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IN THE

Supreme Court of the United States

No. 75-1064

JACK B. KREMENS, *et al.*,
Appellants

v.

KEVIN BARTLEY, *et al.*,
Appellees

Appeal From the Judgment of the United States District Court for the Eastern District of Pennsylvania

BRIEF OF AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, FEDERATION OF PARENTS ORGANIZATIONS FOR THE NEW YORK STATE MENTAL INSTITUTIONS, NATIONAL ASSOCIATION FOR MENTAL HEALTH, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, NATIONAL ASSOCIATION OF SOCIAL WORKERS AND NATIONAL CENTER FOR LAW AND THE HANDICAPPED AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

PATRICIA M. WALD
PAUL R. FRIEDMAN

MENTAL HEALTH LAW PROJECT
1220 Nineteenth Street, N.W.
Washington, D.C. 20036

Counsel for Amici Curiae

Of Counsel:

JAMES W. ELLIS

WILSON - EPES PRINTING CO., INC. - RE 7-6002 - WASHINGTON, D. C. 20001

SUBJECT INDEX

SUBJECT INDEX—Continued

TABLE OF AUTHORITIES CITED

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

TABLE OF AUTHORITIES CITED—Continued

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INTEREST OF *AMICI CURIAE*

Amici curiae are seven organizations of mental health and mental retardation professionals and parents of

children with emotional and developmental handicaps concerned with the legal rights and effective delivery of services to these children and adolescents.[1]

Collectively, *amici* have a strong commitment to the delivery of high quality mental health and retardation services to children and adolescents. They believe that whenever possible such services should be administered on a voluntary basis in the community. Children and adolescents are generally best treated and cared for by their own families in their normal surroundings rather than by segregation in institutions for the mentally ill or retarded. Moreover, *amici* believe that in the great majority of cases such non-institutional treatment or

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[1] Henceforth in this Brief, *amici* will include

(1) The American Orthopsychiatric Association, an interdisciplinary organization of 4,000 members including psychiatrists, psychologists, social workers, educators and allied professionals concerned with the problems, causes and treatment of abnormal behavior;

(2) The American Psychological Association, composed of 40,000 psychologists, which addresses, among other things, issues involving health and education service delivery to juveniles and others;

(3) The Federation of Parents Organizations for the New York State Mental Institutions, an organization of 30,000 parents, relatives and citizens concerned with the treatment of patients in New York Department of Mental Hygiene facilities;

(4) The National Association for Mental Health, a citizens organization of one million lay and professional members whose primary purpose is to encourage efforts to provide better services for the mentally ill;

(5) The National Association for Retarded Citizens, a voluntary organization devoted to promoting the welfare of mentally retarded children and adults with 300,000 adult members;

(6) The National Association of Social Workers, an organization of 70,000 professional social work members with chapters in 50 states devoted to the advancement of sound public policy for social work consumers as well as professionals;

(7) The National Center for Law and the Handicapped, established with HEW funding to provide legal assistance to promote the full social and legal integration of all disabled Americans.

training can be successful when families are given the community support and specialized help they need for their mentally handicapped children. Accordingly, the *amici* groups have worked for the creation of better and more diversified community based facilities and programs for the mentally ill and retarded. They have increasingly emphasized the need for such programs and facilities for disturbed and retarded children because they believe that appropriate and nonstigmatizing help in the early years provides the greatest opportunity for producing healthy and well functioning citizens.

Amici do not oppose institutionalization of children and adolescents in all cases. They recognize that some children have such severe illnesses or need such specialized services that residential care outside the family may be necessary. But they are concerned that children should not be removed from normal family, peer and community contacts without a formalized and searching inquiry into their needs. Although the majority of parents are normally conscientious advocates for their children, they are often beset by conflicts and confusion of their own and by apathy on the part of official agencies. Parents are often unaware of alternatives to institutionalization, when in fact their children might be treated in the community. Although *amici* are sensitive to the sometimes competing demands of due process and therapy, they believe that an accommodation can be accomplished and that the requirement of due process hearings in connection with the institutionalization of children and adolescents will confer genuine benefits on the child and the family.

Amici represent both mental health and mental retardation professionals—psychiatrists, psychologists and social workers—and parents, who deal on a day to day basis with the problems of emotionally disturbed and mentally retarded children and adolescents. This Brief

will inform the Court of studies and experience relevant to the question of how and when due process procedures should be applied to the commitment of children to institutions for the mentally ill or retarded.

Amici have received consent from both Appellants and Appellees to file this Brief.

STATEMENT OF THE CASE

This class action was brought pursuant to 28 U.S.C. §§ 1331, 1343(3) and 42 U.S.C. § 1983 in the United States District Court for the Eastern District of Pennsylvania on behalf of all children eighteen years of age or younger admitted to mental health facilities under the Pennsylvania Mental Health and Mental Retardation Act, 50 Pa. Stat. Ann. § 4402 and § 4403. Under those sections, applications for "voluntary" admission or commitment of a child eighteen years or under to a mental facility [2] may be made by a "parent, guardian or individual standing *in loco parentis*" to the child. If the director of the facility, after examination of the child, determines the child "is in need of care or observation," the child may be admitted to the facility.

The minor plaintiffs alleged they were denied due process and equal protection of the law by Pennsylvania mental health officials under the Fourteenth Amendment to the United States Constitution because, unlike adults subjected to involuntary confinement, they were denied a hearing with prior notice, right to counsel, right to con-

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[2] Under Pennsylvania law in effect at the time of the decision, "facility" included "any mental health establishment, hospital, clinic, institution, daycare center or other organizational unit . . . devoted principally to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons." 50 Pa. Stat. Ann. § 4102. Thus the decision of the court below applies to private as well as public residential facilities for the mentally ill and mentally retarded.

front and cross-examine witnesses and the right to produce evidence against institutionalization.[3]

A three-judge court, convened pursuant to 28 U.S.C. § 2281, after receiving evidence about the circumstances under which the named plaintiffs were admitted to mental facilities and hearing expert testimony by several psychiatrists, ruled, one judge dissenting, that the "voluntary" admission and commitment procedures of Sections 4402 and 4403 were unconstitutional as they applied to

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[3] Regulations issued by the Pennsylvania Department of Public Welfare, 3 Pa. Bull. 1840, subsequent to the filing of the action, required that prior to a child's admission to a mental facility under Sections 4402 and 4403, there must be a referral from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency (in the case of a mentally retarded child the referral might be from a pediatrician, general physician or psychologist). The referral must be accompanied by a psychiatric evaluation of the child or, in the case of a mentally retarded child, a medical or psychological evaluation along with a statement of the reasons why the child needs institutional care. In addition, the director of the facility must, after an independent examination, concur with the referring professional's decision that the child should be institutionalized. Within 24 hours of admission, a child thirteen years or older had to be notified in writing that he could contact his parents or guardian and that, if he objected to admission, he would be furnished with the telephone number of a lawyer whom he could call for representation. If a child thirteen years of age or older objected to staying in the facility, the director had either to agree to his release or arrange within two to four days for involuntary hospitalization proceedings to be filed under 50 Pa. Stat. Ann. § 4406. *See Bartley* v. *Kremens*, 402 F. Supp. 1039, 1042-1043 n. 5 (E.D. Pa. 1975).

On July 8, 1976, subsequent to the decision, the Governor of Pennsylvania signed into law Act No. 143, the Mental Health Procedures Act, which permits any child fourteen years of age or over who understands the nature of his action to volunteer for admission into a facility for the mentally ill. If he does not so volunteer, he can presumably be admitted only under the involuntary commitment procedures applicable to adults. A child under fourteen may still be volunteered by his parents, although any "responsible person" may file in juvenile court to effect his release or transfer to a less restrictive alternative. The Act does not appear to affect placements of children into mental retardation facilities.

children eighteen years old or younger. *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975). The court rejected the defendants' argument that due process guarantees were inapplicable because the purpose of the "voluntary" admission statutes was to meet the child's needs through treatment rather than to punish or incarcerate him. Also rejected was defendants' argument that the state's "interest in protecting the child, preserving the family unit, maintaining the rights of parents to the custody, care, and upbringing of their children," justified the infringement of the child's liberties. 402 F. Supp. at 1045.

In ruling that due process must be accorded to children placed in mental facilities, the court reasoned that "[G]enerally, the state is required to provide substantial procedures where there is the possibility of erroneously and wrongfully depriving persons of their liberty by committing them to mental institutions." A child facing confinement for an indeterminate period in a mental facility is threatened with loss of a significant liberty and property interest cognizable under the Fourteenth Amendment. He may be "involuntarily removed from his home and familiar surroundings . . . committed to an institution where '[he] suddenly faces the regimented routine of ward life and daily confrontation with state employees, however capable, rather than family and friends.'" He faces "stigma . . . which . . . may render civil commitment a more lasting abridgement of personal freedom than imprisonment for commission of a crime." He is therefore entitled to a due process hearing if he wishes to oppose his institutionalization. 402 F. Supp. at 1045-1046.

The court further held that the minor's due process rights cannot be waived by a parent or guardian, because "[i]n deciding to institutionalize their children, parents, as well as guardians ad litem or persons stand-

ing in loco parentis, may at times be acting against the interests of their children." 402 F. Supp. at 1047-1048.

Finally, the court listed the elements of due process required for admission of a minor to a mental health facility. It did not require a hearing prior to admission because it did not wish to "deter parents, already faced with this difficult decision, from attempting to institutionalize children who are in need of treatment only mental institutions can provide" and because it recognized that "the state has an interest in the immediate detention of children who may be dangerous to themselves or others." It did require, however, that the child be seen by an attorney and advised of his rights promptly after admission. One such right was to have "a hearing before an unbiased tribunal . . . to test whether there is probable cause to believe institutionalization is necessary" within 72 hours from initial detention. Following a finding of probable cause, the child is entitled, within two weeks of initial detention, to a full evidentiary hearing on the necessity of his hospitalization.[4] Prior to both the probable cause and commitment hearings, the child and his attorney must be notified of the time, place and date of the hearing and the reasons for institutionalization. The minor has a right to consult with counsel throughout the proceedings; to be present at hearings; to have his need for institutionalization decided by "clear and convincing proof"; to confront and cross-examine witnesses; and to offer evidence on his own behalf. The child or his attorney may, however, waive any or all of

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[4] The court below emphasized that it was requiring a judicial hearing only "[u]ntil the legislature acts to establish an unbiased tribunal to conduct the probable cause and final hearings." 402 F. Supp. at 1049 n. 18. But it felt "constrained, when legislative bodies have failed to act, to find means of enforcing the constitutional rights being denied. Our action is not intended to pre-empt the state which is free to develop its own safeguards so long as they are fully effective as those which we set out." *Id.* at n. 16.

these rights, except notice and counsel, upon a finding by the court that the waiver by the child is informed and competent, or, if the child is not competent, that the attorney's decision to waive is appropriate. 402 F. Supp. at 1049-1053.

Following the decision of the court below, the defendants appealed the judgment to this Court and made application for a stay pending appeal. A stay was denied by the trial court but subsequently granted by this Court. 96 S.Ct. 558. Probable jurisdiction was noted by this Court on March 22, 1976. 96 S.Ct. 1457.

