THE EMOTIONALLY DISTURBED JUVENILE OFFENDER
LEGISLATIVE ANALYSIS AND CASE LAW REVIEW

The authors would like to express their appreciation to Linda D'Amario, Vice President, National Association of Juvenile Justice Administrators and Ted Rubin, Senior Associate, Institute for Court Management, for their contributions to this report.

Technical Assistance Report

Prepared For:

U. S. Department of Justice
Office of Juvenile Justice and
Delinquency Prevention
and
The National Association of
Juvenile Justice Administrators

Under Contract To
Office of Juvenile Justice and
Delinquency Prevention
Contract J-LEAA-021-79

July, 1981

This report was supported by Contract Number J-LEAA-021-79 awarded by the Office of Justice Assistance, Research and Statistics in behalf of the Office of Juvenile Justice and Delinquency Prevention, U. S. Department of Justice. Points of view or opinion stated in this document are those of the author(s) and do not necessarily represent the official position or policies of the U. S. Department of Justice.

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EXECUTIVE SUMMARY

This is the final report of a technical assistance special project requested by the National Association of Juvenile Justice Administrators and the Office of Juvenile Justice and Delinquency Prevention.

The juvenile justice system has a purported focus on meeting the needs of the individual child. This theme is repeated in most of the state juvenile codes in several different forms, e.g., the purpose and legislative intent sections; provisions for evaluations to determine special needs; and dispositional latitude afforded juvenile courts.

Juvenile codes do not define mentally ill or emotionally disturbed juvenile offenders with the same precision as they define juvenile delinquent, child in need of supervision, and, neglected, abused or dependent child. By analyzing the requirements for processing a mentally ill juvenile offender, it becomes apparent that legislative recognition of mentally ill offenders extends only to those juveniles who may be commitable under the involuntary commitment standards of mental health laws.

The procedural requirements for involuntary commitments as well as the recently evolved stringent standards favoring deinstitutionalization of mentally ill persons have resulted in keeping juveniles, not subject to involuntary commitment, but exhibiting a lesser degree of emotionally disturbed behavior in the juvenile justice system as opposed to the mental health system.

By legislating responsibility for diagnostic evaluations to juvenile correctional agencies as well as having broad treatment and rehabilitation purposes for correctional agencies a deduction may be made that correctional institutions are and should be responsible for and responsive to the treatment needs of their wards.

We view as a positive situation the narrow definition of mental illness but also recognize the responsibilities placed on correctional agencies have not been met. The lack of appropriate mental health services in correctional institutions has led to frustration for institutional administrators as well as instigation of legal actions on behalf of children in the system.

There are two separate but parallel processing channels for emotionally disturbed juvenile offenders: the juvenile justice system and the mental health system. The extreme level in each system is institutionalization, e.g., state delinquency institution or state mental health hospital.

There is a great deal of crossover between the two systems as children are processed from one to the other and both systems are experiencing modernization of applicable statutes and emerging case decisions in both state and federal courts. Themes of case decisions in this report are:

- the right to be treated versus the right not to be treated;
- the least restrictive alternative doctrine: applied or not applied;
- due process versus parens patriae;
- judicial authority versus executive authority;
- badness versus madness;
- Federal initiatives versus the status quo.

Another manner of examining court decisions is through identification of critical processing stages and how court decisions have affected the handling of children at these points.

An examination of court decisions with application to preadjudicatory, adjudicatory, dispositional, and institutional phases is made. The case decisions have not always been consistent, however there is a trend toward requiring more due process and requiring that individualized care and treatment be provided.

During the conduct of the study, Arthur D. Little, Inc., became aware of a project conducted by the Institute for Juvenile Justice and Delinquency Prevention at the University of Chicago's Assessment Center. This project consisted of a survey of the states to determine what programs were available to the psychotic juvenile offender. The report of their study is currently being drafted. They have identified programs in six states (California, Illinois, Massachusetts, Minnesota, New York and Pennsylvania) provided by state agencies for the defined client population. Program descriptions, client criteria and referral methods are expected to be published shortly.

- Legislative revisions insuring due process safeguards and adherence to civil mental illness guidelines for any involuntary commitment to a mental hospital.
- Reduced reliance on the "medical model" in favor of expanded use of restitution, community service restituion, victim service restitution, fines and other community level sanctions for offending behavior.

- The least restrictive alternative should have expanded usage, thereby reducing unnecessary pretrial detention, inpatient evaluations, and costly residential and institutional confinement.
- Time frame standards should be adopted to insure speedy trials and expeditious and effective dispositions.
- The right to counsel should be required at any stage of either system.
- Judicial review of delinquent children placed in residential facilities should be required every six months.
- Development of mental health services within state delinquency agencies appears to be more efficient and humane than to add to a delinquency the second label of mental illness.

The above are some of the recommendations embodied in this report. The topic of emotionally disturbed juvenile offenders has not been rigorously studied. There are large gaps in the body of knowledge on the topic. Discussions about who has the responsibility for servicing this client group are probably exercises in futility. By enhancing the level of appropriate services to this group, the opportunity to better serve other juveniles in the system will be realized.

THE EMOTIONALLY DISTURBED JUVENILE OFFENDER

Introduction

Early in this century children were recognized as being in need of specialized legal processes designed to remove criminal consequences of illegal and antisocial acts and to substitute programs of treatment and rehabilitation. The catch words of this movement were "the best interests of the child."

As the juvenile justice system has evolved, a concurrent evolution has taken place in the mental health system. Many of the recently identified issues are the same for both, e.g., deinstitutionalization, least restrictive alternative, due process, and right to treatment. The parallel development of the two systems as well as similar articulations of goals and objectives have blurred the systemic boundaries of responsibilities.

Also contributing to the confused definitions of respective responsibility has been the focus of the juvenile justice system on the child's "need" rather than the purported "deed" and the resultant psycho-medico or clinical treatment model.

There has been extensive discussion about which system should provide services to emotionally disturbed juvenile offenders. A recent study conducted by Kathleen V. Turney found that "practices and procedures for providing intensive mental health services to adjudicated delinquents, particularly the mechanisms for effecting interinstitutional transfers, vary substantially from state to state." (The Provision of Intensive Mental Health Service to Adjudicated Delinquents: A Survey of State Practices, Harvard Law School, May, 1980, p.1). This study found that "when the target population is limited to adjudicated delinquents, state mental health agencies were the most frequently designated service providers. When reliance upon independent service providers by the respective state agencies is considered, state mental health and juvenile correctional agencies provide intensive mental health services to adjudicated delinquents on an almost equal basis." (p.48)

Laurie S. Bederow and Frederic G. Reamer of the National Center for the Assessment of Alternatives to Juvenile Justice Processing at the University of Chicago looked closely at state approaches for treating the severely disturbed juvenile offender. In this study, to be issued by the National Institute for Juvenile Justice and Delinquency Prevention, detailed descriptions of programs in six states are provided. These programs narrowly focus on youth with diagnoses of schizophrenia, seizure disorders and various manifestations of psychosis. The programs described include examples of those operated by juvenile correctional agencies, interagency collaborations, and mental health agencies. Due to the narrow definition of the target population as well as the legal questions involved in

transferring a mentally ill child to a corrections facility, this study favors the placement of operating authority under a state department of mental health if a state has only one program for severely disturbed juveniles. The question still remains, however, about the responsibility for providing services to those disturbed juvenile offenders whose disturbance is not presently severe enough to justify placement in a mental health facility.

The lack of clearly focused lines of responsibility might not present problems in a perfect world with abundant resources available to both systems. In the real world, each system must compete against the other as well as additional human service systems in order to obtain support for its operations.

An examination of clients in each system does not provide much assistance in assignment of treatment responsibility as each system has clients who may be equally appropriate for either, e.g., the mental health system has juvenile justice referrals and the juvenile justice system includes some mental health clients.

