalization. If the adult designated to represent the child finds that his client wishes to contest the hospitalization, the role to be assumed by the adult is that of an adversary. As such, the skills of an attorney are required to prepare a proper defense and to obtain all relevant information which may prove beneficial to the child.<sup>84</sup>



Indeed, the roles played by **amicus** in the cases in question have gone far beyond simple trial representation: in many of those cases in which **amicus** was appointed guardian **ad litem** as well as counsel,<sup>85</sup> orders were entered continuing the Division as guardian **ad litem** beyond the actual formal commitment (or acceptance of the voluntary application) so as to facilitate and insure the implementation of an aftercare plan. In other cases, **amicus** has played an active role in such areas as facilitation of school placement,<sup>86</sup> and unblocking of available funds for special educational programs, assisting the family in obtaining an appropriate community education program for the juvenile,<sup>87</sup> representing juveniles on individualized right to treatment<sup>88</sup> or right to obtain Medicaid funds actions,<sup>89</sup> facilitation of an available family therapy program, provision of independent psychiatric expertise to the family so that the juvenile could readjust to his home setting after commitment, resolution of conflicts between social service agencies (e.g., Division of Youth and Family Services [DYFS]) and the juvenile's family, and finding suitable aftercare or alternative care placements. These various functions again, reflect a "counseling attitude" that far transcends the narrow range of choices often feared as a necessary concomitant to the presence of adversarial counsel.<sup>90</sup>

In addition, while preparing its brief, the Division asked its trial office attorneys to assess how the juvenile's parents felt about their children's representation by independent counsel. Although admittedly subjective, such responses mark the only instance in which such feelings have ever been sought out.

It appears that — in most cases — parents were affirmatively pleased with the involvement of *amicus*. Although parents were hostile to the role of adversary counsel in a handful of cases, in the vast majority, parents were described by *amicus* counsel as “enthusiastic about our involvement,” “thankful for involvement,” “receptive,” “cooperative,” “positive,” “helpful,” “pleased,” “grateful,” “very involved,” “appreciative,” “supportive” and “interested and informative.”

Interestingly, in at least four cases, parents who began with “negative” feelings or who were “uncooperative” with counsel, radically changed their attitudes during the course of representation and became “positive” or “cooperative” by the time of the final hearing. In these cases, it is most clear that counsel did not exacerbate tension; rather, its presence actually served to alleviate such feelings and strengthen interfamilial bonds.

Another phenomenon worth noting is that, in those cases in which counsel either represented the juvenile on treatment questions or actively sought an after-care or out-patient program, in virtually all instances, parents were especially positive about Division of Mental Health Advocacy involvement. Thus, one casenote indicates, “Mother attended hearing; appreciates ‘pushing’ by DMHA [Division of Mental Health Advocacy] for placement” (client placed in appropriate facility for juveniles with learning disabilities); in another, where a juvenile was discharged to the custody of a “JINS” program administrator, the note reads, “Father interested: pleased with final disposition; participated in decision.”

Thus, it has been suggested that, “In a crisis situation, parents may go to the first facility about which they are told or to whatever facility is closest[,] . . . see[ing] hospital care as the only approach to the crisis.”<sup>91</sup> The presence of outside counsel serves to help insure that this parental decision—often premised on incomplete or inaccurate information—is not made and ratified in a factual vacuum, an especially pressing problem in families of lower socioeconomic status: “For poor families, dependent upon public institutions, their problem is compounded by a more limited number of resources from which to choose.”<sup>92</sup>

Finally, the presence of counsel has led to exceptional judicial creativity in an area in which, most likely, such creativity would be conspicuously absent but for the presence of an adversarial role. In one case, a “treatment program” mainly consisting of over 200 electroshock applications and 23 hours a day in seclusion — structured in response to the “behavior problems” of a young girl with an organic brain condition — was struck down as violative of the Eighth Amendment’s ban on cruel and unusual punishment;<sup>93</sup> in another matter, the court held that a juvenile — on his own — could voluntarily admit himself to an institution (thus avoiding the stigma inherent in an involuntary commitment) if he “Understood the nature of a voluntary commitment and grasped the significance of the . . . proceedings;”<sup>94</sup> in another, the court held that all documents and records pertaining to the involuntary commitment proceedings be impounded “To protect the

interests of the juvenile.’’<sup>95</sup> Also, where **amicus** represented a juvenile whose condition had been gravely deteriorating and on whom psychotropic medication was having no positive effect, and where both the juvenile’s independent psychiatric expert witness and the hospital physical advocated the use of electroshock, **amicus** petitioned the court to determine the need for such treatment.<sup>96</sup> Following the hearing, the treatment was ordered and administered, and the juvenile has been subsequently discharged.<sup>97</sup>