SUMMARY OF ARGUMENT

This case requires the Court to decide a novel and difficult question of the "proper resolution of possible competing interests of parents, children and the State." *Wisconsin* v. *Yoder*, 406 U.S. 205, 231 (1972). The issues presented are whether a state may itself, as guardian of minor wards, directly confine them in mental hospitals and institutions for the retarded [5] without court hearings or due process of any kind and whether it may by statute authorize parents or non-public guardians to similarly confine them by unilateral action without due process protections. Resolution of these issues re-

[5] Although children with emotional disturbances are generally treated in mental hospitals and mentally retarded children are placed in schools for the retarded, this Brief will henceforth refer to both types of facilities as "mental institutions." *Amici* wish to note that individuals referred to mental health professionals have traditionally been perceived as suffering from a disease process analagous to a physical ailment. Increasingly, however, many mental health professionals regard these individuals not as sick or ill but rather as displaying behaviors which are indicative of cognitive/emotional problems which are in some way disturbing to others in their environment. Many professionals are accordingly concerned that labels such as "mentally ill" are inappropriate or so inherently vague as to lead to arbitrary classifications with destructive consequences for the individuals concerned.

quire this Court to balance two competing interests to which it has afforded constitutional protection in the past —the right of parents and guardians to control the upbringing of their children and the right of children to due process when their liberty is threatened by state action.

This Court has often been called upon to mediate between the interests of the family on conducting its affairs free from arbitrary state interference and the interests of the state in protecting the welfare of its young citizens. In doing so, it has recognized a presumption in favor of parental prerogatives, stating that "the custody, care and nurture of the child reside first in the parents." *Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944). But it has also stressed that the state may intervene with parental decisions where those "decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Wisconsin* v. *Yoder*, *supra*, 406 U.S. at 234. In addition, this Court has granted to children of all ages significant procedural due process rights when the state attempts to remove them from their homes and place them in juvenile institutions as a result of alleged delinquent conduct. *In re Gault*, 387 U.S. 1 (1967). This case, however, involves neither a state's efforts to curtail family authority nor its efforts directly to remove children from their homes; rather it involves an attempt by the state either directly to initiate institutionalization of children who are its wards without due process oversight of any kind or indirectly to participate with or authorize parents or other guardians to institutionalize their children, also without due process oversight of any kind.

In deciding this case, this Court should consider the serious and potentially damaging effects of institutionalization upon children. Although institutional treatment may at times be necessary for some children with emo-

tional problems or developmental disabilities, protracted or unnecessary institutional stays produce documented, sometimes irreversible, psychic and developmental harm. Recent studies show that once admitted, many children remain in institutions for months and even years; most are unable to obtain release until their parents, who put them there, are willing to take them home. This problem is exacerbated when the state acts as guardian of a child without natural parents in initiating "voluntary" admissions. Obviously, institutionalization involves major restrictions on a child's liberty. But apart from restrictions upon physical liberty, institutionalization for any substantial period of time causes other equally serious harms to children. As a result of institutionalization, children's natural family and community ties are often severed. Moreover, the impact of institutionalization upon the intellectual and emotional development of children can result in irreversible damage to their future potential as adults. And even if they are released, the mere fact that children have once been institutionalized carries with it a life-long stigma which may cause them to be denied admission to employment, licenses, higher education and access to health benefits.

Given the potential damaging impact of the decision to institutionalize on the child, the Court must also consider the context in which the decision is now made by parents. Parents are generally driven to hospitalization as a result of inability to cope with the problems of the child when they are under conditions of great stress. At the time institutionalization of their children becomes a serious option, parents are often ignorant of or unable to find alternatives by themselves and their own interests or the interests of other family members are likely to be in conflict with what is best for the child. Accordingly, it cannot be assumed that parents will automatically make this decision based solely on what they perceive

to be the child's best interests or that they are sufficiently impartial to judge those interests.

When parents are in such extremity, moreover, the requirement that an examining physician approve the child's admission is not an effective safeguard against unnecessary institutionalization. The physician's decision, as the professional members of the *amici* organizations well know, is heavily influenced by the parents' attitude toward the child and by the physician's inability to command alternative treatment resources for the child. If parents will no longer tolerate their child at home, and the physician cannot find, expedite or order an alternative placement, the physician has no choice but to approve institutionalization of the child. The physician therefore acts as a screening agent for the facility or as the parents' consultant but not as the child's physician of choice. *Cf. Planned Parenthood* v. *Danforth*, —— U.S. ——, 44 U.S.L.W. 5197 (July 1, 1976).

In view of the potentially serious harms to children of institutionalization, *amici* recommend that the Court recognize a constitutional right of all children to procedural due process protections when they are admitted to mental institutions by a state guardian. When the state acts *in loco parentis* to initiate the institutionalization of a mentally handicapped child, concerns of family autonomy are not relevant and prolonged institutionalization is more likely. When parents seek to institutionalize children age twelve and over, a balancing of the rights of the individual adolescent to personal autonomy against the interests of parental autonomy also dictates the due process rights ordered by the court below. As the child matures and approaches adulthood, parents must expect increasingly to share with him decision-making about his future. Thus, where parents and adolescent children disagree on so vital a decision as confinement to a mental

institution, the adolescent should be afforded an impartial forum in which to contest this significant deprivation of liberty.[6] Finally, *amici* believe that younger children below age twelve also deserve the protections of due process when they are threatened with institutionalization for more than the briefest periods of one or two weeks required for inpatient evaluation or respite care. The dangers to younger children from unnecessarily prolonged institutionalization are greater than to older children, and younger children are less able to defend themselves against the traumas of separation from parents and friends. These dangers outweigh the interests of parental autonomy. *Amici* do recognize, however, that there are occasions when conscientious parents must institutionalize children for periods up to two weeks for diagnostic evaluations or, on isolated occasions, place them in appropriate residential facilities for temporary respite from their own obligations. These interludes—if brief and infrequent—do not endanger the child to the same degree that indefinite or prolonged commitments do and they are not inconsistent with a parental intention to keep the child as part of the family. It would seem unnecessary and unreasonably destructive of valid parental autonomy to insist that such brief confinements

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[6] Even an older child, of course, may not be competent, for reasons other than age, to make a decision about inpatient treatment or confinement. One should, for example, be particularly sensitive to the possibility that an older mentally retarded child may be functioning at a mental age level below twelve years. The court below required the child's lawyer to report to the court if he deemed the child incompetent to make a decision about requesting a hearing on the need for institutionalization. If the child was found to be incompetent, the lawyer would himself recommend a hearing or waiver and the court would then decide what action to take. 402 F. Supp. at 1053-54 n. 26. *See also Planned Parenthood* v. *Danforth, supra,* 44 U.S.L.W. at 5204, recognizing that not all females will be competent to make the abortion decision by themselves.

be surrounded with the same due process protections as longer or indefinite institutional placements.[7]

Accordingly, *amici* support the due process requirements outlined by the court below for institutionalization of children. They do, however, recommend that this Court provide a limited exception for the placement of children under the age of twelve for a one or two week nonrecurring period of evaluation or respite care in facilities appropriate for those purposes, where it is not the intention of the parents to institutionalize their child indefinitely.

Finally, *amici* believe that due process inquiry into the need for any but the briefest institutionalization need not interfere with, and may indeed contribute to, therapeutic objectives for emotionally disturbed and retarded children. Such hearings should help deter unnecessary institutionalization. And they should focus the attention of professionals and parents on locating and creating adequate community based care facilities for handicapped children who need not be institutionalized. The placement of emotionally disturbed and retarded children in normal community settings, whenever possible, but with the specialized help they need, is a fundamental principle of the *amici* organizations.

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[7] To insure that this limited exception is not abused, parents might be required to execute an affidavit about the purpose of the admission, the expected duration of confinement (not more than two weeks) and the unavailability of nonresidential or less restrictive services. For example, it should not be acceptable to place a child in a state hospital for respite care in lieu of a group home or community based shelter facility.

ARGUMENT

I. THE CONSTITUTION PROHIBITS STATES FROM DIRECTLY OR INDIRECTLY DEPRIVING CHILDREN OF HEALTH, WELFARE OR LIBERTY WITHOUT DUE PROCESS, REGARDLESS OF PARENTAL CONSENT

This Court has previously recognized that involuntary commitment to a mental facility involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Certainly for adults, such a deprivation must be attended by due process procedural safeguards. *See O'Connor* v. *Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring).[8] *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973).[9] And there can be little doubt that due process safeguards would also apply to any attempt by the state to initiate the involuntary institutionalization of a child. This Court ruled in *In re Gault*, *supra*, that despite the state's *parens patriae* purpose in juvenile delinquency proceedings, due process required a judicial hearing before children could be removed from their homes and placed in juvenile institutions. Moreover, in a recent case, *Goss* v. *Lopez*, 419 U.S. 565 (1975), the Court ruled that a brief suspension of a few days from public school must be accompanied by rudimentary due process procedures.[10] As Section II of this Brief will

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[8] "Commitment must be justified on the basis of a legitimate state interest, and reasons for committing a particular individual must be established in an appropriate proceeding." 422 U.S. at 580.

[9] *See also Lynch* v. *Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded on other grounds*, 414 U.S. 473 (1974), *redecided*, 379 F. Supp. 1376 (1974), *remanded on other grounds*, 421 U.S. 957 (1975), *redecided*, —— F. Supp. —— (1976); *Dixon* v. *Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971); *Bell* v. *Wayne County*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975).

[10] Appellants suggest in their Brief at pp. 39-42 that, since commitment to a mental facility is based on the child's need for care

show, children in mental institutions very often suffer loss of liberty, risks to intellectual and emotional development and stigma similar to children in juvenile facilities. Moreover, children who are institutionalized are often denied education for months and years. Accordingly, where the state is an active participant in the institutionalization of children either through its initiation of admission as their guardian or through its operation of the facility in which they are placed, the reasoning of *Gault* and *Goss* appears to compel due process.

But the proposition that the state may not directly initiate the involuntary institutionalization of a child without affording him procedural safeguards is not dispositive of a major issue in this case.[11] For in the case of the majority of children in the plaintiff class, the state has not itself initiated institutionalization but has instead permitted parents to confine their children without due process safeguards either in public or private institutions.

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and treatment and not on the commission of a specified wrongful act, due process fact-finding procedures are unnecessary. This argument is erroneous. An adult whose commitment is grounded on his status as a sexual psychopath or a mentally disabled person is clearly entitled to a hearing as to whether he meets the statutory criteria for that status. *See Specht* v. *Patterson*, 386 U.S. 605 (1967); *cf. Jackson* v. *Indiana*, 406 U.S. 715 (1972). In addition, a decision that a disturbed or retarded child needs institutionalization is usually based in part on specific behavior attributed to the child, which may be subject to factual dispute.

[11] It is, however, critical to the decision whether the state, acting *in loco parentis* for particular children who have been placed in its custody as a result of parental abandonment or neglect, must provide a hearing before placing such children in mental institutions. *See* Part III A, *infra, and cf. Planned Parenthood* v. *Danforth, supra*, 44 U.S.L.W. at 5202 ("the State cannot 'delegate to [parents] . . . power which the state itself is absolutely and totally prohibited from exercising. . .' ") [citation omitted].

The granting to parents of broad powers of control over their children is customarily in accord with the parents' natural and fundamental rights to supervise the upbringing of their children—rights zealously guarded by this Court against arbitrary state interference on many past occasions. The primary issue in this case, thus, is whether the nature of the decision to commit indefinitely to a mental facility is so threatening to a child's welfare and liberty that the state cannot directly or indirectly, by relying on parental discretion, allow institutionalization without due process protections.[12]

While recognizing that the rights of parents to "establish a home and bring up children" have been deemed "essential," *Meyer* v. *Nebraska*, 262 U.S. 390, 399 (1923), and the "primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition," *Wisconsin* v. *Yoder*, *supra*, 406 U.S. at 232,[13] this Court has nonetheless approved state limitations upon parental decision-making when the child's welfare appeared endangered.

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[12] *Amici* frame their analysis of this case in terms of the appropriate resolution of conflicting interests of parent and child. The court below, however, analyzed the case as one in which children had due process rights to procedural protection from confinement, and the relevant question was whether parents could "waive" such rights for their children. 402 F. Supp. at 1047-1048. *Amici* believe that even if the waiver formulation were used, the conclusions would be similar since setting constitutional procedures to insure a valid waiver of fundamental rights would require the same inquiry into the competence of the child and possible conflicts between parent and child as is necessary to *amici's* analysis.