The Dimensions of the Problem

Lloyd E. Ohlin in a 1973 study states that most institutionalized children appear to be "without serious physical or mental handicaps, though almost all are seen as having some degree of emotional disturbance or behavior problem (87%). Furthermore, slightly more (16%) are judged to have severe emotional disturbance or behavior problems in contrast to those (13%) perceived as having no such problem." (p.191)

From Ohlin's study, the imprecision of the designation of emotional disturbance is apparent. As earlier reported by Arthur D. Little, Inc. in a technical assistance report to the North Carolina Juvenile Code Revision Committee (IV NC ADL-24 78-1), "The lack of a standardized or generally accepted definition makes it difficult to identify who is actually emotionally disturbed." (p. 1) If one accepts the findings of Ohlin's study, the possible range of incidence of emotional disturbance within juvenile correctional facilities is between 16 and 87 percent, therefore it becomes obvious that the identification of the problem is dependent upon the broadness of the definition.

This study was conducted by Arthur D. Little, Inc., at the request of the National Association of Juvenile Justice Administrators through a technical assistance contract with the Office of Juvenile Justice and Delinquency Prevention. Their request is reflective of the level of frustration and concern experienced in their efforts to provide suitable programs for the juveniles placed in correctional institutions around the country.

The study has three components:

- Legislative Analysis - Through studying the Children's Codes of a variety of States, Arthur D. Little attempts to determine the legal definitions of emotionally disturbed children.

- Case Law Review - This review suggests policy and program implications of recent court decisions related to emotionally disturbed juveniles.

- Future Directions - Based upon the results of the study, ADL suggests future actions.

Special mention is given to H. Ted Rubin of the Institute for Court Management, ADL's subcontractor, who wrote Chapter II, the case law review. He also was a key contributor to Chapter III - Future Directions.

LEGISLATIVE ANALYSIS

Introduction

Any examination of the processing of emotionally disturbed children through the juvenile justice system should begin with a definition of the term. Arthur D. Little, Inc., sought a definition for emotionally disturbed juvenile offenders through an examination of juvenile codes from various states. While our quest for a definition was unsuccessful, there were several procedural themes that are significant and impact upon eventual dispositions of cases involving emotionally disturbed children. One note of caution may be indicated (each of the statutes cited are the most current ADL had access to) -- there is often discrepancy between statutory language and application or interpretation of a particular law. The legislative analysis includes only analysis of the language not of practice.

Statutory Purposes

Many of the juvenile codes examined set forth the legislative intent of the code. In most cases the purpose section would include statements such as:

> "to develop a disposition in each juvenile case that reflects consideration of the facts, the needs and limitation of the child, the strengths and weaknesses of the family, and the protection of the public safety." (G.S. 7A-506(3) North Carolina)
>
> "consistent with the protection of the public interest, to remove from children committing delinquent acts the consequences of criminal behavior and to substitute therefore a program of supervision, care and rehabilitation." (32-1-2 B New Mexico Statutes Annotated 1978)
>
> "Any child brought before the court under this section shall have a right to treatment reasonably calculated to bring about an improvement of his condition." (KRS Chapter 208A Section 2(4) Kentucky)
>
> "To remove children who are within the provisions of this act from the criminal justice system whenever possible and to reduce the possibility of their committing future law violations through the provision of social and rehabilitative services to such children and their families." (Nebraska Laws 43-201.01 (3))

There is clearly an expectation in each of these that each juvenile offender should have access to appropriate services designed to provide rehabilitation and thereby lessen the occurrence of future delinquent

activity. Logically, one could expect, based on these stated purposes, that emotionally disturbed children within the jurisdiction of juvenile justice agencies would have opportunities for treatment of their disorders.

Diagnostic Provisions

Many of the juvenile codes examined make provision for predisposition studies. Most state codes require a petition to be filed prior to authorizing an involuntary mental examination. Typical of these is Florida:

> "After a petition has been filed, the judge may order the child named in the petition to be examined by a physician willing to do so. The court may also order the child to be evaluated by a psychiatrist, a psychologist or the department's developmental disabilities diagnostic and evaluation team. If it is necessary to place a child in a residential facility for such an evaluation, then the criteria and procedures established in section 394.463(2) or Chapter 393* shall be used, whichever is applicable." (Florida Statutes 1977 Section 39.08(1))

Other states such as Ohio appear to give much broader discretion to the court in requiring psychological examinations:

> "The Juvenile Court may subject any person within its jurisdiction to a mental and physical examination. The examination shall be performed by physicians, psychologists and psychiatrists pursuant to division C of section 2151.06 of the revised code. When a child is committed to any organization pursuant to this chapter, a record of the child's mental and physical examinations shall be sent to the organization." (2151.18(B) RC State of Ohio)

However, Ohio law requires adjudication to be completed prior to an institutional commitment for diagnosis of a juvenile offender's mental status.

Some states such as Minnesota and New Mexico mandate the juvenile correctional institutions to perform diagnostic evaluations:

> "...with the consent of the commissioner of corrections and agreement of the county to pay the costs thereof, the court may, by order, place a minor coming within its jurisdiction in an institution maintained by the commissioner for the detention, diagnosis, custody and treatment of persons adjudicated to be delinquent, in order that the condition of the minor be given due consideration in the disposition of the case...." (Chapter 260, Section 260.151 Minnesota Statutes)

*Florida Mental Health Laws

Minnesota laws further require that this can only take place after a complaint has been filed. In cases of delinquency the child must have appeared before the court and heard the charges. If the delinquency charges are denied, then a hearing must be held prior to a diagnostic commitment.

New Mexico law requires adjudication to have taken place prior to a diagnostic commitment by the corrections facility.

> "The court may order that a child adjudicated as a delinquent child or a child in need of supervision be transferred to an appropriate facility of the department of corrections for a period of not more than sixty days for purposes of diagnosis with direction that the court be given a report indicating what disposition appears most suitable when the interests of the child and the public are considered." (32-1-32 New Mexico Statutes Annotated 1978)

There is clearly a reasonable basis in these and most of the other state codes for expecting that the court should consider the mental condition of the child at the time of disposition. There also appears to be a dependency upon the corrections systems for providing that information to the court. One supposition as to the reason for this may be the simplicity of the commitment process to corrections as opposed to the more rigorous requirements for involuntary commitment to a mental health program.

Dispositional Alternatives

The amount of judicial discretion in disposing of cases involving juveniles thought to be mentally disturbed varies from state to state. Some states, e.g. Connecticut, South Dakota, Illinois, Mississippi, permit the placement of a child in a mental health treatment facility as a consequence of the delinquency hearing. Some of these states also permit status offenders to be placed in mental health programs as a result of the petition alleging the status offense and without further court or administrative hearings.

A larger number of states make provision for discontinuing proceedings under the juvenile code and initiating commitment proceedings under the state mental health codes. It is common in these states to find one of two situations:

1. Proceedings under the juvenile code are held in abeyance pending the results of the mental health proceedings--

> "If as a result of a mental examination conducted before adjudication of the petition it appears to the court that a child alleged to be delinquent or in need of supervision is incompetent to participate in further

proceedings by reason of mental illness or mental retardation to a degree rendering the child subject to involuntary commitment to the Wyoming State Hospital or the Wyoming State Training School, the court shall hold further proceedings under this act [§§14-8-101 to 14-8-144] in abeyance and the county attorney shall forthwith commence proceedings in the district court for commitment of the child to the appropriate institution as by law provided. The juvenile court shall retain jurisdiction of the child on the petition pending final determination of the commitment proceedings in the district court. If proceedings in the district court result in the child being committed to the Wyoming State Hospital or the Wyoming State Training School, or to such other facility or institution for treatment and care of the mentally ill or the mentally retarded as the district court may direct, the petition shall be dismissed and further proceedings under this act terminated. If proceedings in the district court result in a determination that the child is not mentally ill or mentally retarded to a degree rendering him subject to involuntary commitment, the court shall forthwith proceed to a final adjudication of the petition under the provisions of this act." (Laws 1971, Chapter 255, Section 20, Wyoming Statutes)

2. The juvenile court maintains jurisdiction even after the treatment plan is concluded--

> "(a) If it appears to the juvenile court, on suggestion of a party or on the court's own notice, that a child alleged by petition or found to have engaged in delinquent conduct or conduct indicating a need for supervision may be mentally ill, the court shall initiate proceedings to order temporary hospitalization of the child for observation and treatment.
>
> (b) The Texas Mental Health Code (5547-1 et seq., Vernon's Texas Civil Statutes) governs proceedings for temporary hospitalization except that the juvenile court shall conduct the proceedings whether or not the juvenile court is also a county court.
>
> (c) If the juvenile court enters an order of temporary hospitalization of the child, the child shall be cared for, treated, and released in conformity to the Texas Mental Health Code except:

> (1) a juvenile court order of temporary hospitalization of a child automatically expires when the child becomes 18 years of age;
>
> (2) the head of a mental hospital shall notify the juvenile court that ordered temporary hospitalization at least 10 days prior to discharge of the child; and
>
> (3) appeal from juvenile court proceedings under this section shall be to the court of civil appeals as in other proceedings under this title.
>
> (d) If the juvenile court orders temporary hospitalization of a child, the proceedings under this title then pending in juvenile court shall be stayed.
>
> (e) If the child is discharged from the mental hospital before reaching 18 years of age, the juvenile court may:
>
> (1) dismiss the juvenile court proceedings with prejudice; or
>
> (2) continue with proceedings under this title as though no order of temporary hospitalization had been made."