In the case of a nine-year old autistic child, **amicus** successfully petitioned the court to prohibit the use of aversive, electroprod therapy, unless rigorous standards for staff training and program management were met.<sup>98</sup> As the hospital did not comply with the court-ordered conditions, a previously entered order mandating such “treatment” was subsequently vacated. Elsewhere, the court ordered a local school board to reconvene from recess so as to immediately appropriate funds (the release of which would be otherwise blocked due to the recess) to provide specialized treatment for the juvenile in question.<sup>99</sup>

**Amicus** concluded:

Cases such as these reflect the end results of the presence of counsel: the presentation to the courts of individual cases in a manner susceptible to individualized creative determinations. Clearly, fears as to the involvement of counsel appear groundless. A system which affords counsel and other procedural protections to juveniles facing commitment is eminently workable.<sup>100</sup>



In addition, **amicus** Division argued that procedural due process safeguards would **not** be detrimental to juveniles; rather, it suggested, such safeguards are beneficial to all parties involved in juvenile commitment matters. At such hearings, independent counsel should have multiple roles, including, *inter alia*, ascertaining the juvenile’s true wishes, explaining possible outcomes to the client (including, specifically, potential restrictivity of setting, alternative treatment modalities, facility regulations, etc.), counseling the client on consequences of hospitalization, and “present[ing] . . . [the client’s] wishes in as effective a manner as possible.”<sup>101</sup> It cited Ellis’ seminal article:

Finally, while the lawyer should try to avoid becoming a middle person in future power struggles between the client and the hospital (or parents) because of the detrimental impact that might have on the client’s acceptance of ordered treatment, it is appropriate for the attorney to reassure the client that counsel will again be available at the time of the periodic review of commitment, and may also be available if problems arise concerning in-hospital civil liberties. The knowledge that there is someone on the “outside” who is concerned about his or her fate after hospitalization may be one of the most valuable things a lawyer can give to a child-client.<sup>102</sup>



This position, of course, in no way conflicts with Alan Stone's on the same issue:

Surely, some of the aforementioned functions are social service roles which far transcend what has traditionally been viewed as the attorney's function, but if the attorney does not fill some of these needs, it is unlikely that anyone else will; and without aid of counsel, commitment can easily become a summary or self-fulfilling process. There are, increasingly, lawyers who understand and are willing to fill these needs, and if counsel come to be perceived as coworkers in the mental health system, dedicated to the aforementioned array of purposes, and not merely as righteously contentious obstructors, their presence during the commitment process will be welcomed rather than dreaded.<sup>103</sup>



**Amicus** also dealt with the issue of the **impact** of active counsel on the involuntary commitment process and found that it was clear that counsel plays a critical, and in some cases, nearly dispositive role in involuntary commitment proceedings — where active attorneys are employed, fewer persons are committed,<sup>104</sup> and that “Intervention by counsel acting as patient’s attorney tremendously increases chances of discharge, not to mention the other alternatives to hospitalization that may also be worked out to the patient’s satisfaction.”<sup>105</sup>

In the same vein, **amicus’** review of the literature found that, if a child is not afforded due process, it is likely that the resulting institutionalization will not result in any “lasting peace” in the family.<sup>106</sup> It has been suggested, thus, that judicial nonintervention supports the integrity of the family unit only in the sense that it allows the parents in a dysfunctional family to deny the existence of real family problems by “Blaming them on the illness of one of their children.”<sup>107</sup> Such “artificial domestic tranquility”<sup>108</sup> should not serve as a rationalization for the denial of procedural due process.

Not a single one of **amicus’** points, however, was dealt with in the Supreme Court’s ultimate opinion. Although a lead article — published after the **Parham** briefs were filed, but before a decision was rendered — analyzed **what actually happens** at commitment hearings, and concluded that such inquiries “Contain considerable potential for therapeutic effects,”<sup>109</sup> that article was not cited anywhere in the Supreme Court’s lengthy opinion in **Parham**. Nowhere are any of the arguments in question addressed.