[13] *Wisconsin* v. *Yoder*, of course, upheld the right of Amish parents to disobey compulsory education laws that required attendance of their children at secular secondary schools and *Meyer* v. *Nebraska* upheld the right of parents to provide foreign language instruction for their children at private schools. *See also Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925) (right of parents to send children to private schools); *Stanley* v. *Illinois*, 405 U.S. 645 (1972) (necessity of providing due process hearing before removal of child from custody of natural father).

> "Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor, and in many other ways. . . . The catalogue need not be lengthened. It is sufficient to show what indeed appellant hardly disputes, that the state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare. . . ." [*Prince* v. *Massachusetts*, *supra*, 321 U.S. at 166-167 (footnotes omitted).]

See also Ginsberg v. *New York*, 390 U.S. 629 (1967).

Although the issues are not precisely the same here, *amici* believe that the same balancing of potential harm to the child against harm to the integrity of the family must take place where children's and parental interests are pitted against each other as in cases where the court mediates between asserted state and parental interests.

In its recent decision, *Planned Parenthood* v. *Danforth*, *supra*, this Court had to strike a balance between children's and parents' rights in a situation somewhat analogous to this one. This Court there rejected as unconstitutional a state statute permitting a "parental veto" over minors' abortions within the first twelve weeks of pregnancy.

> ". . . the State may not impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy. Just as with the requirement of consent from the spouse, so here, the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.

> "Constitutional 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." [44 U.S.L.W. at 5203-04.]

In *Planned Parenthood* this Court refused to credit the alleged state interest in "the safeguarding of the family unit and of parental authority" as a sufficient justification for requiring parental consent as a condition of the minor's right to abortion.

> "It is difficult . . . to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant." [*Id.* at 5204.]

In assessing the relevance of *Planned Parenthood* to the instant case, certain differences are, of course, readily apparent. In *Planned Parenthood,* for example, the parents objecting to an abortion were aligned against the minor and her medical consultant, whereas in this case the parents desiring to institutionalize their child must first obtain the approval of the admitting physician. And while the plaintiffs in *Planned Parenthood* sought and obtained the complete invalidation of the requirement of parental consent, what appellees seek here is only an impartial forum in which minors can contest institutionalization, when they disagree with their parents' recommendation. *Cf. Planned Parenthood, supra,*

44 U.S.L.W. at 5208-5209 (Stewart and Powell, J.J., concurring).[14] If, after full consideration of the child's problems and needs at a due process hearing, the impartial tribunal decides that institutionalization is appropriate, it can still order such institutionalization over the child's objections.

But, despite these differences, a careful reading of *Planned Parenthood* suggests that the competing interests in both cases are similar and that the results should also be similar. Both cases involve the issue whether minors, as well as adults, have constitutionally protected rights to liberty and self autonomy, and both cases involve the question whether the state has the constitutional authority to give a third party the power to take away such rights from a minor even though it could not itself do so directly.

The presumption in favor of parental control of minor children is strong. But, as *Planned Parenthood* indicates, parents cannot be affirmatively authorized by the state to act in serious derogation of the rights of their children to life and liberty without any semblance of due process protections for the child.

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[14] "The Court's opinion today in *Bellotti* v. *Baird*, —— U.S. ——, ——, suggests that a materially different constitutional issue would be presented under a provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest. Such a provision would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child."

In *Bellotti* v. *Baird*, —— U.S. ——, 44 U.S.L.W. 5221 (U.S. July 1, 1976), the Court vacated and remanded to allow for state court interpretation of a law which required parental consent for a minor's abortion, but permitted a judge to grant consent for good cause, if the parents refused.

II. THE DECISION TO INSTITUTIONALIZE SERIOUSLY ENDANGERS A CHILD'S HEALTH, WELFARE AND LIBERTY

Although in some cases, hospitalization of an emotionally disturbed or developmentally disabled child may be appropriate and indeed beneficial to the child, there is nonetheless a serious risk of grave and often irreversible harm to a growing child stemming from institutionalization for any significant period of time. This potential for harm to the child is coupled with the unfortunate circumstance that parents are often driven to institutionalization by conflicting motives, and by ignorance of how to obtain community based help or by the unavailability of alternatives. The result has traditionally been to overinstitutionalize children with emotional or developmental problems with resultant grave harms to these children.

A. The Decision to Institutionalize a Child Interferes with the Child's Liberty and Development, and Presents a Substantial Likelihood of Serious, Irreversible Harm

Institutionalization, by its very nature, has a severe impact on a child's liberty. The child is taken from his family, and is subjected to the rigid structure and rules of a closed facility, including locked wards, isolation cells, physical and chemical restraints and restriction of contact with the extrahospital community.[15] Of course, the

[15] *See, e.g., Price* v. *Sheppard,* No. 320 (Minn. Feb. 20, 1976) (use of electroconvulsive therapy on minors); *Hearings on the Use of Children as Subjects in Biomedical and Behavioral Research before the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research* (April 9, 1976) [hereinafter Hearings] (Testimony of Dr. Robert Sprague) (66% of children in institution for retarded are on psychotropic drugs without sufficient monitoring or individualization of dosage); Mitchell, *Experimentation On Minors: Whatever Happened To Prince* v. *Massachusetts?,* 13 Duquesne L.Rev. 919 (1975) (medical experimentation performed on minors in mental institutions).

degree of liberty children enjoy differs from adults', since they are subject in varying degrees to the control of their parents. But there is little question that a child's liberty of movement and how he spends his time is substantially restricted when he moves from home and neighborhood into a mental facility. The change in his situation is often not qualitatively different from that of the delinquent child placed in a rehabilitative facility by the juvenile court, a move which this Court has already circumscribed with due process procedures.[16]

But apart from restrictions of physical liberty, institutionalization for any substantial period of time can cause other equally serious harms to children; its impact on their intellectual and emotional development can result in irreversible damage to their future potential as adults, and the mere fact of institutionalization carries with it a lifelong stigma which may prejudice them in admission to employment, licenses, higher education and access to health benefits.

1. *Institutionalization Can Result in Loss of Family and Community Ties*

When a child is institutionalized for any period of time,

> "His world becomes 'a building with white-washed wall, regimented routine and institutional hours . . .' Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by guards, custodians, [and] state employees . . . ."

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[16] *See Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968), "It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-minded or mental incompetent—which commands observance of the constitutional safeguards of due process."

In re Gault, supra, at 27, *quoting Holmes' Appeal,* 379 Pa. 599, 616, 109 A.2d 523, 530 (1954). Deprivation of family and community life, however brief or necessary, is almost certainly traumatic for both younger children and adolescents.[17] Although brief residential stays in mental facilities may on occasion be necessary for evaluation or treatment of disturbed children or for the specialized training or respite care of retarded children, it is still a serious matter for the child.[18]

Lengthy institutionalization, however, compounds the trauma by weakening family ties. It often amounts to and in fact does lead to formal severance of parental involvement. After he has been away from home for a substantial period, the child's "parents have sort of fallen out of love with him" and reintegration into the realigned family circle becomes more difficult.[19] In many cases, admission to a mental institution amounts to a life sentence. According to the Joint Commission on the Mental Health

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[17] *See, e.g.,* M. Grob & J. Singer, Adolescent Patients in Transition 115 (1974) [hereinafter Grob & Singer]. A survey of adolescents who had been institutionalized in a private facility of high quality showed that a majority of their families "had a negative view" of the hospitalization. They cited as "added problems which accrued from hospitalization . . . exposure to other sick people, drugs, sex, removal from the community of normal adolescents" and the fact that "the child had irretrievably lost an entire stage of his development." *Id.* at 120, 116.

[18] The younger the child, the shorter the period before he suffers the psychological pangs of abandonment. J. Goldstein, A. Freud & A. Solnit, Beyond the Best Interests of the Child, 40-49 (1973).

[19] DeMyer, *New Approaches to the Treatment of Very Young Schizophrenic Children,* in The Mental Health of the Child, 424 (Public Health Service Publication No. 2168, 1971). *See* Hammond, *Parental Interest in Institutionalized Children: A Survey,* 20 Hosp. & Comm. Psychiatry 338 (1969) (a survey of 5400 parents of Willowbrook residents to determine if they wanted progress reports or exploration of the feasibility of outplacement for their retarded children produced only 15% replies; only 10% of those replying wanted progress reports, and fewer than 2% were willing to discuss the child's return home).

of Children, one fourth of the children admitted to one state's mental hospitals "can anticipate being permanently hospitalized for the next 50 years of their lives." [20] Mentally retarded institutional residents, 90 percent of whom are initially admitted as minors, have a current median stay of 15 years.[21] In general, children are more likely to stay longer in institutions than adults, because their ability to leave is often blocked by family unwillingness to take them back.[22]

Testimony before the trial court in this case emphasized that mental hospitalization means isolation from family, school and community, the loss of a "social support system" for the child, a "derailment from the usual course of one's life" and it signals difficulties in reentering family, school and neighborhood upon release. Testimony of Dr. Messinger (620-621a).[23]

Thus, there is a definite threat to an institutionalized child after a certain point of time [24] of losing his place in the family and community.

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[20] Joint Commission on the Mental Health of Children, Crisis in Child Mental Health: Challenge for the 1970's at 6 (1969) [hereinafter Joint Commission Report].

[21] Cohen, *Advocacy*, in President's Committee on Mental Retardation, The Mentally Retarded Citizen and the Law 592, 599 (1976).

[22] Joint Commission Report, *supra*, at 271. *See also*, Reiger, *Changing Concepts in Treating Children in a State Mental Hospital*, 1 Int. J. Child Psychotherapy 89, 104 (1972) ("most mentally ill children who are treated in a state hospital overstay, by months and even years, the optimum period required for their partial or total social restoration"). In New York State hospital inpatients stay significantly longer than any other age group except those over 64. Weinstein, *et al., Relationship Between Lengths of Stay In and Out of New York State Hospitals*, 130 Am. J. Psychiatry 904, 907 (1973).

[23] References to material in the Appendix will appear as (Xa).

[24] *See J. L.* v. *Parham*, —— F. Supp. ——, No. 75-163 M.A.C. (M.D. Ga. 1976), *stay granted*, 96 S.Ct. 1503 (1976).

> ". . . the evidence indicates there are some parents who . . . under the guise of admitting a child to a mental hospital actually abandon their child to the state." (sl. op. at 39-40.)

The child's interest in remaining in the mainstream of family and community life is at least as compelling as the parent's interest in retaining control of his child. In *Stanley* v. *Illinois*, *supra*, 405 U.S. at 653, this Court underscored the parent's interest in not being "needlessly separate[d] . . . from his family." Removal of a child from his family, friends and community is just as much a severe deprivation. Thus, in *Wisconsin* v. *Yoder*, *supra*, 406 U.S. at 211-212, the Court recognized that a secular secondary education "takes [children] away from their community, physically and emotionally, during the crucial and formative adolescent period of life" and thereby may "result in great psychological harm to Amish children."

Children thus deserve due process protections when they are institutionalized initially, and frequent periodic review thereafter to safeguard their interest in remaining in the family and in the community.[25]

2. *Institutionalization Threatens the Intellectual and Emotional Development of Children*

It is widely recognized that although brief periods of residential treatment may occasionally be necessary for disturbed or retarded children, any unnecessary prolongation of institutional treatment presents the threat of deleterious long-term effects on cognitive, emotional and social development.[26]

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[25] *See* Joint Commission Report, *supra*, at 44.

[26] For these reasons many professional child care workers have a "pervasive feeling" that institutionalization should be a last resort. R. Glasscote, *et al.*, Children and Mental Health Centers 20 (1972); Joint Commission Report, *supra*, at 269.