(Chapter 55, Section 55.02, Texas Family Code)

The key element in determining which system, e.g., mental health or corrections should have responsibility for treating the child appears to be the ability to commit the child under the state's mental health code.

Post Dispositional Transfers

Kathleen V. Turney in a report entitled, "The Provision of Intensive Mental Health Services to Adjudicated Delinquents: A Survey of State Practices," provides a state-by-state listing of legal requirements for inter-institutional transfers. These range from complete administrative discretion to requiring involuntary commitment proceedings to be instituted by the correctional agency with vested custody.

Findings

An examination of the state juvenile codes gives a mixed perspective on the goals and objectives of the juvenile justice system and of the methods and resources available to achieve its purposes.

There is clearly an articulation of opportunity for explication of delinquent behavior and of status offenses based upon mental conditions. The state codes, however, seem not to recognize specialized needs from any degree of emotional disturbance less than that required for involuntary commitment to a mental institution.

A contributing factor to emotionally disturbed children being committed to juvenile correctional institutions may be partially attributable to the change in standards used by the mental health authorities for involuntary commitments. With the growth of community mental health centers and the concomitant acceptance of deinstitutionalization, requirements for involuntary commitment due to mental illness have become much more stringent.

Law makers assume that correctional facilities will have competent diagnostic and treatment staff as evidenced by the assignment of diagnostic responsibilities to correctional agencies in a great many states. Often the nature of the evaluation is not specified in the legislation and speculation may be appropriate as to the true motivation for such commitments.

Generally, the juvenile codes examined are concerned about maintaining procedural safeguards that provide protection from inappropriate labeling. And, while there is no explicit statement that a child is not mentally ill unless commitable to a state institution, it may be commendable that this definition is maintained in its narrowest construction.

The law, in this interpretation, would then say that the juvenile justice system must provide adequate psychological and psychiatric services to meet the needs of its wards and to achieve the purposes of the juvenile codes.

CHAPTER II

A CASE LAW REVIEW

Introduction

This chapter will consider certain major themes and tensions that bear on the legal procedures and treatment approaches related to disturbed delinquent youths, will present and comment upon certain court decisions that have occurred at the different juvenile justice processing stages together with developments in mental health law, and will point to issue areas that might beneficially be addressed by juvenile justice and mental health officials as well as legislative policymakers. The contextual background of this presentation is the interest of state delinquency program administrators in implementing more effective procedures and treatment services for these youths within their own resources, those of the mental health system, or through shared, interagency collaboration. The current context involves juvenile justice and mental health systems which are engaged in rapid change both as to treatment precepts and modalities and with the legal parameters that constrain what they might do for and in behalf of these youngsters. Preliminarily, certain themes and competitive directions should be isolated to help explain today's medico-legal environment.

Major Themes and Cross Currents

Juvenile Justice Track versus Mental Health Track

In pure form, there are two separate processing channels. The juvenile justice system, whose center is the juvenile court, adjudicates delinquent offenders as well as dependent, neglected, and abused children, and in a decreasing number of states, the status offense child. While its procedures have become far more formalized during the past fourteen years or so, it retains numerous informal procedures, such as those at the intake stage where voluntary agreements, informal adjustments, and diversion avert formal proceedings, and at the dispositional stage where youngsters' social and psychological characteristics are weighed by a judge in entering a disposition presumably in the best interest of the child and the community. This system's last outpost is the state delinquency institution. In some states, juvenile court judges may commit these youths to state mental hospitals as a delinquency disposition.

The outer reach of the mental health system is the state mental hospital. A child may enter such a facility through voluntary admission to such an institution upon application of a parent or

guardian followed by professional staff approval, or through involuntary commitment procedures initiated in a court which has jurisdiction to ascertain whether a youngster is mentally ill, dangerous to himself or others, and in need of treatment. Some states now require that the minor consent to voluntary admission by the parents if he has reached a certain age such as fourteen years.

In reality, the juvenile justice system deals with many youngsters who have experienced significant emotional disturbance. Also, mental health agencies, non-residential as well as residential, treat many youths accused of or found to have committed delinquency offenses.

Crossovers occur between these systems, particularly crossovers from the juvenile justice system to the mental health system. These occur from the beginning to the end of the juvenile justice process and include such events as:

- A police officer apprehends a juvenile law violator, is concerned about the latter's mental status, and takes him to a mental health or medical facility rather than a juvenile detention facility.

- A detention center employee, concerned about a resident's emotional well-being, requests an evaluation of this child by mental health professionals employed by the court or a community mental health service.

- A probation intake official or a juvenile prosecutor decide against formally processing a delinquency complaint on the basis of a parent's agreement to obtain community mental health treatment for their youngster or to enter him into a private or public residential mental health facility.

- Delinquency processing is held in abeyance and civil mental illness commitment proceedings are brought.

- As an aid to a delinquency disposition, a judge obtains a psychological evaluation of a youth.

- Following court commitment to a state delinquency institution, a youngster is transferred to a state mental health facility for residential care.

- Upon release from a delinquency institution, a condition of parole requires ongoing mental health treatment.

Crossovers occur from other directions as well:

- A mental health agency, making no progress with a youngster, urges the parent to seek the court's authority to coerce more cooperation from the child.

- Psychiatric evaluation of an acting out youngster recommends treatment in a closed, structured environment, i.e., delinquency institution, rather than out-patient mental health services.

- A mental health track youngster who assaults treatment personnel is referred for juvenile court processing.

- A private residential treatment facility rejects, at intake, the admission of a juvenile court ward who does not appear likely to respond to psychotherapeutic intervention; the child is then committed to a delinquency facility though he is considered quite disturbed.

- The state has a highly publicized closed treatment facility administered by the state youth agency; its entry criterion of delinquency commitment forces a delinquency label rather an optional procedure into the mental health system.

Both of these systems, in their pure forms, have been beset in recent years by modernizations of applicable statutes, including procedural facets, and by an accelerating string of case decisions in both state and federal courts. The law, statutory and decisional, is evolving also as to the crossover process though less so. While, in general, legal developments have enhanced the rights of juveniles and have reduced the discretion of juvenile court judges and of state executive agencies in determining how they will operationalize their decision-making or administer their programs, the effectuation of elegant due process and of effective delinquency and mental health treatment remain unfulfilled goals.

The Right to Treatment versus the Right Not to be Treated

Cutting across both juvenile justice and mental health tracks is the legal doctrine of the right to treatment. Postulated in regard to involuntary mental illness commitments, this thesis urged a requirement upon the state to in fact provide treatment when a person's liberty had been constrained for the purpose of treatment. Applied initially with individual adult mental illness cases both civil and criminal (26, 51), this doctrine subsequently was extended to large populations in mental health and mental retardation institutions (61, 66), and to juvenile delinquency institutions (16, 39, 40, 41, 58). Along the juvenile justice track, the right to

treatment has been accepted on both statutory grounds (the purpose clauses of juvenile codes stress that if it becomes necessary to remove a child from the care of his parents, the child shall be provided the type of care and rehabilitative treatment he otherwise should have been provided by his parents) and on constitutional grounds (through the application of the Due Process Clause of the Fourteenth Amendment to the states). At the federal circuit court level, one court squarely upheld the constitutional validity of this doctrine's foundation in the Heyne case; another federal circuit court in the Morales case suggested in dicta that a due process consitutional basis was doubtful and indicated that consitutional abuses in institutional care could be corrected through applying the Eighth Amendment's prohibition against cruel and unusual punishment. All federal district courts, in which the due process basis of a right to treatment has been considered have ruled affirmatively on this issue.