In summary, in spite of the Chief Justice’s assertions, the credible—and uncontroverted—evidence before the Court could lead only to the inescapable conclusion that counseled due process hearings for juveniles are necessary, effective and ameliorative; the suggestion that they are merely

“time-consuming procedural minuets” distorts the fact, the law and reality. The startling fact that no state has voluntarily abrogated its own pre-Parham procedural due process safeguards scheme in the last year-and-a-half perhaps indicates that no one will dance the minuet with the Chief Justice.

#### References

1. 198 US 49 (1905).
2. 347 US 483 (1954).
3. 369 US 186 (1962).
4. 438 US 265 (1978).
5. E.g., State v. Krol, 68 NJ 236, 344 A. 2d 289 (1975).
6. E.g., Wyatt v. Stickney, 325 F. Supp. 781 (MD Ala. 1971), 334 F. Supp. 1341 (MD Ala. 1971), 344 F. Supp. 373 (MD Ala. 1972), 344 F. Supp. 387 (MD Ala. 1972), aff'd sub nom. Wyatt v. Aderholt, 503 F. 2d 1305 (5 Cir. 1974).
7. E.g., Rennie v. Klein, 462 F. Supp. 1131 (DNJ 1978), supplemented 476 F. Supp. 1294 (DNJ 1979), stay den. 481 F. Supp. 552 (DNJ 1979).
8. \_\_\_\_ US \_\_\_\_ 99 S. Ct. 2493 (1979).
9. \_\_\_\_ US \_\_\_\_ 99 S. Ct. 2523 (1979).
10. \_\_\_\_ US \_\_\_\_ 100 S. Ct. 1804 (1980).
11. \_\_\_\_ US \_\_\_\_ 100 S. Ct. 1254 (1980).
12. 412 F. Supp. 112 (MDGa. 1976).
- 12A. Parham, 99 S. Ct., above, at 2511.
13. Id. at 2506.
14. Id.
15. Id.
16. Id.
17. See, e.g., Note, “Postadmission Due Process For Mentally Ill and Mentally Retarded Children After Parham v. J. R., and Secretary of Public Welfare v. Institutionalized Juveniles,” 29 Cath. UL Rev. 129, 157 (1979). The decisions are also analyzed in Note, “Institutionalization of Juveniles: What Process is Due?” 59 Nebr. L. Rev. 190 (1980), and Note, “Due Process Rights of Minors and Parental Authority in Civil Commitment Cases,” 31 Mercer L. Rev. 617 (1980).
18. Parham, 99 S. Ct., above, at 2503.
19. Id. at 2504.
20. Rennie, 476 F. Supp., above, at 1307.
21. Id., citing 462 F. Supp., above, at 1145-1147.
22. 612 F. 2d 84, 115, n. 38 (3 Cir. 1979), cert. granted, \_\_\_\_ US \_\_\_\_, 49 USLW 3802 (1980).
23. See Ferleger, “Special Problems in the Commitment of Children,” in I Friedman, ed., Legal Rights of Mentally Disabled Persons 397, 399 (PLI ed. 1979) (hereinafter Legal Rights).
24. Parham, 99 S. Ct., above, at 2505.
25. See, e.g., 412 F. Supp., above, at 116-126.
26. See, e.g., Bartley v. Kremens, 402 F. Supp. 1039, 1043-1045 (E.D. Pa. 1975); Institutionalized Juveniles v. Secretary of Public Welfare, 459 F. Supp. 30, 36-38 (ED PA 1979).
27. Parham, 99 S. Ct., above, at 2505-09.
28. Id. at 2505.
29. Id. at 2506 (emphasis added).
30. Id.
31. Id., at n. 14 citing Friendly, “Some Kind Of Hearing,” 123 U. PA L. Rev. 1267, 1276 (1975).
32. Id.
33. Id. at 2507.
34. Id.
35. 422 US 563, 584 (1975) (Burger, C.J., concurring).
36. Parham, 99 S. Ct., above, at 2507.
37. Id. at 2508.
- 37A. Footnote 17 reads as follows:  
See Albers and Pasewark, Involuntary Hospitalization: Surrender at the Courthouse, 2 Am. J. Comm. Psych. 288 (1974) (mean hearing time for 300 consecutive commitment cases was 9.2 minutes); Miller & Schwartz, County Lunacy Commission Hearings: Some Observations of Commitment to a State Mental Hospital, 14 Soc. Prob. 26 (1966) (mean time for hearings was 3.8 minutes); Scheff, The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State, 11 Soc. Prob. 401 (1964) (average hearing lasted 9.2 minutes). See also Cohen, The Function of the Attorney and the Commitment of the Mentally Ill, 44 U. Texas L. Rev. 424 (1966).