> "It is the conviction of this Commission that no child or young person should be placed in a mental hospital without a careful professional diagnosis and without preliminary attempts to

To develop normally, a child must undergo certain basic life experiences at particular stages of his development. For very young children, there is an overwhelming need for a consistent, affectionate "mothering" relationship with one person. Without adequate "mothering," the child never learns to form close personal relationships or to develop inner self controls. As the child grows, he needs individualized responses and guidance in his attempts to master physical, social and intellectual skills. If he is not responded to promptly and positively, he will not continue to strive for mastery of these skills and he may suffer emotional disturbance.[27] A growing child also needs a "wide range of experiences in seeing, hearing, touching, handling and moving" or he will not learn to talk, to develop his intellectual skills or to master conceptualization and abstraction.[28] Further, the preadolescent child needs an increasing involvement with the community, outside of his immediate family environment, if he is to learn to function as a constructive member of society.[29]

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help him through other forms of treatment on an outpatient basis in his own home or at least in his home community."

The expert testimony before the trial court also emphasized that hospitalization for disturbed children and adolescents should be a "last resort." Psychiatrists stressed that the potential damaging effect of institutionalization even for a "couple of months" was "tremendous." Testimony of Dr. Feiner (474-475a); Dr. Kandler (582a); Dr. Ingall (590a); Dr. Messinger (620-622a, 631a, 633-634a).

[27] J. Bowlby, Child Care and the Growth of Love 60-61 (1953) [hereinafter Bowlby].

[28] Joint Commission Report, *supra*, at 321.

[29] Joint Commission Report, *supra*, at 331. The literature indicates that retarded children have an intensified need for all these life experiences. Their more limited cognitive skills make parental contacts and community ties even more necessary if the child is to gain a measure of self-autonomy and become as self-sustaining an adult as he can. *See generally* W. Wolfensberger, Normali-

In view of these developmental needs, it is significant that studies of young children in institutions document the conclusion that "most infants living in institutions do not get enough mothering in purely quantitative terms." Infant care is typically routinized, the baby "is fed, diapered, lifted up and put to sleep on a schedule, that is almost exclusively externally determined." The mother-child communications that form the infant's earliest and often most decisive learning experiences are "reduced to a minimum." [30]

In most institutions there are several different "shifts" of staff each day and the rate of staff turnover is extremely high. In one facility studied, the children on one ward were cared for by 246 different adults in a three and one-half year period.[31] Under these circumstances consistent "mothering" is an impossibility.

The growing child in institutions suffers deprivation as well. He seldom, if ever, receives the individualized response he needs for his experimental forays into physical and mental skill development.

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zation (1972); W. Wolfensberger & L. Glenn, Program Analysis of Service Systems (1973).

> "The principle of normalization is deceptively simple . . . [T]he means employed for training should be as culturally normative as possible. . . . If the ultimate goal is the individual's optimal level of self-sufficiency, then the program processes and content that are used should be as close as possible to those typically utilized in the normal culture. Only in this way will retarded citizens develop more normal adult behavior and improve their relations with others."

Glenn, *The Least Restrictive Alternative in Residential Care and the Principle of Normalization*, in The Mentally Retarded Citizen and the Law, *supra*, at 501 [hereinafter Glenn].

[30] S. Provence & R. Lipton, Infants in Institutions 19 (1962) [hereinafter Provence & Lipton].

[31] N. Hobbs, The Futures of Children 129 (1975) [hereinafter Hobbs].

> "The most serious deficiency of the total (institutional) program is the lack of awareness that each child is an individual. . . . The children are herded in groups from one place to another and no opportunity arises for them to be treated as individuals. Individual treatment is, of course, essential for a child to grow into a socially sensitive person." [32]

As one research team observed, "any attempt to make a personal decision such as is typical of normal childhood will probably cause the individual to be punished because he is deviating from administrative routine." [33]

Children in institutions are also unlikely to be exposed to the stimuli and challenges a growing child needs. They are often confined to one indoor living unit and one daily period of outdoor recreation. "Nothing is new, nothing is different, therefore nothing is memorable. Life is dull and plodding; an interminable sequence of sameness over and over again." [34]

Finally, life in an institution rarely offers opportunity for integration of a child into community life. The family is the usual "socializing agent" and bridge to community life. Children of a very young age develop marked identification with their kinfolk which assists them in finding a community identity.[35] When they are denied community

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[32] B. Flint, The Child and the Institution 16 (1966).

[33] H. Leland & D. Smith, Mental Retardation: Present and Future Perspectives 84 (1974) [hereinafter Leland & Smith]; Bowlby, *supra*, at 61:

> "The child is not encouraged to individual activity because it is a nuisance; it is easier if he stays put and does what he is told . . . often the children sit inert or rock themselves for hours together. . . . In these conditions, the child has no opportunity of learning and practising functions which are as basic to living as walking and talking."

[34] B. Flint, *supra*, at 15.

[35] Elkin, *Agents of Socialization*, in Children's Behavior 360 (Bergman ed. 1968).

experiences and involvement, "their behavior as young adults reflects their lack of contact with normal people during their developmental period." Institutionalized children "have as models only other handicapped persons." [36]

There has been extensive empirical documentation of the psychological and developmental harms that beset an institutionalized child or adolescent. These include low scores on intelligence tests, poor progress in school, deficiencies in emotional and social development. These harms accelerate with the length of the institutionalization, the age at which the child was first admitted and the impoverished conditions in the institution.[37] Institutionalized infants show marked retardation in intellectual and language development.[38] Moreover, this retardation does not readily disappear even when the infants are placed in foster homes before the age of two.[39] This phenomenon applies to well-staffed nurseries, as well as to poorly run state hospitals. "[T]he residential nursery considered as a language laboratory appears to be inferior to a 'good' working-class home." [40]

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[36] Leland & Smith, *supra*, at 86; Glenn, *supra*, at 499.

[37] Hobbs, *supra* at 135, 142-143. Of course, in recent years, mental health and mental retardation professionals have learned more about how, given adequate resources, institutions can have more effective habilitation programs. Possibly, in the relatively few institutions which now have such adequate habilitation programs, children would not show such impaired development relative to children who are not institutionalized. Unfortunately, such comparative information is not currently available.

[38] Yarrow, *Maternal Deprivation: Toward an Empirical and Conceptual Reevaluation in Maternal Deprivation* 3, 9-11 (Child Welfare League of America, 1962) [hereinafter Yarrow].

[39] Provence & Lipton, *supra*, at 149, 155-156.

[40] Tizard & Joseph, *Cognitive Development of Young Children in Residential Care: A Study of Children Aged Twenty-Four Months*, 11 J. Child Psychology-Psychiatry 177, 185 (1970). *See also* Lagmeir & Matejcek, *Mental Development of Children in Families and in Infant Homes*, 4 Soc. Sci. & Med. 569, 570-573 (1970).

The harms of institutionalization extend to social and emotional as well as cognitive development. Institutionalized children tend to become "apathetic" [41] and unable to form meaningful relationships with others, or they acquire "affection hunger" characterized by "incessant and insatiable seeking of affection." [42] This emotional and social lag, like its cognitive counterpart, typically persists even after the institutionalized infant is removed to a family environment.[43]

In the case of mentally retarded children, the harms of institutionalization are even more dramatic, particularly with younger children. Several comparisons of matched institutionalized and noninstitutionalized children with Down's Syndrome (mongolism) have shown that the home-reared children scored consistently higher in IQ tests.[44] Similar findings have been made as to comparative verbal functioning between noninstitutionalized and

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[41] *See* Hobbs, *supra*, at 143.

[42] Yarrow, *supra*, at 14.

[43] Provence & Lipton, *supra*, at 150-155. *See also* Youngleson, *The Need to Affiliate and Self-Esteem in Institutionalized Children*, 26 J. Personality and Soc. Psychology 280 (1973); Tizard & Rees, *The Effect of Early Institutional Rearing on the Behavior Problems and Affectional Relationships of Four-Year-Old Children*, 16 J. Child Psychology-Psychiatry 61 (1975).

[44] Stimpson, *et al.*, *Effects of Early Institutionalization on Growth and Development of Young Children with Down's Syndrome*, 67 Mich. Med. 1213 (1968); Centerwell & Centerwell, *A Study of Children with Mongolism Reared in the Home*, 25 Pediatrics 678 (1961). A third study compared matched groups of institutionalized and noninstitutionalized mentally retarded children in their ability to form learning sets, *i.e.*, to learn from experience; "All community subjects demonstrated significant amounts of learning . . . whereas one-third of the institutional group continued to function at chance level." The younger institutionalized children in this study exhibited the poorest performances of all. Kaufman, *The Formation of a Learning Set in Institutionalized and Non-Institutionalized Mental Defectives*, 67 Am. J. Men. Def. 601, 604 (1963).

institutionalized retarded children.[45] And some studies also suggest that the motor development of institutionalized retarded children is inhibited by lack of stimulation, enforced quiescence and verbal chastisement following active or experimental behavior.[46]

It is for these reasons that professionals in the mental illness and retardation fields caution against the institutionalization of a child[47] except when it is absolutely necessary.

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[45] ". . . the difference in verbal ability between the two groups was attributable to the institutional environment itself . . . even those children who could speak on entry into the institution were found to be significantly retarded in present verbal functioning when compared with a matched group of day school [retarded children]."

Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children*, 1 J. Men. Def. Res. 1, 12 (1960). When the institutionalized youngsters were removed into a residential family unit, they "developed verbally at a greater rate than the matched controls which remained in the institution." *Id.* at 21. Younger retarded children appear to suffer the greatest developmental harms. Sternlight & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. Men. Def. Res. 119, 123 (1968).

[46] Klaber & Butterfield, *Stereotyped Rocking—A Measure of Institution and Ward Effectiveness*, 73 Am. J. Men. Def. 13, 18-19 (1968) [hereinafter Klaber & Butterfield]; Kaufman, *The Effects of Institutionalization on Development of Stereotyped and Social Behaviors in Mental Defectives*, 71 Am. J. Men. Def. 581 (1967); Mosley, *et al., Effects of Social and Non-Social Stimuli on the Stereotyped Behaviors of Retarded Children*, 74 Am. J. Men. Def. 809 (1970).

[47] "[N]o matter how good a treatment program for children in the state hospital is, hospitalization of an emotionally disturbed child is not the best answer."

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The "basic experiences which a child needs in order to grow into an emotionally happy, healthy and productive adult . . . cannot be found in a hospital."

Reiger, *Changing Concepts in Treating Children in State Mental Hospitals*, 1 Int. J. Child Psychotherapy 89, 104, 107 (1972).

[Footnote continued on page 31]

The inherent dangers of institutionalization are, moreover, exacerbated for many children because they are placed in substandard facilities, lacking in adequate staff, physical facilities and constructive programs designed to improve or cure the child's underlying condition. In 1969 the Joint Commission reported that each year thousands of minors are removed from their homes, schools and communities and confined to hospital wards with psychotic adults or to depersonalized institutions which deliver little more than custodial care.[48] The report cited shortages of professional staff, untrained attendants, failure to provide education and recreation, "outmoded facilities" operating on "long abandoned theory," and it concluded pessimistically that "instead of being helped, the vast majority [of children] are the

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[47] [Continued]

"It makes little difference whether the institution is called hospital or school, whether it is supposedly medically oriented or educationally oriented; in either case the child is trained to live in an institutional setting, and thus learns many of the very things that we do not want him to learn."

Leland & Smith, *supra*, at 87.

[48] Joint Commission Report, *supra*, at 269.

"What happens to these emotionally sick children for whom there are no services in the community? Each year, increasing numbers of them are expelled from the community and confined in large state hospitals so understaffed that they have few, if any professionals trained in child psychiatry and related disciplines. It is not unusual in this year 1969 to tour one of these massive warehouses for the mentally ill and come upon a child, aged nine or ten, confined on a ward with 80 or 90 sick adults." *Id.* at 5.