Along the mental health track, the U.S. Supreme Court avoided ruling on the constitutional basis of this doctrine with an adult mental illness case review. The Court left open for future interpretation its holding that "in short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends" (42). Subsequent to the O'Connor ruling, at least one federal district court stated that "the right to treatment now appears as a solid tenet of constitutional law" and that the O'Connor ruling "invites such a determination" (24). Some legislatures have inserted express requirements of right to treatment in updating their civil commitment statutes.

While the right to treatment doctrine has obtained wide application, the nation, concurrently, has developed a skepticism, if not a paranoia, as to both the validity and the viability of treatment efficacy. Paired with concerns about labeling and stigma, consumers, theorists, and policymakers are wondering whether there may be a right not to be treated. Recent legislative reforms based on proportional sentencing, presumptive sentencing, and determinate sentencing embody these concerns. Some critics of rehabilitation has suggested there should be a right to reasonable and human punishment and not to treatment (Sanford Fox, "The Reform of Juvenile Justice: The Child's kight to Punishment", 25 Juvenile Justice 2 [1974]). Suggestions have been made that counseling intervention and other rehabilitative services should be available on a voluntary basis to those who are incapacitated but should not be a requirement or a condition for release (IJA-ABA, Standards Relating to Dispositions, Standard 4.2 [1980]). Determining that a juvenile or his parents have provided informed consent for the youth's participation in a "voluntary" program is especially

difficult within the context of the coercive atmosphere of a correctional institution. (National Juvenile Law Center, Inc., and the Youth Law Center, An Introduction to Litigative Advocacy under the Juvenile Justice and Delinquency Prevention Act [1980] pp. 223-32.) It is significant that the U.S. Supreme Court recently ruled that an adult prisoner cannot be transferred from a prison to a mental hospital over his protest, without being first provided such procedural protections as adequate notice and an adversary hearing before administrative officials (60).

The Least Restrictive Alternative Doctrine: Applied and Not Applied

The least restrictive alternative, also known as the least drastic alternative or the least stringent practicable alternative, is a developing legal doctrine that aims at removing only that amount of freedom that is necessary under the circumstances. As applied, alternative constraints from the least severe to the most severe are considered and the burden of proving that the court should utilize a more rather than a less severe sanction is placed upon the state. The doctrine was at first used primarily in First Amendment cases (57), then in adult mental illness and mental retardation commitment cases (29,63) and then in criminal cases with Eighth Amendment challenges (15). The doctrine, more recently, has been extended successfully to placement considerations involving mentally retarded, physically handicapped, and delinquent youngsters (12) and to dependent, in need of supervision, and delinquent youngsters committed by a juvenile court to a state mental hospital (24), and to delinquent youths (47).

The concept and the term are finding their way into statutes relating to involuntary mental illness procedures (Art. 59, 12 Md. Ann. Code [1977]) and into juvenile codes. The Iowa Juvenile Code directs juvenile court judges at the delinquency dispositional hearing to "enter the least restrictive dispositional order appropriate in view of the seriousness of the delinquent act, the child's culpability as indicated by the circumstances of the particular care, the age of the child and the child's prior record" (Iowa Code Annotated, 232.52.1 [Supp. 1979]; Also see LW. Va. Code 49-5-13 [Supp. 1980]; N. Ca. Gen. Stat. 7A-580 [1979]; and Pa. Cons. Stat. Ann. 6342 [Supp. 1980]).

The doctrine has found more support in relation to mental illness treatment than with delinquency dispositions. The Wisconsin Supreme Court, for example, declined to bind juvenile court judges to this test. (18); This approach has also been rejected by New York's highest court (45). Nonetheless, there is impressive support for the application of this doctrine with juvenile dispositions. Its use is advocated by the Institute of Judicial Administration--American Bar Association Juvenile Justice Standards

Project (Standards Relating to Dispositions, Standard 2.1 [1980]) and by the National Advisory Committee on Juvenile Justice and Delinquency Prevention (Juvenile Justice and Delinquency Prevention, Report of the Task Force on Juvenile Justice and Delinquency Prevention, Standard 14.4 [1980]).

A litigational spin-off of this doctrine seeks to restrain or otherwise curb the use of out-of-state resources for youngsters. During the 1970s, concern grew as to the quality of residential care provided by a treatment facility housed and licensed in one state but providing care to children resident of another state. Illinois officials, for example, removed a substantial number of children from Texas institutions by administrative actions. The developing case law on the subject does not bar out-of-state placements, but instead cautions against their use if in-state facilities exist, and would prohibit their use if their standards were inferior to those established for the committing state's own facilities (24).

Due Process versus Parens Patriae

Along both tracks we need to note the ascendency of due process protections and the diminished tolerance of unbridled discretion to help or treat youngsters in the absence of constitutionalized proceedings. However, the regularization of procedures relating to juveniles is far from "straight jacketed" and parens patriae remains a useful precept in expecting that the state will provide at least a modicum of beneficial services to youngsters. Though, historically, both juvenile justice and mental health treatment personnel may have preferred to ply their therapies without being constrained by the law or the Constitution, ample latitude remains for their work with youngsters. Both judicial decisions and law-medicine theorists retain a strong desire to see that treatment is, indeed, effectuated, and that experimental but human treatment modes are not stifled (24); Alan A. Stone, Mental Health and Law: A System in Transition, National Institute of Mental Health, [1975]).

Due process requirements of involuntary mental health commitments tend to include:

- Notice of hearing
- A hearing
- Right to counsel
- Proof of mental illness and dangerousness to a clear and convincing degree (Addington V. Texas, 441 U.S. 418 [1979])
- Written findings as to mental illness and dangerousness (and to other criteria which a statute may require, such as the least restrictive alternative) and the bases for these findings

- Periodic court review hearings, with the right to counsel to determine whether a person remains mentally ill and dangerous (and to consideration of the use of the least restrictive alternative)
- The right to treatment for one's mental illness

It should be noted that at least one state permits a youth, though not an adult, to be involuntarily confined though harmless, but requires that treatment be provided which is reasonably likely to be beneficial (50).

Due process safeguards for delinquent youths do not extend so far, except that the proof requirement is stronger. They tend to include:

- Notice of the charge and of a hearing
- A hearing
- The right to counsel
- A standard of proof of beyond a reasonable doubt
- The right to treatment

A sub-conflict that is pertinent in the mental health sector concerns the right of parents to voluntarily admit their youngster to a mental hospital in the absence of a pre-admission court hearing. The lead case on this subject permitted parents "to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse, and that the traditional presumption that the parents act in the best interest of their child should apply". The check on parental abuse was perceived as the "neutral factfinder", the staff physician who needs to concur with parental judgments of their child's mental illness and need for treatment. Further, voluntary admissions must be followed by periodic administrative review of these conditions and needs (45). Earlier, the California Supreme Court had ruled similarly, though it afforded an objecting juvenile, 14 years of age or older, the right to a precommitment administrative hearing, with the right to counsel (50).

Other Bill of Rights protections bind state practices when applied through the Fourteenth Amendment's Due Process Clause. The right to counsel (Sixth Amendment) extends to both tracks, although, in general, a mandatory right to counsel as opposed to a waivable right to counsel is more apparent in mental health procedures, presumably, because a mentally ill person is still more unable to effectively determine the wisdom of waiving counsel and other rights. The prohibition against cruel and unusual punishment (Eighth Amendment)

clearly applies to both systems. Its application has been a co-feature of juvenile delinquency right to treatment cases. Further, child advocates have sought to apply the Equal Protection Clause of the Fourteenth Amendment to insure that juveniles receive at least the same constitutional protections afforded adults. Juveniles have both been accorded such equal protection (24) and have been distinguished as a separate class for whom lesser protections may be maintained (50).

It must be expected that continuing due process challenges will be hurled both at procedures and at the treatment afforded by the two systems we are reviewing.

Judicial Authority versus Executive Authority

There are several dimensions of this boundary issue. One concerns the extent to which juvenile courts may order executive agencies to do or not to do something. The other concerns the authority of the executive to take an action without returning to a court for an express grant of authority to execute this action.