38. See generally, Perlin, "Representing Individuals in the Commitment and Guardianship Process," in 1 *Legal Rights*, above, at 497, 500-501; Van Ness and Perlin, "Mental Health Advocacy — The New Jersey Experience," in Kopolow and Bloom, eds., *Mental Health Advocacy: An Emerging Force in Consumers' Rights* 62, 63, 68-69, nn. 31-39 (1977).
39. Parham, 99 S. Ct., above, at 2508.
40. *Id.* at 2515, 2519.
41. *Id.*
42. *Id.* at 2520.
43. *Id.* at 2522.
44. Ferleger, "Special Problems in the Commitment of Children," above, at 404.
45. Brief of amicus curiae American Psychiatric Association, et al., in Parham v. J.R., No. 75-1690 (1977), reprinted in 1 *Legal Rights*, above, at 479, 487 (hereinafter APA amicus brief).
46. *Id.* at 488, and n. 3, citing, inter alia, Hartmann, et al., *Adolescents in a Mental Hospital* 84 (1968); Lessem, "On the Voluntary Admission of Minors," 8 U. Mich. J. L. Reform. 189, 203 (1974).
47. *Id.* at 489, n. 4, citing Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 CA L. Rev. 840, 889-890 (1974).
48. *Id.*
49. *Id.*
50. *Id.* at 491.
51. *Id.*, citing Snyder, "The Impact of the Juvenile Court Hearing on the Child," 17 *Crime and Delinq.* 180, 189 (1971).
52. *Id.*
53. E.g., Stiller and Elder, "PINS — A Concept in Need of Supervision," 12 *Am. Crim. L. Rev.* 33, 59 (1974).
54. APA amicus Brief, above, at 492, citing Note, "Recognition and Protection of the Family's Interests in Child Abuse Proceedings," 13 *J. Fam. L.* 803, 813 (1974).
55. *Id.* at 491, citing Stiller and Elder, above (emphasis added).
56. *Id.* at 492, n. 8, citing Snyder, "The Impact of the Juvenile Court Hearing on the Child," above, at 181.
57. *Id.* at 492.
58. *Id.*
59. Miller, "Children's Rights and the Juvenile Court," in APA, *Scientific Proceedings in Summary Form*, 129th Annual Meeting 35-36 (1976).
60. APA amicus Brief, above, at 493, n. 9, citing Miller, above.
61. *Id.* at 493, citing Beran and Dinitz, "An Empirical Study of the Psychiatric Probation-Commitment Procedure," 43 *Am J. Orthopsych.* 660 (1973).
62. See Parham, 99 S. Ct., above, at 2508, n. 17, citing Scheff, above. The APA amicus Brief, above, at 493, n. 10, cites Scheff, *Being Mentally Ill* 135 (1971), which incorporates the earlier Scheff study.
63. APA amicus Brief, above, citing Beran and Dinitz, above.
64. See, e.g., Brief of amicus curiae APA in *Addington v. Texas*, NO. 77-5992 (1978), reprinted in 1 *Legal Rights*, above, at 297.
65. See, e.g., Brief of Appelles in Parham v. J.R., No. 75-1690 (1977), at 8.
- 65A. Miller, "Children's Rights and the Juvenile Court," above, at 36.
66. See, e.g., Ellis, above; Scheff, *Being Mentally Ill* (1971) (cited in APA amicus Brief, above, at 493, n. 10).
- 66A. The bulk of the references in the material accompanying footnotes 67 to 108 can be found in Brief of amicus curiae Department of the Public Advocate, Division of Mental Health Advocacy, State of New Jersey, in Parham v. J.R., No. 75-1690 (1977) (hereinafter DMHA amicus Brief).
67. See NJSA 52:27E-21 et seq.
68. See, NJ Ct. R. 4:74-7.
69. See generally, DMHA amicus Brief, above, at 10-17.
70. *Id.* at 9, citing Herr, *Advocacy Under the Developmental Disabilities Act* 11 (1976), citing Sen. Rept. 94-160, at 38.
71. See, e.g., Ellis, above; Stone, *Mental Health and Law: A System in Transition* 59, 233-237 (1975).
72. In three cases, the Division did not represent the juvenile because of lack of indigency, see, e.g., NJSA 52:27E-26, 27, and, in one case, the juvenile eloped before the hearing.
73. The phrase "discharge pending placement" — apparently unique to New Jersey practice — covers those cases in which orders are entered discharging patients subject to the availability of a suitable alternative care or aftercare facility. These orders are usually accompanied by retention of jurisdiction by the Court to insure that the placements are, indeed, made within the specific time limits contained in the order. Cf. *Dixon v. Weinberger*, 405 F. Supp. 974 (DDC 1975).
74. See generally, NJSA 30:4-165.1 et seq.
75. See generally, NJSA 18A:46-9, 13-15.