Cf. Jackson v. *Indiana*, 406 U.S. 715, 734-735 n. 17 (1972): "[There are] substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *See also* A. Stone, Mental Health and Law: A System in Transition 21 (1975) ("As one considers the entire law-mental health system, its most tragic faults are to be found in what it does to the young.").

worse for the experience." Joint Commission Report, *supra*, at 6.

There are, of course, some high-quality public and private residential facilities for mentally ill and retarded children.[49] But unfortunately, good residential treatment is very expensive and therefore, unless publicly supported, inaccessible to the vast majority of parents.[50] The state mental hospitals to which most children are admitted are chronically underfinanced and overcrowded. Most institutions for the mentally retarded are in an equally deplorable state. As the National Association for Retarded Citizens reports:

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[49] Most minors who are hospitalized for mental illness or institutionalized for retardation go to public facilities. In 1966, there were 8,400 children in private mental hospitals compared to 27,400 in state and county mental hospitals, 8,000 in residential treatment centers and 28,000 in general hospitals with psychiatric services. Joint Commission Report, *supra*, at 268. In 1973 there were 25,830 admissions under eighteen to state and county mental hospitals. HEW, Pub. No. (ADM) (75-158), Statistical Note 115, at Table 1 (1975) [hereinafter Statistical Note 115].

In 1974, 42% of the residents of public residential facilities for the mentally retarded (approx. 60,000) were of school age (3-21). Approximately 30% of these children were only "moderately" retarded. Of new admissions to such facilities during 1974, 67.5% were age 3-21 and 3% under age two; 25.6% of all new admissions consisted of moderate, mild and borderline retarded persons of school age. Only 11% of the facilities believed that they had adequate staffing and their median population was 585. Nat. Assoc. Supts. of Public Residential Facilities, Current Trends and Status of Public Residential Services for the Mentally Retarded 7, 17-18, 45 (1975) [hereinafter Current Trends].

[50] It requires "an all-embracing therapeutic environment . . . individualized, highly skilled attention to . . . educational and recreational requirements . . . highly trained mental health specialists . . . counselling services . . . available to . . . parents." Joint Commission Report, *supra*, at 271. *See also* American Psychiatric Association, Standards for Psychiatric Facilities Serving Children and Adolescents (1971).

> "Most residential facilities for the retarded throughout the country are large, overcrowded, and impersonal. . . . Too often seclusion and restraint are used for the convenience of the staff or as a means of punishing the residents. . . . Abuse, neglect, accidents and questionable deaths are not adequately investigated or reported." [51]

In *New York State Association for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 756 (E.D. N.Y. 1973), the judge labelled conditions at the Willowbrook State School for the Mentally Retarded "inhumane," citing "failure to protect the physical safety of . . . children, and deterioration rather than improvement after they were placed in Willowbrook School." In *Wyatt* v. *Stickney*, 344 F. Supp. 387, 391 (M.D. Ala. 1972), *aff'd sub nom Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974), the court announced: "Put simply, conditions at Partlow are grossly substandard"; it is "a warehousing institution which, because of its atmosphere of psychological and physical deprivation, is wholly incapable of furnishing [habilitation] to the mentally retarded and is conducive only to the deterioration and the debilitation of the residents."

Children placed in such substandard institutions tragically receive little or nothing in return for the deprivations of liberty and developmental harms they suffer.

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[51] NARC, Policy Statements on Residential Care 6, 9 (1968). *See also* Leland & Smith, *supra*, at 81 ("Virtually all of the large general residential institutions today are warehouses for children"); R. Kugel & W. Wolfensberger, Changing Patterns in Residential Services for the Mentally Retarded 438-439 (1969) ("the vast majority [of attendants] come to the job with no relevant past experience . . . no particular educational qualifications . . . fewer than two percent of all institutional personnel are classified as psychiatrists, psychologists and social workers . . . hardly any physicians are boarded [board certified] in their specialties").

3. *Institutionalization Stigmatizes a Child Thereby Causing Him Future Harm*

Confinement in a mental facility carries a special stigma, not present in placements of children in general hospitals, camps or boarding schools. *See* Testimony of Dr. Ingall (596a); Dr. Messinger (622a); *In re Ballay*, 482 F.2d 648, 668 (D.C. Cir. 1973);[52] *Matthews* v. *Hardy*, 420 F.2d 607, 610-611 (D.C. Cir. 1969), *cert. denied*, 397 U.S. 1010 (1970).

Institutionalization in such a facility may produce a negative self-image in the child.[53] It also produces negative expectations in those with whom he later comes into contact, including teachers and prospective employers.[54] There is also evidence suggesting that persons with mental disturbances suffer greater rejection from their peers if they seek help in an inpatient psychiatric residence, rather than from a clergyman or a physician or on a psychiatric outpatient basis.[55] Finally, and perhaps most critically, former mental patients suffer documented discrimination in job placement, admission into higher

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[52] *See also* Joint Commission Report, *supra*, at 269.

[53] One study which interviewed 110 mildly retarded former institutional residents found:

> "All persons interviewed said that their former status had burdened them with a shattering stigma and that they were forced to create elaborate ways of evading recurrent social ostracism—for instance, by rejecting as false the initial diagnosis and inventing ingenious ways to cover real deficiencies."

I Issues in the Classification of Children 214 (N. Hobbs ed. 1975).

[54] *See* Whatley, *Social Attitudes Toward Discharged Mental Patients*, in The Mental Patient: Studies in the Sociology of Deviance 401 (1968). Because of a "lingering social stigma attached to newly discharged patients . . . their social relations are often characterized by social distance, distrust or denial of employment." *See also* Grob & Singer, *supra*, at 117.

[55] Phillips, *Rejection: A Possible Consequence of Seeking Help for Mental Disorders*, in Mental Illness and Social Processes 63 (T. Scheff ed. 1967).

education,[56] military and government services and applications for licenses and health insurance.[57]

> ". . . a former mental patient may suffer from the social opprobrium which attaches to treatment for mental illness and which may have more severe consequences than do the formally imposed disabilities. Many people have an 'irrational fear of the mentally ill.' The former mental patient is likely to be treated with distrust and even loathing; he may be socially

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[56] This Court has already acknowledged that short-term suspensions of children from school "could seriously damage the students' standing with their fellow pupils and their teachers as well as interfere with later opportunities for higher education and employment." *Goss* v. *Lopez, supra,* 419 U.S. at 575 (1975). *See also, In re Gault, supra,* 387 U.S. at 23-24 (1967). Former Secretary of the Department of Health, Education and Welfare, Elliot Richardson, has declared that "the inappropriate labelling of children as *delinquent, retarded, hyperkinetic, mentally ill, emotionally disturbed* . . . has serious consequences for the child." Hobbs, *supra,* Preface at ix.

[57] *See* Testimony of Dr. Feiner (475a); Dr. Messinger (622a); American Psychiatric Association, Task Force Report 9, Confidentiality and Third Parties 27, 53-59 (1975) ("Attitudes of a large part of our social world are still prejudicial and the livelihood and social well-being of some of our patients can be threatened in reality by . . . disclosures"; rejection by school systems and many government agencies of those with psychiatric histories; use of psychiatric information in school records to detriment of child). N. Spingarn, Confidentiality, A Report of the 1974 Conference of Confidentiality of Health Records 5 (American Psychiatric Association 1975) (graduate school rejection on basis of a student's history of emotional problems). *See also* The Mentally Retarded Citizen and the Law, *supra,* chs. 6, 8, 10, 11.

There is also evidence that once hospitalized, a mental patient is more likely in the future to be differentially diagnosed as in need of rehospitalization.

> "Physicians responsible for hospitalization seem, unwittingly, to take this history into account, independent of the number of symptoms and apparently even the severity of the patient's present illness."

Roth, *Some Comments on Labelling,* Bulletin of the American Academy of Psychiatry and the Law (in press, 1976) *citing* Mendel & Rapport, *Determinants of the Decision for Psychiatric Hospitalization,* 20 Arch. Gen. Psychiatry 321 (1969).

ostracized and victimized by employment and educational discrimination." [58]

B. The Decision to Institutionalize a Child Is Often Made on the Basis of Conflicts of Interest Between the Child and Other Family Members or Because of Ignorance or the Unavailability of Alternative Resources

The consequences of institutionalization for children require that the initial decision be made in a manner which provides assurances that the child's interests in remaining in the mainstream of family and community life and avoiding developmental harms is protected. Institutionalization for mental illness or retardation is not, as appellants argue, Brief for Appellants at 40, primarily a medical decision in which parents' interests can be assumed to be in harmony with their children's interests. *Cf. Planned Parenthood, supra.*[59] Rather, it is too often a decision based on whether the child's family has sufficient resources, emotional and financial, to tolerate the child's behavior at home and whether the community has sufficient tolerance for his behavior or resources to offer the family an alternative to institutionalization.[60]

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[58] Note, *Developments in the Law, Civil Commitment of the Mentally Ill,* 87 Harv.L.Rev. 1190, 1200 (1974) (footnotes omitted).

[59] *Cf. Planned Parenthood, supra,* 44 U.S.L.W. at 5212-5213 (Stevens, J. concurring in part & dissenting in part). Justice Stevens referred to the fact that "the most significant consequences of the decision [to abort] are not medical in character . . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales. The overriding consideration is that the right to make the choice be exercised as wisely as possible."

[60] *See, e.g.,* Lindsey, *Adolescent Pathways to Residential Treatment: The Enforced Expedition,* 9 Adolescence 135 (1974). This survey suggests that "rather than performing an illness-reduction service, mental hospitals alleviate community and family displeas-

ures through an annoyance-reduction service." *Id.* at 136. The study showed that most adolescent admissions into a public mental hospital resulted from "unmanageable" or "inappropriate" behavior as defined by police, community members or family. *Id.* at 140. The author concluded: "[F]or most of these adolescents the prescription of residential placement is more often the result of a response on the part of social agencies in the adolescent's social world than by the specific nature of the behaviors performed by the adolescent." *Id.* at 143. He warned "mental illness is distinctly different from physical illness. Mental illness is not just an adolescent's private troubles and personal problem. Rather, it is a label applied to the alleged and inappropriate behavior engaged in by the adolescent. The conflictive nature of this behavior emerges from an analysis of the social environment of the prepatient adolescent." *Id.* at 144.

This is not to say that the parents should not have an active voice in the ultimate decision. Their counsel, experiences and problems in coping with the child should be given careful attention. *Cf. Planned Parenthood* v. *Danforth, supra,* 44 U.S.L.W. at 5210 (Burger, C.J., White & Rehnquist, J.J., concurring & dissenting).

> "The abortion decision is unquestionably important and has irrevocable consequences whichever way it is made. Missouri is entitled to protect the minor unmarried woman from making the decision in a way which is not in her own best interests, and it seeks to achieve this goal by requiring parental consultation and consent. This is the traditional way by which States have sought to protect children from their own immature and improvident decisions."

See also id. at 5209 (Stewart & Powell, J.J., concurring).

> "There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child. That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advice and emotional support."

Finally, Justice Stevens, dissenting in *Planned Parenthood,* stresses "the State's interest in maximizing the probability that the decision be made correctly and with full understanding of the consequences of either alternative."

> "It is unrealistic, in my judgment, to assume that every parent-child relationship is either (a) so perfect that communication and accord will take place routinely or (b) so imperfect that the absence of communication reflects the child's correct prediction that the parent will exercise his or her veto arbitrarily to further a selfish interest rather than the child's interest." *Id.* at 5212-5213.