With the first dimension, juvenile court judges have taken more seriously their responsibility to ensure that youngsters within their jurisdiction obtain the services they appear to need. Accordingly, these judges have sought to hold in contempt a welfare department director when specified services for a retarded youth were not furnished appropriately (21), to require that a state institutional department initiate an extensive drug treatment program (4), and to direct particular institutional procedures prior to the imposition of disciplinary action or solitary confinement (62). While these and other examples did not succeed upon appeal, there have been successful cases (7). Nonetheless, executive agencies often accept judicial impositions or negotiate agreements which may compromise the integrity of their own prerogatives in order to avoid confrontations with the judiciary. Further, the legislature may expressly authorize the juvenile court to order an executive agency to carry out its public functions (1972 Session Laws of New York, Ch. 1016, Sec. 255 [1972]). As will be described later, appellate courts have not upheld the authority of a juvenile court to order an executive agency to provide extremely costly private psychiatric care when these costs jeopardize the reservoir of funds to be expended for other children.

As to the authority of the executive, earlier, delinquency institutions not infrequently transferred disruptive residents to adult penal institutions via administrative directives. This practice has been eliminated, essentially, by legislative prohibition, administrative regulation, or case decision. However, the transfer of disturbed delinquents from delinquency settings to

state mental health facilities is of major concern here. there are several primary approaches used with such transfers: informal administrative referrals from one executive agency to another, formal administrative hearings following objection, or a requirement of involuntary civil commitment proceedings (Kathleen V. Turney, The Provision of Intensive Mental Health Services to Adjudicated Delinquents: A Survey of State Practices, Harvard Law School manuscript, [1980]). Despite judicial reluctance to add further procedural requirements to mental health's provision of services to youths, or for that matter to further burden courts with additional hearings, there is some judicial trend to increase hearings and procedural protections for these youngsters and further legislative interest in bringing more formalism and due process safeguards to this nexus. An example of this statutory expansiveness is the express repeal of the authority of juvenile court judges to commit delinquent youths to mental institutions as a delinquency disposition (36). Further, at least 23 states now require that such interinstitutional transfers be processed through judicial civil commitment procedures (Turney, supra).

Badness versus Madness

Another analytical concept that dovetails with the two track framework may be characterized as badness (delinquent behavior) and madness (mental illness). Society prefers to punish the law violator but treat those who are not responsible for their behaviors or misbehaviors. However, the invention of the juvenile court during the progressive era (see Lamar T. Empey, ed., Juvenile Justice: The Progressive Legacy and Current Reforms, [1979]) sought to exchange the punitive emphasis of the criminal law, as applied to juvenile law violators, for a more civil scheme using coercive judicial authority to reorder errant youths, provide helping services, and facilitate constructive maturation. Both psychological and sociological theories of delinquency causation were important to the juvenile court foundation and operation. A multi-disciplinary hybrid approach to psychotherapeutic intervention was an accompaniment to this forum. The widespread criticisms of the juvenile court and the juvenile justice system in the 1960s and 1970s were founded, in part, on failures to furnish effective rehabilitation, the historic quid pro quo for the alegal, informal proceedings. A liberty interest was proclaimed for juveniles (13) and law and lawyers were interposed here to constrain state intervention and good intention.

Parallel developments associated with the rise of juvenile crime acknowledged punishment as a legitimate juvenile court objective. The sharp policy retreat from intervention with status offenders now provides juveniles more equal protection with adults whose actions may be disquieting but are not law violating. Juvenile

deinstitutionalization remains a vital concern but since, in the main, the size of juvenile institutions has in no way been comparable to state mental hospital populations, the scope of this effort is substantially smaller than the movement to deinstitutionalize the mentally ill. The legal reform of the mental health system, likewise, has been implanted from the criminal law, evolving from anxieties regarding state usurpation of freedom absent due process. There is acute concern, along both tracks, with the negative consequences of labeling. Both systems incorporate prediction... as to future misdeeds or dangerousness... and yet mental health prediction of future violence is very poor (John Monahan, "The Prediction of Violent Behavior in Juveniles", from The Serious Juvenile Offender, [1978]). Juvenile courts, however, remain wedded to psychological diagnosis and psychotherapeutic intervention despite countervailing data which questions their reliability and effectiveness.

The adjudication of delinquency is a clearer and cleaner determination than the vagueness associated with the definition of mental illness and its adjudication. To be first adjudicated bad and to then be transferred without ceremony from the juvenile justice system to the mental health system as "mad" may well be an ephemeral strategy. A gathering storm of opinion, case decision and otherwise (Thomas S. Szasz, Law, Liberty and Psychiatry [1963]), suggests that sooner or later "easy transfers" will need to be constrained by legal finery despite the absence of clarity as to what constitutes mental illness and the grave uncertainty as to the reliability of prediction. One who is double-labeled is "twice cursed" (33).

Federal Initiatives versus the Status Quo

The Federal Constitution has become an anchor to present and future juvenile justice and mental health systems. But other federal initiatives affect engaged youngsters. The Juvenile Justice and Delinquency Prevention Act promotes community-based services and less locking up of youths. In effect, families and communities are made more responsible for assisting their youngsters. Delinquency juveniles are encompassed within the Education For All Handicapped Children Act of 1975, P.L. 94-142. Local school system use of federal funds now must assure that all handicapped youngsters, including delinquency youths, are provided a free and appropriate education which emphasizes special education and related services designed to meet their needs. Individual children possessing individual needs are to be placed on the basis of these needs in the least restrictive settings (Alan Abeson and Jeffrey Zettel, "The End of the Quiet Revolution: The Education for All Handicapped Children Act of 1975," Exceptional Children 115 [October 1977]). Handicapped youngsters must receive free placement in a private

residential facility when this is necessary (31). Tied to this act is Section 504 of the Vocational Rehabilitation Act of 1973, P.L. 93112, which prohibits discrimination against handicapped individuals under programs receiving federal financial assistance. The legislation and implementing regulations clearly encourage strengthened educational provisions, "mainstreaming" juveniles as quickly as possible, avoiding unnecessary or overlong hospitalization, and guaranteeing the least restrictive environment (24). Thus, mental hospitalization of delinquent youths faces further challenge as to its necessity and duration.

Legal Issues and Case-Decisions at the Critical Processing Stages

Pre-Adjudicatory

Police Processing upon Taking into Custody

Juvenile codes often provide broad authority for police apprehension (taking into custody) of a youth. This may occur when there are "reasonable grounds to believe that the child is suffering from illness or injury or is in immediate danger from the child's surroundings and that the child's immediate removal from such surroundings is necessary for the protection of the health and safety of such child" (Alabama Juvenile Code 5-119 (d) [1975]). Under such circumstances, the child shall be brought "to a medical or mental health facility designated by the court if the child is believed to be suffering from a serious mental health condition, illness, or injury which requires either prompt treatment or prompt dianosis for the child's welfare or for evidentiary purposes" (Ibid., 5-120(e)).

The police decision to take a child to a mental health facility rather than a juvenile detention facility may determine that a youngster is processed through mental illness rather than delinquency procedures, or may lead to diversion from both formal systems. Police officers often try to find parents or other caretakers to whom a child's custody can be surrendered rather than pursuing emergency hospitalization (Egon Bittner, "Police Discretion in Emergency Apprehension of Mentally Ill Persons", 14 Social Problems 278 [1966-1967]). This practice is compatible with national standards that urge police agencies to use "the least restrictive alternative in attempting to resolve juvenile problems" (IJA-ABA, Standards Relating to Police Handling of Juvenile Problems. Standard 2.5. C.2. [1980]). Since the police may prefer to bring this youth to a juvenile detention facility, statutes frequently authorize detention center personnel to obtain emergency medical services (California Welfare and Institutions Code, Section 739). Police decisions in this juncture have not been subject to important appellate court review.