76. See generally, NJSA 30:6C-5.
77. E.g., that the juvenile participate in a specific aftercare program.
78. See generally, NJSA 30:7B-1 et seq.
79. This, e.g., requires the release of certain funds by the board of education in the municipality in which the juvenile resided. See generally, NJSA 18A:46-13, 14. Cf. 20 USCA §1415.
80. See generally, NJSA 2A:4-45, 56, 57.
81. As to the stigmatic consequences of commitment, see, e.g., Addington, 99 S. Ct., above, at 1809; Vitek, 100 S. Ct., above, at 1261, 1264.
82. See, e.g., In re Williams, 140 NJ Super, 495, 356 A. 2d 458 (Essex Cty. JDR Ct. 1976); NJ Ct. R. 4:74-7(j).
83. In two of the latter cases, special orders were entered mandating independent psychiatric evaluation of the juvenile. See, e.g., In re Alfred, 137 NJ Super. 20, 347 A. 2d 539 (App. Div. 1975).
- 83A. See generally, DMHA amicus Brief, above, at 21.
84. Pannenton, "Children, Commitment and Consent: A Constitutional Crisis," 10 Fam. L. Q. 295, 332 (1977).
85. See NJ Ct. R. 4:74-7(j).
86. A corollary of such a role is, of course, its inverse: amicus also has acted to deter inappropriate placements.
87. See generally, NJSA 18A:46-14.
88. See, e.g., NJSA 30:4-24.1; In re D.D., 118 NJ Super. 1, 285 A. 2d 283 (App. Div. 1971).
89. See generally, 42 USCA §1396 et seq.
90. See generally, DMHA amicus Brief, above, at 23.
91. Note, "'Voluntary' Admission of Children to Mental Hospitals: A Conflict of Interest Between Parent and Child," 36 MD L. Rev. 153, 160 (1976).
92. Id.
93. In re Pamela T., Docket No. ESCC 16-68 (Essex City. J.D.R. Ct. 1975).
94. In re Williams, above.
95. In re D.G., Docket No. HNCC 1-76 (Hunterdon Cty. Ct. 1976).
96. In re G.G., Docket No. MECC 164-75 (Mercer Cty. Ct. 1975).
97. This case is described in greater detail in Perlin, "The Right to Refuse Treatment in New Jersey," 6 Psych. Annals 300, 304 (1976).
98. In re CB, Docket No. MECC 802 (Mercer Cty. Ct. 1976).
99. In re MVR, Docket No. MECC 251-76 (Mercer Cty. Ct. 1976).
100. DMHA amicus Brief, above, at 28.
101. Id at 32, citing Ellis, 62 CA. L. Rev., above, at 888-889.
102. Id. at 33, citing Ellis, 62 CA. L. Rev., above, at 890.
103. Stone, above, at 59.
104. DMHA amicus Brief, above, at 41, and authorities cited therein.
105. Id., citing Gupta, "New York's Mental Health Information Service: An Experiment in Due Process," 25 Rutgers L. Rev. 405, 438 (1971).
106. Note, "'Voluntary' Admission of Children to Mental Hospitals," 36 MD L. Rev., above.
107. Ellis, 62 CA. L. Rev., above, at 854-855.
108. Note, "'Voluntary' Admission of Children to Mental Hospitals," 36 MD L. Rev., above.
109. Ensminger and Liguori, "The Therapeutic Significance of the Civil Commitment Hearing," 6 J. Psych. L. 5 (1978). □