1. *Parents Often Have Conflicting Interests When They Decide to Institutionalize Children*

Testimony in the court below emphasized that a mentally ill child's problems are "inextricably connected" with his relationships with parents and other family members. As Dr. Messinger explained at trial:

> ". . . . it is impossible to understand the symptoms and behavior of any one member of the family without understanding their role in the family in meeting family equilibrium." (617a)

Some children unwittingly become the "scapegoats" for family hostilities; some parents have "hidden agendas" and even unconscious motivations for institutionalizing the child. A parent may be mentally ill or under severe psychological stress himself, and projecting his own illness onto the child. Testimony of Dr. Feiner (470-472a); Dr. Ingall (588-589a, 601a); Dr. Messinger (617-619a, 621a, 628a).[61]

The Joint Commission Report, *supra*, at 263, accurately acknowledged "a growing recognition that a child's emotional disturbance is frequently . . . associated with the complex and intricate interpersonal relations within the family and the interactions that the family has with larger social systems." Indeed, the hospitalization of named plaintiffs in this case, according to the court below, had been triggered by factors so diverse as inability of a child to get along with one of his divorced parents, family fatigue, fear of a mother's nervous breakdown, a father's poor health, a foundering marriage,

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[61] *See also* Lidz, *Parental Behavior and the Origins of Schizophrenia* (marital schisms or skewered relationships in all families of schizophrenic children studied) and Teicher, *Why Adolescents Kill Themselves* (profile of suicidal adolescents displays long-standing problems with family, escalating into alienation) in Mental Health of the Child 267, 329 (NIMH, 1971).

intractable physical ailments and delinquent behavior. 402 F. Supp. at 1043-1044.

The motives of parents in deciding on institutionalization for a mentally ill child are not necessarily blameworthy; they may simply reflect priorities for family survival.[62] One commentator has listed such motives as including the interests of other children in the family, the mental and physical frustration of the parents, economic strain resulting from the care of the child, the stigma of the handicap itself, hostility toward the child caused by fatigue and frustration of the parents' success-oriented expectations for the child.[63] But, as the court below and several other courts have recognized, these interests compete with those of the institutionalized child. *See, e.g., Heryford* v. *Parker, supra,* 393 F.2d at 396; *Saville* v. *Treadway,* 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *In re Long,* 25 N.C. App. 702, 214 S.E.2d 626, 629 (1975); *J.L.* v. *Parham,* —— F. Supp. —— No. 75-163 M.A.C. (M.D. Ga. 1976), *stay granted,* 96 S.Ct. 1503.

2. *Parents Often Decide to Institutionalize Children Because Alternative Care in the Community Is Unknown or Unavailable to Them*

Parents of emotionally disturbed or retarded children are often driven to institutionalization because they cannot locate or obtain community based care for their children,[64] or because such care does not exist.

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[62] Grob and Singer, *supra,* at 122 (followup interview of institutionalized minors and their families showed that virtually no parents perceived the hospitalization as resulting in cure of the child's problems. "Most parents did see the hospitalization serving an ameliorative function, *e.g.,* releasing them of responsibility and of home tensions, and protection of the patient and/or society.").

[63] Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues,* 48 Notre Dame Lawyer 139-143 (1972).

[64] "It is striking that the method always thought of first is the institution .... Of all clinical groups, the mentally retarded are

One study, for example, involving 103 families with Down's Syndrome children, showed parents with more adequate information and understanding about the child's condition were less likely to institutionalize him.[65] Another study of 1,000 New York children whose families were seeking residential treatment in mental health facilities revealed that 72 percent of the children had received no prior psychotherapy; 85 percent no prior casework; 71 percent no prior special education or school services. In a third study 80 percent of institutionalized mentally retarded children had no prior diagnostic work-up performed in the community.[66]

The decision to institutionalize a child has been shown to relate more closely to the characteristics of the family than to the severity of the child's condition or the optimum treatment. Children from broken homes, from homes with substandard incomes, from homes with other physically or mentally ill persons are disproportionately represented in the institutional population, even among the mentally retarded where the etiology of the child's condition is extrinsic to the family situation.[67] Thus, the

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almost the only ones for whom the automatic first choice is the most extensive, most drastic, and most expensive way of providing services."

Leland & Smith, *supra*, at 79. *See also* D.C. Mental Health Association, Focus on Children Under Stress 82-3, 109, 116 (1975).

[65] Stone, *Family Factors in Willingness to Place the Mongoloid Child*, 72 Am. J. Men. Def. 16, 18 (1967).

[66] D. Block & M. Behrens, A Study of Children Referred for Residential Treatment in New York State 43 (Report to the New York State Interdepartmental Health Resources Board, 1959) ; G. Saenger, Factors Influencing the Institutionalization of Mentally Retarded Individuals in New York City 13 (Report to the New York State Interdepartmental Health Resources Board, 1960).

[67] G. Saenger, *supra*, at 11, 84 (44% noninstitutionalized versus 77% institutionalized children come from broken homes) ; D. Block & M. Behrens, *supra*, at 32-35 (half of institutionalized children came from multiproblem families, half had mentally ill family mem-

decision by parents to place their children in a mental institution is too often a decision made in default of knowledge about or access to other alternatives in the form of community based support services.

C. Examination by Admitting Personnel at the Mental Facility Does Not Protect the Child Sufficiently from Unnecessary Institutionalization

Given the complex nonmedical reasons for a parent's decision to institutionalize a mentally disabled child,[68] an admitting physician has limited opportunity to act as a check on behalf of the child against unnecessary institutionalization.

In its decisions constitutionally protecting a woman's right to decide whether or not to bear a child, this Court has given weight to the fact that this vital decision is reached with the consultation and medical approval of her physician. *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973); *Planned Parent-*

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bers); Appell & Tideall, *Factors Differentiating Institutionalized from Non-Institutionalized Referred Retardates*, 73 Am. J. Men. Def. 424, 429 (1968) (37% institutionalized children versus 14% noninstitutionalized children from broken homes; 62% institutionalized versus 22% noninstitutionalized children from impoverished homes). *See also J.L.* v. *Parham, supra*, sl. op. at 15 (50-75% children in Georgia mental institutions had no family or were part of "severely dysfunctional" family units).

[68] *Cf.* Child Caring: Social Policy and the Institution 112 (D. Pappenfort, *et al.*, eds. 1973):

> "One thing that is clear from a variety of statistical data is that both the decision to place a child in an institution and the selection of a type of institution for him are dependent to a great degree on factors other than the needs of the child."

See also R. Glasscote, *supra*, at 973, quoting psychiatric program personnel who decided between inpatient and outpatient admissions.

> "Diagnosis itself has minor significance. . . . Rather we look to the criteria of the child's daily living situation at home."

hood v. *Danforth, supra.*[69] In the present case, however, the physician does not play the traditional role of the chosen confidante and medical counsel of the patient, but rather a more ambiguous one of family or parental consultant or even gatekeeper for the mental facility. As a result, the requirement of due process protections surrounding the decision to institutionalize a child does not in any way interfere with a confidential relationship of child and doctor.

The admitting physician at a mental facility typically sees the child in a single interview in a strange setting under abnormal stress. In such instances, the doctor will have difficulty in gaining the child's confidence and may indeed be hostilely perceived as an agent of the parents;[70] he will rarely be able to make a thorough evalaution or prediction of the child's future behavior from such an interview. Testimony of Dr. Feiner (478-479a); Dr. Kandler (550a); Dr. Armstrong (47a) (typical admitting examination of a child takes 45-60 minutes). As far as past behavior is concerned, he must rely on the parents' and the child's too-often conflicting

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[69] *See, however,* the skeptical comments of Justices Stewart and Powell, concurring, in *Planned Parenthood, supra*: "It seems unlikely that she will obtain adequate counsel and support from the attending physician at an abortion clinic, where abortions for pregnant minors frequently take place." 44 U.S.L.W. at 5209.

[70] *See* Lourie & Rieger, *Psychiatric and Psychological Examination of Children,* in 2 American Handbook of Psychiatry 19 (S. Arieti ed. 1974).

> "From the child's viewpoint, his degree of cooperation with the examiner will be very different if he feels the examiner is a benevolent adult, interested in his side of any reported troubles and understanding of his worries, as against his perception of a demanding, punitive, authoritative figure who has the power to recommend significant changes in his way of life . . . . His approach to the examination may limit the amount of information available to the examiner, or obscure his assets and conflict-free areas of functioning, or give a distorted picture of his functioning in other situations."

reports. Dr. Messinger, (630a). Sometimes, too, there are complicating cultural differences between the physician and the child and his family which can influence the examiner's perception of what the child's behavior or responses indicate. Testimony of Dr. Feiner (473-474a).[71] In sum, he will often have great difficulty in accurately assessing the degree, or even the existence, of mental illness or retardation in the child.[72]

The examining phychiatrist or psychologist is also influenced by the admission policies of the institution.

> "In psychiatry more often than in general medicine and surgery, it is policy rather than clinical necessity that determines which admissions are considered appropriate and what type of treatment will be provided." [73]

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[71] *See* Joint Commission Report, *supra*, at 267:

> "For example, mentally ill and emotionally disturbed low-income children and youth are often seen as being untreatable by psychiatrists . . . treatment is strongly related to social class, as is the length of treatment and the kind of diagnosis that is given to the person's illness. Lower-class people are less likely to be given intensive psychiatric treatment, more likely to be treated by inexperienced therapists, and more often labelled as psychotic or near-psychotic."

See also Roth, *supra* (greater prevalence of stressful events in lower social classes may result in greater labelling of poor people as mentally ill).

[72] *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif.L.Rev. 840, 864 (1964); Eisenberg, *A Developmental Approach to Adolescence*, in Readings in Adolescent Development 61 (H. Bernard ed. 1969) ("The clinician must exercise great caution lest he attribute too great a significance to the turbulent but temporary maladaptive patterns manifested by the adolescent. Incorrect diagnostic formulations may lead to social consequences—for example . . . . institutionalization—that will freeze into permanence an otherwise correctible deviation in the growth pattern.").

[73] Richman & Pinsker, *Utilization Review of Psychiatric Inpatient Care*, 130 Am. J. Psychiatry 900, 901 (1973). *See also* Mendel & Rapport, *Determinants of the Decision for Psychiatric Hos-*

Institutions of the same kind in the same area vary widely on admission rates of similar patients. Dr. Kandler (560a). Some physicians and institutions prefer to hospitalize children for diagnosis and formulation of a treatment plan; others prefer to conduct such evaluations on an outpatient basis. Dr. Ingall (599a, 608-609a). Many admitting physicians depend heavily on the referring physician's recommendations; others are more independent. Dr. Messinger (629a).[74]

All too often, admitting physicians cannot provide and are not even aware of the full range of alternatives to

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pitalization, 20 Arch. Gen. Psychiatry 321 (1969); Rabiner, *et al.*, *The Assessment of Individual Coping Capacities in a Group Therapy Setting*, 45 Am. J. Ortho. 399 (1975) ("few clinical decisions in psychiatry are as difficult to make as those involving hospitalization"; doctor must rely on estimates of patients' "coping capacities" and prediction of demands that will be made on them in the community).

[74] Mendel & Rapport's study, *supra*, showed a significant difference in admission rates between clinicians with less than six months experience and those with three or more years. There was a clear tendency of the less experienced clinicians to lean more heavily toward hospitalization. *See also J.L.* v. *Parham*, *supra*, sl. op. at 40-41:

> "The court is impressed by the conscientious, dedicated state employed psychiatrists who, with the help of equally conscientious, dedicated state employed psychologists and social workers, faithfully care for the plaintiff children to the extent that state furnished resources and facilities permit. Nevertheless, psychiatry according to psychiatrists is still an inexact science as to which there is the opportunity for wide, sincere differences of opinion among psychiatrists. The opportunity for such wide differences of opinion stems initially and primarily from the fact that psychiatry is dependent upon information that comes from the patient and from other people—parents, family, friends, and staff—who themselves have their own personal interests and problems in communication. To suggest, as we here do, that psychiatrists are not infallible is not an indictment of psychiatry. It is simply to say that psychiatrists like all humans are capable of erring. Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards. . . ."

institutionalization that would better serve the child's and the family's needs.[75] They are usually able to provide only one kind of service—institutionalized service. They know that if they refuse that service and offer no alternatives, the parent will seek to institutionalize the child elsewhere, or the child will be returned without help to unwilling and resentful parents. Dr. Kandler (560a); Dr. Ingall (602a).