Voluntary or Involuntary Mental Health Admission as a Substitute for Delinquency Proceedings

It is believed that police officers as well as juvenile intake officers are receptive to parental interest in seeking out-patient psychiatric resolution of a delinquency offense. This practice may lead to a class bias result, middle class youngsters going off to psychiatrists and low income youngsters penetrating further into the juvenile justice system. Issues relating to out-patient services are simpler than those that occur when a parent or guardian seeks to admit his child to a residential mental health facility, particularly when the child objects. With residential admission, legal questions arise with both pre-admission and post-admission procedures. The lead case in this arena upheld the constitutionality of Georgia practices permitting a parent or guardian to obtain admission of a child to a state mental hospital upon the superintendent's finding of evidence of mental illness and suitability for treatment in the hospital. No pre-admission or post-admission judicial hearing was held necessary. The periodic post-admission administrative reviews that were used were seen as satisfactory and necessary to "reduce the risk of error in the initial admission". Admission of a child ward by the state family and children's agency without a judicial hearing was held constitutional due to the presumption that the state agency acts in the best interest of the child. The court acknowledged that post-admission procedures required in reviewing a ward's need for continuing care may be different from those used to review a child with natural parents since there may be an absence of an adult "who cares deeply for a child" which "may have some effect on how long a child will remain in the hospital". On remand, the federal trial court should consider this issue.

The majority opinion had emphasized parental and guardian rights to seek care for their youngsters, believed that mental health personnel could better determine questions of mental illness and treatment need than judicial personnel, and expressed concern with the cost and burden of requiring judicial hearings (43, 56). The dissenting justices would have required at least one post-admission judicial hearing following parental admission, as well as pre-confinement and post-confinement judicial hearings for juvenile wards admitted by the state in loco parentis. The dissent expressed concerns over the accuracy of psychiatric diagnosis, particularly where children are involved, the consequences of erroneous hospitalization upon children, and the duration of many juvenile confinements.

Prior to this decision, due process critics of voluntary admissions of juveniles had won victories in the original Parham trial and in a similar Pennsylvania case where a number of youngsters 15 years and

older had objected to hospitalization on their parents' initiatives. The latter court accepted the initial parental entry of the child, but required a probable cause hearing by a court within 72 hours thereafter, a full hearing before an impartial tribunal on the need for commitment within two weeks later unless there is a valid waiver, written notice of hearings, a statement of the grounds for the proposed commitment, the right to counsel, the child's right to attend or not attend hearings, a proof requirement of clear, unequivocal, and convincing evidence, and the opportunity to present testimony and cross-examine adverse witnesses (2a, 17a).

Some laws and decisions, described later, have invalidated juvenile court commitment of a delinquent youngster to a state mental hospital as a delinquency disposition. The consequence is an encouragement to the parent to seek voluntary admission of their child or, to a lesser degree, undertake a civil mental illness proceeding in behalf of that child. The particular court having jurisdiction over civil proceedings may be a juvenile court or a different court. A civil proceeding also is required by a growing number of statutes to effectuate inter-institutional transfers from delinquency facilities to mental hospitals. Despite the difficulties with definitions of mental illness (10), the problems with prediction (Florida's statute requires a finding that a person is "likely to injure himself or others if allowed to remain at liberty"), as well as problems concerning treatment efficacy (Florida requires the person be "in need of care or treatment," Fla. Stat. Ann. 394.467), civil proceedings appear to provide more protections than accompanies hospitalization as a delinquency disposition or interinstitutional transfer preceded only by executive agency approval. For example, the 1979 New Mexico statute relating to involuntary mental health treatment of children mandates counsel for the child, a finding by clear and convincing evidence that no less drastic treatment alternative is feasible, and provides other due process safeguards (N.M. Stat. Ann. 43-1-16.1 [1979]).

The proof standard as to mental illness and dangerousness is now universalized as clear and convincing (1). Further, the statutes tend to require periodic judicial review hearings as to ongoing diagnosis and need for treatment, along with a least restrictive alternative standard. "Recent statutory enactments appear to indicate a trend toward restricting involuntary civil commitment to the dangerous mentally ill and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness" (Note, "Civil Commitment of the Mentally Ill", 87 Harvard Law Review 1190 [1974]).

The Right to Treatment in a Pretrial Detention Facility

Several significant cases should be cited. The first is believed to be the first application of the right to treatment doctrine to

juvenile justice. A youth detained in the District of Columbia Detention Center requested psychiatric assistance. Detention officials denied this request and the juvenile court rejected providing a hearing to consider this claim. The appellate court ruled that the juvenile court should have granted a hearing, thereby adhering to the statutory purpose clause which provided that when a child is removed from his family, "the court shall secure for him custody, care and discipline as nearly as possible equivalent to that which should have been given him by his parents". Accordingly, if parents should provide needed psychiatric attention for their children, then the court, as to children removed from their parents, must insure that this care is provided" (8).

A federal court in New York ruled that the physical conditions of a juvenile detention center which held youngsters prior to trial or placement violated the Eighth Amendment protection against cruel and unusual punishment, and that prevalent deficiencies at this and two other centers violated a constitutional right to due process for youngsters detained there for more than thirty days. To effectuate the right to treatment for longer term detainees, the court ordered minimal staffing ratios (two counselors for 20 children, one recreational worker for 15 children, one caseworker for 15 children), prescribed educational qualifications for program staff, and among other provisions, required the formulation and review of individualized treatment plans for these youngsters (32).

A third case, a District of Columbia holding also, found the pretrial detention facility functioning below acceptable statutory standards and ordered it closed within two years. In the interim, a resident population lid was decreed together with certain education, counseling, and recreational provisions (55). Further a constitutional right to treatment has been applied to youngsters held in the Pittsburgh detention facility (48). Extensive orders regulating care and procedures in the Philadelphia facility and a Massachusetts center have been entered (54, 17).

The right to treatment, then, has been applied in juvenile detention settings, both as to individual cases and collective milieus, and on statutory and constitutional grounds.

Competency to Stand Trial

The question here concerns the capacity of the child to understand the nature of the proceedings against him and to assist in his defense. Statutes rarely provide for consideration of the competency issue at the pre-adjudicatory stage. The District of Columbia Code is an exception and provides that if this issue is raised the court may order an examination of the child and if the child is found incapable of participating in the proceedings,

commitment procedures may be instituted (16-2315(a) and (c) [1973]). Case decisions, however, have uniformly permitted juveniles to raise the claim of incompetency. This has been approved as a matter of constitutional due process (6, 59, 23). Consideration of incompetency in understanding the nature of a transfer or fitness hearing and to assist his counsel at such a hearing was approved on an inherent power of the court theory (20).

Standards used by the courts in these cases include an effectuation of the right to effective counsel, communication and cooperation with counsel being necessary, and the inference of a mandate that safeguards extended to adult defendants be extended to juveniles. Presumably, a youth found incompetent to stand trial would be accorded treatment and would stand trial when he is capable of understanding the proceedings and assisting in his defense. Alternatively, civil mental illness proceedings could be instituted and the delinquency petition either deferred or dismissed.

The Right to Counsel

The Gault decision, of course, specified that in delinquency proceedings a juvenile who may be institutionalized must be notified of his right to counsel and to free counsel if indigent. The existence of the right at the pre-adjudicatory stage seems clear as to detention hearings but less clear at the intake conference stage. The right to counsel prior to adjudication may be set forth in mental illness commitment statutes or by case decision. For example, the California Lanterman-Petris-Short Act authorizes a habeas corpus proceeding by which a detained person may obtain a judicial hearing and seek release following a 72 hour emergency detention period and may obtain free court-appointed counsel of indigent. Although Parham foreclosed on a federal constitutional basis pre-adjudicatory judicial hearings upon a parent or guardian's request for mental hospitalization, the California Supreme Court has held that if the youth is 14 years or older, a pre-confinement administrative hearing must be held upon request and that due process requires that counsel be provided for the minor (50). In an important adult mental illness case, a federal court held "imperative the assistance of counsel as soon after proceedings are begun as is realistically feasible. Certainly the detained individual must have counsel at the preliminary hearing on detention". The court, also, was insistent that the appointment of a guardian ad litem for the respondent did not satisfy the constitutional requirement of representative counsel when the guardian perceived his function to decide what was in the best interest of the client-ward and then proceed almost independent of the will of the respondent and without a defense advocacy posture (Lessard v. Schmidt, supra).