Thus, the admitting physician is in no position to compensate for the parent's conflicting motives or for the unavailability of alternatives—both major factors in unnecessary institutionalization of the child.[76] If the decision to institutionalize a child is to be based primarily or exclusively on the child's needs and best interests, that decision, as in the case of an adult, must be made by someone less involved than the parent or with more information and access to resources than the admitting physician.

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[75] *See* Kelly & Menolascino, *Physicians' Awareness and Attitudes Toward the Retarded,* 13 Mental Retardation 10 (Dec. 1975) (study of sample group of pediatricians and general physicians found a large number were unfamiliar with local community based services for mentally retarded children and made no referrals of patients to such services; 80% still recommended institutionalization for some moderately retarded patients).

[76] Fifty-five percent of mental retardation facilities said they retain minor residents they believe could function as well or better in the community in the face of parental objections to their release. Current Trends, *supra,* at 27.

III. IN VIEW OF THE HARMS OF INSTITUTIONALIZATION AND THE UNRELIABILITY OF PARENTAL DISCRETION AS THE MEANS OF PROTECTING CHILDREN FROM UNNECESSARY INSTITUTIONALIZATION, CHILDREN SHOULD BE ACCORDED A DUE PROCESS HEARING IN AN IMPARTIAL FORUM TO DETERMINE THE NEED FOR INSTITUTIONALIZATION

Amici have documented the serious harms attendant upon institutionalization of children and the unreliability of parental decision-making concerning its necessity. These harms, including loss of liberty, stigma and educational interruptions too closely parallel those suffered by children placed in juvenile rehabilitation facilities or suspended from public schools to permit their infliction directly by the state without some form of due process hearing. *In re Gault, supra; Goss* v. *Lopez, supra.*

A somewhat different question is presented, however, when a child's parents or private guardian seek to institutionalize him. In this situation, *amici* recognize that the dangers of institutionalization must be weighed against the legitimate interests of conscientious parents and their professional consultants in meeting genuine emergencies and the need for short-term psychiatric evaluation and treatment for the emotionally disturbed child or for brief specialized training and respite care for the mentally retarded child. This Court has always treated due process as a stricture whose application must be molded to the competing needs and interests involved in the specific factual situation. *See Goss* v. *Lopez, supra,* 419 U.S. 577-584; *Morrissey* v. *Brewer,* 408 U.S. 471, 481, 490 (1972).

Amici respectfully submit that the balancing of competing interests in this case require that, with one limited exception, children must be accorded due process

procedures, including a hearing [77] when they are institutionalized by either the state or their parents. The limited exception consists of brief placements of not more than two weeks made by parents for evaluations and respite care of their younger children.

A. Children Placed in Institutions by State Guardians Deserve Immediate Due Process Protection

When a child is placed in a mental facility by a state guardian rather than by parents, the constitutionally protected interests of family autonomy are not relevant. The situation is indistinguishable from cases in which the state initiates involuntary commitment proceedings against adults or children. *Cf. In re Gault, supra.*[78] And the threats of harm to institutionalized state wards are, if anything, greater than to children admitted by natural parents. State wards are denied both the oversight of natural parents as to their treatment inside the institution and the bridge of their family to the normal world outside the institution. They tend to remain in hospitals longer because of pervasive lack

[77] *Amici* will not discuss in detail the precise formulation of due process enunciated by the district court. They find the procedures laid down by the court to be reasonable. Appellants apparently do not take issue with those procedures as such, but rather with the decision that due process applies at all to admissions of minors. The new Pennsylvania Mental Health Act, *see* n. 3 *supra,* provides the same due process procedures for admission to the facilities for the mentally ill of children fourteen and above as for adults.

[78] The court in *Gault* found "extraordinary" the notion that a child could be relegated to a juvenile institution without "the procedural regularity and the exercise of care implied in the phrase 'due process'." 387 U.S. at 27-28. State involuntary commitment statutes which require due process hearings can be invoked against children as well as adults. The state may also invoke neglect jurisdiction when it believes that a parent is unjustifiably withholding needed psychiatric treatment from his child. Neglect proceedings, of course, would require a hearing in which the parents (and usually the child) can contest the need for residential treatment.

of adequate community facilities to treat and house them on discharge. *See J.L.* v. *Parham, supra.*[79]

B. Children Twelve or Older Should Be Accorded Due Process Protections Similar to Adults

The interests of an adolescent approaching adulthood in protecting his liberty and avoiding the detrimental consequences of stigma are so important as to merit the same due process protections as an adult threatened with involuntary commitment.

Legislatures and courts have increasingly recognized the adolescent's claim to legal autonomy. Youths over twelve can commonly choose which parent to live with; they can often obtain medical treatment for contraception, pregnancy, abortion, venereal disease and addiction.[80]

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[79] One of the named plaintiffs in *J.L.* v. *Parham* had been in seven foster homes as a neglected child; at age eight he was placed in the state mental hospital. He remained there for five years despite official predictions that he "will only regress if he does not get a suitable home placement, and as soon as possible." *See also,* D. Block & M. Behrens, *supra,* at 16-17, 32-35 (40% of institutionalized children had lived in four or more different homes or institutions prior to admission; less than one-fourth were living in their natural homes at the time of admission).

[80] *See, e.g.,* Stern, *Furnishing Information and Medical Treatment to Minors for Prevention, Termination and Treatment of Pregnancy,* 5 Clearinghouse Rev. 131; Pilpel & Wechsler, *Birth Control, Teenagers and the Law,* 1 Fam. Planning Perspectives 29 (1969); Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy,* 88 Harv.L.Rev. 1001 (1975); Note, *The Minor's Right to Abortion and the Requirement of Parental Consent,* 60 Va.L.Rev. 305 (1974). *See also* Worsfold, *A Philosophical Justification for Children's Rights,* 44 Harv.Ed. Rev. 142, 150 (1974); Rodham, *Children Under the Law,* 43 Harv. Ed.Rev. 495 (1974). *Cf. Planned Parenthood, supra,* 44 U.S.L.W. at 5213 referring to:

> ". . . the predicate which underlies all State legislation seeking to protect minors from consequences of decisions they are not yet prepared to make. In all such situations chronological age has been the basis for imposition of a restraint on the minor's

Courts no longer automatically require that a guardian *ad litem* be appointed to represent them in litigation. *Foe* v. *Vanderhoof*, 389 F. Supp. 947 (D. Colo. 1975).

Research into the cognitive and moral development of children also gives credence to the legal claims of adolescents to participate meaningfully in important decisions which affect their future. According to Jean Piaget [81] and others, children from about the age of twelve possess the ability to conceptualize and engage in abstract reasoning and can apply such reasoning to situations in which they are personally involved.[82] And, while parents

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freedom of choice even though it is perfectly obvious that such a yardstick is imprecise and perhaps even unjust in particular cases." (Stevens, J., concurring & dissenting.)

See also State v. *Koome*, 84 Wash.2d 901, 530 P.2d 260, 267 (1975) recognizing that the state legislature could create "age limits which do not perfectly correspond with the capacity of minors to act as adults . . . a subjective inquiry into the maturity of each individual minor is a practical impossibility, and any flat age limit is necessarily arbitrary."

[81] *See, e.g.*, J. Piaget, The Moral Judgment of the Child (1965); J. Piaget, The Origins of Intelligence in Children (1952); Piaget, *Intellectual Evolution from Adolescence to Adulthood*, 15 Human Devel. 1-12 (1972); P. Mussen, Adolescent Behavior and Society (1971); J. Flavell, The Developmental Psychology of Jean Piaget (1963).

[82] "All the available evidence on cognitive development and the growth of intellectual abilities suggests that the adolescent's capacity for exercising independent judgment is limited, as compared to the adult's, only by a lack of relevant experience and information. . . . Furthermore, it will often be particularly important to the adolescent that his competence and autonomy be carefully respected. Adolescents are often deeply involved in the process of developing a sense of separate identity, and will be very resentful of parents or other adult authorities who make decisions for them. . . . Adolescents generally react most favorably in situations in which they are given information which they feel is reliable and the opportunity to form their own judgments."

Hearings, *supra* (Jan. 30, 1976) (Testimony of Dr. Luch Ferguson). With retarded young people, there may be a discrepancy

obviously continue to maintain a strong interest in the upbringing of their adolescent children, they must necessarily cede an increasing measure of control over their destinies to the children themselves.[83]

> "Parental authority wanes gradually as the child matures; it does not suddenly disappear at adulthood. Similarly, the ability to competently make an important decision, such as that to have an abortion, develops slowly and at different rates in different individuals. Both law and science have realized that children below voting age are capable of making many important decisions." *State* v. *Koome*, *supra*, 530 P.2d at 266.[84]

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between developmental and chronological age. It is vital, nonetheless, that the preferences of these young retarded persons be accorded due weight in making the decision about institutionalization and that their participation in any hearing be as broad as their abilities allow.

[83] The large majority of children hospitalized for mental illness are over twelve years, whereas a substantial percentage of children institutionalized for retardation are under that age. Statistical Note 115, *supra*, at Table 4 (among admissions under the age of eighteen to state and county mental hospitals in 1973, 0.8% were under 5; 6.9% age 5-9; 29.8% age 10-14; 62.5% age 15-17); Kugel & Wolfsenberger, *supra*, at 437 (half of new admissions to public facilities for retarded between 1960 and 1967 were under age 10); Current Trends, *supra*, at 7, 17 (42% of residents and 67.5% of new admissions in public facilities in 1974 were age 3-21).

[84] *Amici* stress, however, that despite their cognitive maturity, adolescents deserve special consideration in insuring that their exercise of due process rights is meaningful. If they are required to affirmatively request release or the right to counsel on pain of waiver of their rights to a hearing, they may be intimidated or frightened out of exercising their rights; in some cases tranquilizing drugs may make it impossible for them to choose at all. The district court required that children be seen by counsel promptly after admission in order to consult on their situation; *amici* feel that such a requirement for consultation with an independent advocate is absolutely essential. *See, e.g., In re Long*, *supra*, 214 S.E.2d at 629 (hospitalized child need not request release but must be given hearing). Courts in dealing with children in other situations have emphasized that there is a presumption against waiver of their procedural due process rights. *Cf. In re Gault*,

C. Younger Children Require Due Process Protections Except for Very Brief Periods of Institutionalization

Although children under the age of twelve may not have matured sufficiently to be entrusted with decision-making about their own welfare, they are, if anything, more subject to developmental and emotional harms from unnecessary institutionalization. They are also apt to be less articulate in voicing their grievances and anxieties during institutionalization.