A Child's Ability to Reject Mental Health Intervention

No legal decisions were discerned that considered whether a youth had a right to reject proffered mental health intervention in the absence of a court hearing finding this necessary and ordering these services. In the non-legal context, juveniles find ways to ignore, reject, or subvert mental health intervention. While the case for psychiatric evaluation, treatment, and hospitalization with as few legal restrictions as is possible has been made over many years by child psychiatrists, a converse position, expressed frequently by Thomas S. Szasz, appears to be growing. Szasz would afford children all the protections accorded to adults regarding institutional or involuntary psychiatry even less well than adults, they need more stringent protections than adults". He is concerned with the power differential between "diagnostician and diagnosed, child sorter and sorted child", and that "the child psychiatrist's function as agent of social control is so pervasive as to virtually nullify his function as agent of the child" (Thomas S. Szasz, "The Child as Involuntary Mental Patient: The Threat of Child Therapy to the Child's Dignity, Privacy, and Self-Esteem", 14 San Diego Law Review 1005 [1977]).

Adjudicatory Stage

The Entry of a Not Guilty by Reason of Insanity Plea

Case decisions tend to accept an insanity defense in juvenile court. Its application was approved in Wisconsin on the rationale that insanity eradicates the requirement of criminal intent to commit an offense (64), in Louisiana where this defense was seen as a "due process-fundamental fairness right" (6), and in a New Jersey case where the defense was held to be included in a statute entitling juveniles to all defenses available to adults in criminal prosecutions (46). Conversely, the District of Columbia statutory bar against the use of the insanity defense in a juvenile proceeding was held constitutional. The court reasoned that since juvenile proceedings do not result in penal sanctions but determine the treatment required to rehabilitate a child, due process is satisfied since a dispositional hearing reviews the mental health of the youth both at the time of the offense and the time of disposition, and any institution utilized by the court must provide appropriate care for the child (5).

Litigation of this issue may be avoided by rerouting this type of case through voluntary or involuntary mental health proceedings.

Right to Counsel

The right to counsel exists with delinquency adjudication though many statutes permit waiver of this right. Kansas law, however, requires appointment of a guardian ad litem for unrepresented

children, Iowa law will not permit waiver of counsel at this stage, and Texas law requires a youth consult with counsel before waiving any of his rights. Particularly in large urban juvenile courts, court rule or practice requires counsel for each child. The right to counsel also exists with the two primary routes to involuntary mental hospitalization, the court-based civil mental illness proceeding and the juvenile court-based delinquency disposition to a mental hospital. With the latter procedure, the federal court that declared the Maryland provision and practice unconstitutional decreed that no juvenile court shall commit a child to a state mental hospital unless counsel has been provided (24). Mandatory counsel representation had not earlier been required by Maryland juvenile courts.

There appear to be a stronger requirement for mandatory counsel in proceedings related to mental hospitalization than with delinquency adjudication, reviewing courts expressing the belief that the youth or adult who may be mentally ill is in especial need of counsel.

The Dispositional Stage

The Validity of Commitment to a Mental Hospital as a Delinquency Disposition

The handwriting is now on the wall for states whose juvenile codes provide paternalistic criteria and broad discretion for judges to commit delinquency youths to mental hospitals. There is now official recognition that this relatively carte blanche approach provides inadequate protections for youngsters and offends the Constitution. The safeguards provided are far fewer than those granted with civil mental illness proceedings. Maryland's juvenile code dispositional standards had provided: "The overriding consideration in making a disposition is a program of treatment, training, and rehabilitation best suited to the physical, mental, and moral welfare of the child consistent with the public interest". The standards were held "impermissibly vague and otherwise unconstitutional as violative of due process and equal protection in that they do not require a finding that a juvenile is dangerous to himself or others and do not guarantee that commitment will bear a rational relationship to underlying parens patriae principle justifying a juvenile's loss of liberty". The court ordered the juvenile court to instead use involuntary mental illness proceeding standards as requirements for state mental hospital commitment: "The juvenile (i) has a mental disorder; (ii) for the protection of himself or others, needs inpatient medical care or treatment; and (iii) is unable or unwilling to be voluntarily admitted to such a facility". The failure of the juvenile code to require periodic court review as to the continuing suitability of such commitments occasioned the federal court's ruling that

mandatory review hearings must be conducted at least every six months (the court had received evidence that juvenile delinquents committed by the juvenile court remained hospitalized far longer than non-delinquent youths committed through civil mental illness procedures and that many of the former group had no progress reports submitted and had received no placement review hearing by the juvenile court whether or not progress reports had been submitted to the court). The court entered other requirements to bring the juvenile code into consonance with civil mental illness procedures and constitutional requirements. The court had not voided, but rather took steps to constitutionalize juvenile court authority to commit a youth to a mental hospital (24).

At least two state legislatures expressly repealed prior juvenile code authority that earlier permitted juvenile court judges to commit delinquent, in need of supervision, or dependent and neglected children directly to a state mental hospital. The revised legislation required that involuntary procedures be brought through mental health codes rather than through juvenile codes, thereby effectuating proof of mental illness and dangerousness, hearing and re-hearing benefits, counsel provision, and other strengthened due process protections. The resort to juvenile code direct commitments by judges in California and North Carolina, despite these legislative changes, was found impermissible (36, 37). A West Virginia case also should be cited. There, a juvenile court had ordered a social, physical, and mental examination for a youth at a state hospital following which she was to be returned to the court. Instead, she continued to remain at the state hospital and was transferred later to another state hospital where she petitioned for habeas corpus relief. The West Virginia Supreme Court found that the youth had been denied the same rights afforded adults and that the denial of a hearing, counsel, and the absence of a lawful court order contravened both due process and equal protection (14).

In sum, the due process safeguards set forth in civil mental illness proceedings have now surpassed the safeguards institutionalized into juvenile codes following the Gault decision.

The Least Restrictive Alternative

Certain converging directions, both with juvenile justice and mental health law, combine to support the least restrictive alternative doctrine. Yet, court rulings in this regard are inconsistent along the juvenile justice track, and voluntary mental hospital admissions, as approved by Parham, weaken its application in the latter context. The bottom line in both systems is the containment of liberty. With the recent growth in support of punishment sanctions for juvenile law violators, it is understandable that juvenile courts have some reluctance to apply this doctrine.

Earlier, long before the present community-based alternatives in both systems were set in place, the laws granted wide latitude to judges to institutionalize or hospitalize following a finding of delinquency or mental illness. Rather than trust judges to institutionalize only as a last resort, advocates of this doctrine would require a judge to explicate the reasons why less restrictive alternatives were not utilized. Dangerousness has been rather well established as a criterion for mental hospitalization. It is not so established with juvenile delinquency where many youths are institutionalized not because of the seriousness but because of the repetitiveness of their offenses. It should be noted that part of the basis for the successful deinstitutionalization of status offenders was that these youths had committed no harm to others.

The doctrine is not fully consistent with the ideology of proportional sentencing where punishment is tailored to offense severity, prior delinquency history, and age, rather than treatment efficacy in less restrictive resources. In pure form, the least restrictive alternative is a dimension of the right to treatment since the state, in deciding to curb liberty, should provide treatment resources which least infringe upon one's liberty interest. A federal judge in a delinquency right to treatment case made this point: "[the state] must cease to institutionalize any juveniles except those who are found by a responsible professional assessment to be unsuited for any less restrictive, alternative form of rehabilitative treatment" (39).

There are a number of state appellate courts that have reversed juvenile court orders of delinquent institutionalization. The reversals have been based on the failure to first explore available less restrictive alternatives (22), that the statutory requirement that the child will benefit from commitment was not shown by the evidence (2), that particular youths were not dangerous to society (61), and because of the failure of the trial court to consider the offending child's best interest (65). However, institutionalization dispositions have been upheld despite challenges that the least restrictive alternative should have been applied (18, 45, 34).

There is less ambivalence in applying this doctrine to juvenile mental hospitalization where no "committed juvenile shall be admitted to a mental institution if services and programs available in the community can afford such person adequate care, rehabilitation, and treatment in a setting which is not only suitable and appropriate to his needs, but also least restrictive of his liberty" (24).