It is true that parental discretion with younger children normally extends to selecting and obtaining medical and psychiatric care from licensed providers, and that such discretion can involve brief residential placements of the child for specialized evaluation or care. But young children have fundamental interests in liberty and protection from developmental harms that deserve safeguarding from prolonged institutionalization. Thus they need due process hearings to insure that they are not unnecessarily institutionalized and segregated from family and community life. In *amici's* view, the proper balance of interests would allow parents of younger children to place them in appropriate residential care facilities for very brief periods of a week or two, at the end of which the due process procedures ordered by the court below would come into force. Where the parents are anticipating only a brief institutionalization for a finite purpose, which cannot be achieved through existing nonresidential

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supra, 387 U.S. at 55; *Heryford* v. *Parker, supra,* 396 F.2d at 396. And with mental patients, courts have been especially solicitous that they not be forced to affirmatively assert their rights against authorities or be deemed to have waived them. *Covey* v. *Town of Somers,* 351 U.S. 141 (1956); *Moore* v. *Michigan,* 355 U.S. 155 (1957); *Lynch* v. *Baxley, supra,* 386 F. Supp. at 396; *Dale* v. *Hahn,* 440 F.2d 633, 638-639 (2d Cir. 1971); *Anderson* v. *Solomon,* 315 F. Supp. 1192, 1194 (D. Md. 1970); American Bar Foundation, The Mentally Disabled and the Law 40, 42 (Lindman & McIntyre ed. 1961).

programs, parental decision-making power deserves to be honored.[85] As the period lengthens into several weeks, however, and the risk of institutional harms and severance of family ties becomes more acute, the child's interests then become preeminent and require the invocation of a due process inquiry into the need for continued institutionalization.

D. Due Process Hearings Should Not Impede the Delivery of Needed Therapy or Training to Mentally Disabled Children

Amici do not believe, as appellants assert, Brief, p. 45, that the child who prevails at a hearing need win only a "Pyrrhic" victory resulting in return to a family which does not want and cannot help him. In fact, families often feel ambivalent and helpless about a disabled child, driven to institutionalization because they do not know what else to do, and are genuinely searching for a resolution that will allow the child to remain with them.

Thus a hearing before an impartial tribunal can fulfill a therapeutic purpose for both parents and child by reviewing the reasons which allegedly justify hospitalization, whether the treatment or training the child needs can be provided outside of the institution,[86] what treat-

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[85] The court should, however, recognize the need even in brief evaluative or respite situations, of independent monitoring of the young child's situation to prevent abuse or neglect. *Amici* recommended that all young residents of any mental health or retardation facility be regularly and frequently seen by a representative of an advocacy organization to insure their welfare.

[86] *See also,* A. Stone, Mental Health and Law: A System in Transition 12-14 (1975). Professor Stone argues that in our society institutionalization is generally overused because of the incorrect assumption (or perhaps hope) that "technical" assistance is available when often such expertise is lacking. As a result, we tend to seek scientific solutions where humane care and responsibility are what is needed. Thus, Stone urges a return to family responsibility, rather than increased use of institutionalization.

ment the child will actually receive inside the institution,[87] how long he is expected to be institutionalized, whether and when his natural parents are willing and able to receive him back into their home, and what the child's desires are in the matter. All of these factors would be relevant in deciding whether the child with mental, developmental and/or physically handicapping conditions is in fact "in need of treatment, care or observation." [88] The child's total spectrum of needs for care, safety, treatment, (re)habilitation and emotional warmth has to be examined to decide if residential treatment is indicated.

With a hearing mechanism in place, the choice need not be between institutionalizing a child and returning him to a hostile and helpless family.[89] The decision-maker

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[87] Thus, if the institution is substandard or not substantially in compliance with accreditation standards, or not equipped to administer the treatment or training the child needs, the child should not be institutionalized there.

[88] The lower court did not pass on the proper standard for commitment for a minor. The Pennsylvania statute providing for voluntary commitments uses criteria of "in need of treatment, care, or observation." Many federal and state courts have, however, required a stricter standard of dangerousness to self or others for involuntary commitments. *See* n. 9, *supra.*

[89] Experts agree that the majority of children presently institutionalized could be treated in the community if sufficient programs existed. Joint Commission Report, *supra,* at 266-267 ("most communities have programs even for a portion of the population. . . . In those few communities where most of these services are available, the programs tend to be fragmented . . . the very poor, who need these services most, have least access to them"). (1) Daytime and partial-hospitalization programs have proven successful for many mentally ill and retarded children as an alternative to institutionalization. *See, e.g.,* Fenichel, *A Day School for Schizophrenic Children,* 30 Am. J. Ortho. 130 (1960); R. Glasscote, Partial Hospitalization for the Mentally Ill (American Psychiatric Association and National Association for Mental Health Joint Information Service (1969); Jubenville, *A State Program of Day Care Centers for the Severely Retarded,* Community Services for

in such a hearing can explore the family situation. He may arrange appropriate treatment for the child and/or the family. When only the child is institutionalized, the family's critical role in the treatment or training process is too often neglected.[90] A hearing officer can also order a thorough review of existing community alternatives and may even mandate the creation of these sorely needed

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Retarded Children: The Consumer-Provider Relationship (Dempey ed. 1975). (2) Community services for the families of these children have also reduced the need for institutionalization. M. Gula, Child Caring Institutions: Their New Role in the Community Development of Services 19 (HEW 1958). (3) Specialized foster care programs for mentally ill and retarded children have been established in several states. Wolfensberger, *A New Approach to Decision-Making in Human Management Services,* in Changing Patterns in Residential Services for the Mentally Retarded, *supra,* at 379 (1969); O'Regan, *Foster Family Care for Children With Mental Retardation,* 3 Children Today 21 (1974); Garrett, *Foster Family Services for Mentally Retarded Children,* in Community Services for Retarded Children, *supra,* at 248; Simmons, *et al., Natural Parents as Partners in Child Care Placement,* 54 Social Casework 224-232 (1973). (4) Finally, group homes provide a substitute for mentally ill or retarded adolescents. M. Gula, Agency Operated Group Homes 1 (HEW 1964); Mosher, *et al., Soteria: Evaluation of a Home-Based Treatment for Schizophrenia,* 45 Am. J. Ortho. 465 (1975). *See also* McCormick, Ballam & Zigler, *Resident Care Practices in Institutions for Retarded Persons: A Cross-Institutional, Cross-Cultural Study,* 80 Am. J. Men. Def. 1416 (1975) (small community based settings for retarded persons are characterized by more resident-oriented care practices; the number of residents per living unit is more determinative of individualized care than the staff-resident ratio).

Nebraska has been able to reduce its population of institutionalized retarded persons dramatically by a continuum of community care services, including special foster homes, intensive-training group homes, five-day hostel residences for family respites; Glenn, *supra,* at 505-514; Wolfensberger & Menolascino, *Reflections on Recent Mental Retardation Developments in Nebraska,* 8 Mental Retardation 20 (1970).

[90] *See, e.g.,* Testimony of Dr. Messinger (621a) ("if there are going to be real changes in that child, there have to be concomitant changes in the family"); Joint Commission Report, *supra,* at 112-113, 263.

resources.[91] He can insist that the child be provided with the services by public agencies when the family has been frustrated by bureaucratic delays. Hearings can also satisfy a child's inherent sense of fairness and his need to be heard when he feels strongly that he is being dealt with unjustly.[92] Even in those cases where hospitalization is necessary, the hearing can relieve parents of the burden of unilateral action. Testimony of Dr. Messinger (623a, 625a, 636-638a); Dr. Feiner (480a, 483a, 484a, 494-495a); Dr. Kandler (561a, 567-568a, 574-576a). And a hearing may improve the relationship between the child and the professional therapist. Once he has had a full hearing, the child may become more cooperative in the treatment plan. Testimony of Dr. Kandler (561a, 574-576a); Dr. Messinger (633a). The therapist will perhaps no longer be perceived as a co-conspirator with the parents in committing the child. Testimony of Dr. Kandler (593-594a); Dr. Ingall (612-613a); Dr. Messinger (624a).

Several studies suggest that an opportunity for juveniles to contest institutionalization at hearings will not necessarily interfere with therapy. Encouraging active participation of the patient in decision-making about his own future is both a tenet of psychotherapy and a maxim of "normalization" for the mentally retarded.[93] Adoles-

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[91] *See, e.g., J. L.* v. *Parham, supra,* sl. op. at 43 (court order to "provide necessary physical resources and personnel for whatever non-hospital facilities are . . . most appropriate for these children").

[92] *Cf. In re Gault, supra,* 387 U.S. at 26.

> "[T]he appearance as well as the actuality of fairness, impartiality and orderliness—in short, the essentials of due process—may be a more impressive and more therapeutic attitude so far as the juvenile is concerned."

[93] *See, e.g.,* Tucker & Maximen, *The Practice of Hospital Psychiatry: A Formulation,* 130 Am. J. Psychiatry 889 (1973).

> "In the design of a hospital program it is . . . essential to create an atmosphere that encourages patients to take active

cent as well as adult mental patients very often have a realistic notion of whether they need hospitalization.[94] And they have apparently exercised their existing limited rights to object to hospitalization in a way that has not been unduly disruptive of hospital routine.[95]

In sum, the rational application of due process to the commitment of children can help to decrease unnecessary and damaging institutionalization [96] and to bring to bear

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responsibility for themselves and others. In other words, instead of being the passive recipients of the staff's therapeutic efforts, the patients should assume the role of change agents."

See also NARC, Policy Statements on Residential Services, *supra*, at 4 (need for the mentally retarded person to have "involvement in decisions affecting oneself").

[94] In one study, patient and staff judgments agreed on the avoidability of hospitalization in two-thirds of the cases studied if alternative treatment were available in the community. This ratio was not significantly different for adolescent patients (over fourteen) than for adults. The study concluded:

"Judgments made by patients, even though they are acutely disturbed, are much more valid . . . than might have been expected. . . . The clinical significance of this is that the psychiatrist deciding upon admission versus alternative treatment can validly take into account the opinion of the patient."

Lipsius, *Judgments of Alternatives to Hospitalization*, 130 Am. J. Psychiatry 892, 895 (1973).

[95] Meisel, *Due Process in the Civil Commitment of Children*, 10 Psychiatric Spectator 5-6 (1975).

[96] Estimates vary as to how many children in mental hospitals and retardation institutions would not be there if community based services were adequate. A federal court recently cited a study that "more than half" of Georgia's juvenile mental inpatients "would not need hospitalization if other forms of care were available", *J.L.* v. *Parham*, *supra*, sl. op. at 13. The Department of Health, Education and Welfare cites studies showing only one-third of the children in St. Elizabeths Hospital and in 20 Texas mental hospitals need hospitalization. Statistical Note 115, *supra*, at 4. A survey of public retardation facilities showed that lack of community services was the primary reason given for 50% of readmissions to such facilities in 1974. The directors estimated that the total residential population could be decreased by 52% if community services were adequate. Current Trends, *supra*, at 20, 23.

on the unfortunate situation of disturbed and retarded children the attention and community resources they require.

CONCLUSION

For the reasons set forth above, *amici* urge this Court to affirm the judgment of the court below insofar as it applies due process procedures to children admitted to mental facilities. In the case of younger children, a limited exception should be made for brief periods not to exceed two weeks when they are placed by parents in residential facilities for evaluation or respite care.

Respectfully submitted,

PATRICIA M. WALD

PAUL R. FRIEDMAN

MENTAL HEALTH LAW PROJECT
1220 Nineteenth Street, N.W.
Washington, D.C. 20036

*Counsel for Amici Curiae**

Of Counsel:

JAMES W. ELLIS

* Counsel for *amici* gratefully acknowledge the assistance of Gail Marker, M.S.W., for her invaluable assistance in the preparation of this Brief.

IN THE SUPREME COURT OF THE

UNITED STATES

No. 75-1064

JACK B. KREMENS, ET AL.,
Appellants

v.

KEVIN BARTLEY, ET AL.,
Appellees

CERTIFICATION OF SERVICE

I, Paul R. Friedman, hereby certify that on August 3, 1976, I served by mail one copy of the foregoing Brief for *Amici Curiae* on David Ferleger, Esquire, 2321 Sansom Street, Philadelphia, Pennsylvania 19103, Counsel for Appellees, and on Norman J. Watkins, Esquire, Capitol Annex Building, Harrisburg, Pennsylvania 17120, Counsel for Appellants.

Paul R. Friedman