Juvenile Court Authority to Order Treatment of a Delinquent Youth in a Private Residential Facility at Public Expense

Few juvenile courts are budgeted to pay the cost of private residential care for delinquent youths. Juvenile codes tend to be

silent as to the authority of the court to order such placements and the obligation of executive agencies to pay the costs of these placements. Yet the purpose clauses of juvenile codes direct the court to obtain the type of care that is needed and dispositional statutes guide judges to select alternatives that operate in the best interest of court youths. Court-ordered placement in a private boys' ranch, against the opposition of the public welfare agency which disagreed with the appropriateness of the placement and opposed paying for the care, was upheld: "The juvenile court has the power and the duty to make such determinations as it deems appropriate" (7). A similar practice was approved on the basis that "While we are cognizant of the risk of depletion of the county's resources inherent in the placement of jurisdictional children in expensive, privately operated facilities, we nevertheless believe that the legislative intent was the trial courts have such an available resource as an alternative" (27). Conversely, an order that a juvenile with a severe psychiatric disorder be placed by the state division of youth and family services in an adjoining state's psychiatric institute at a cost of $110 per day was voided as an infringement on the executive agency's determination as to how best to use its limited funds for the children in its care (9). A similar ruling was issued in voiding a family court order finding an executive department director in contempt for not placing an emotionally disturbed juvenile in an out of state treatment facility at a cost of $65,000 per year when the placement budget had been expended (9a).

Consideration of an Out-Patient versus an In-Patient Psychological-Psychiatric Evaluation

Legal challenges to the certain juvenile court proclivity to order psychological and psychiatric evaluations of accused juveniles in an inpatient facility, such as the detention center or a mental health resource, have not been located. One national standard urges that such evaluations first be sought without resort to any form of confinement, but where confinement is represented as a necessary condition and the juvenile or his attorney objects, "The court should conduct a hearing on the issue and determine whether the proposed confinement is necessary". The standard places the burden on the juvenile prosecutor to demonstrate that no less drastic alternative is suitable or available. Confinement would not exceed 30 days (IJA-ABA, Standards Relating to Dispositional Procedures 2.3D. [1980]).

It should be noted that a number of juvenile codes authorize judges to commit an adjudicated youth for a 60 or 90 day evaluation at a state delinquency facility. Although the statutory purpose is for diagnosis as an aid to disposition, its use is referred to as "shock probation". Judges are often more interested in providing a

youngster with a taste of the institutional experience than they are in obtaining a bona fide evaluation. Frequently, upon return to the court for disposition, the youngster is placed on probation or some community status. Case decisions have not mitigated in any meaningful way the practice of using such diagnostic commitment orders.

Along the mental health track, the Maryland case which reordered juvenile court procedures in civilly committing delinquent and other youngsters to state mental hospitals decreed, as part of its plan for compliance, that such juveniles must be evaluated but that "if it is feasible and appropriate considering the juvenile's condition, this evaluation be conducted on an outpatient basis". Inpatient evaluations in a mental health facility were not to exceed 30 days (24).

The correlation between outpatient evaluation and the least restrictive alternative doctrine is visible.

Court Authority to Order Parent of Delinquent Child to Participate in Child's Rehabilitation Program

Though most parents, at least nominally, accept a court directive that they join in treatment services to be arranged for their child, no cases appear to have ruled on the constitutionality of such directives. While there may be value in parental participation, the mental health relationship with delinquency is often arguable, as is parental responsibility for a child's delinquent conduct. The Mississippi Supreme Court, however, upheld a juvenile court order requiring that all members of a child's family participate in guidance counseling at a mental health center on the basis of a broadly conceived statute authorizing a court to be encouraging, causing, or contributing to delinquency, do any acts which the judge deems reasonable and necessary for their child's welfare. Though the youth court had not made findings that the parents were in any way responsible for their child's delinquency, the Supreme Court held that the youth court nonetheless possessed the requisite authority (11). A Florida appellate court, however, found no statutory authority which would permit it to uphold a juvenile court's requirement that the mother of a delinquent girl participate in her daughter's drug rehabilitation program in a neighboring city. The appellate court also rejected recommending the enactment of additional judicial authority which, with "recalcitrant or unrit parents . . . would probably be self-defeating and lead only to frustration and increase in the jail population (52).

Institutional Stage

Adequacy of Process of Administrative Transfer from Delinquency Institution to Mental Health Facility Administered Other than by the State Youth Agency

There are three principal means by which youths committed for delinquency violations may be transferred by a state executive agency to a state mental health institution: the least common method utilized requires an administrative hearing when a juvenile objects to this transfer; more commonly, an administrative referral is effectuated without ceremony, which is the simplest and least burdensome procedure and is most lacking in constitutional trappings; the most common procedure used is to initiate a civil mental illness proceeding in regard to the child. The court proceeding approach is most likely to pass constitutional muster. At least 23 states appear to require the civil proceeding (Turney, supra). Presumably, state regulations could require resort to civil mental illness proceedings in the absence of the statutory requirement.

It is now the law of the land that an incarcerated adult criminal found to suffer from a mental disease or defect that cannot be given proper treatment in prison has a liberty interest that entitles him to the "benefits of appropriate procedures in connection with determining the conditions that warranted his transfer to a mental hospital" (60). The U.S. Supreme Court has not ruled on the constitutionality of administrative transfer procedures for juveniles. In the adult case, the Court disagreed with the contention that incarceration for a crime entitles a state not only to confine the convicted person but also to determine he has a mental illness and to subject him involuntarily to institutional care in a mental hospital absent due process protections. "Involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual." Transfer can be accomplished administratively, but it must be preceded by written notice, a hearing which discloses evidence relied upon for the transfer, an opportunity for the defense to present testimony of witnesses and cross-examine the state's witnesses, an independent decisionmaker, written findings, the provision of legal counsel or non-attorney assistance, and a timely notice of all of these rights (60).

Though the parens patriae residuum, society's interest in obtaining helping services for youngsters, the leeway given states in programming for "bad" children, and the Parham ruling all mitigate against the likelihood of a Supreme Court application of Vitek to a juvenile scenario, state courts might find that state constitutions require more protections to juveniles than are afforded by administrative referrals, or even present administrative hearing procedures.

Administrative referrals seem particularly vulnerable to constitutional challenge. The validity of an administrative hearing process depends upon the express procedures of a particular state and whether they comport with standards derived over time and which are similar to those set forth in the Vitek decision. It is not likely that a state appellate court, in the absence of a prohibitive law, would hold that a civil mental illness proceeding is a requisite to transfer rather than an administrative hearing that comports fully with due process. Nonetheless, even viable administrative hearing procedure lacks certain safeguards set out in civil court proceedings, namely application of the least restrictive alternative doctrine and mandatory periodic reviews conducted by judicial personnel. While administrative referrals and administrative hearings may be upheld, it is sounder practice to initiate civil involuntary commitment hearings whether or not this is required.

This route must be followed if mental hospitalization is to continue beyond the expiration date of a delinquency commitment. In an important and related adult case, the U.S. Supreme Court held that the then existing New York statute providing for an abbreviated civil commitment procedure upon the expiration of the prison term of a mentally ill convict was unconstitutional since its standards and requirements (3). However, in some states which have determinate but extendable delinquency commitments, the state may return to the committing juvenile court and petition for a renewed commitment (Colorado).

The Right to Treatment

This right, based either on statutory or constitutional interpretation, has received extensive application at the delinquency institution level. These cases often have been joined with findings of violations of the constitutional protection against cruel and unusual punishment and, on occasion, with First Amendment rights. These provisions have been applied to:

- Individualized diagnosis and treatment

For example, "The right to treatment embraces a requirement of initial diagnosis and of periodic assessment of the [institutionalized] PINS child's needs in order that individualized treatment may be revised as the diagnosis develops (28)."

Also, "In our view the 'right to treatment' includes the right to minimum acceptable standards of care and treatment for juveniles and the right to individualized care and treatment. Because children differ in their need for rehabilitation, individual need for treatment will differ . . . Without a program of individual treatment the result may be that the juveniles will not be rehabilitated, but warehoused. . ." (41).

Further, "It is manifest that denial of psychiatric care to some of the inmates is to ignore their needs and may hasten a process of deterioration. . .defendants are ordered to submit an appropriate plan within thirty days" (16).

- Require Humane Conditions

Such minimum conditions of confinement as room lighting, seasonal clothing, bedding changes, personal hygiene supplies, provision of undergarments and socks, daily showers, 24-hour nursing service, and prescription eyeglasses if needed, have been ordered (16).

Also, "the practice of prohibiting or discouraging juveniles in Texas Youth Council institutions from conversing in languages other than English. .is a violation of the first amendment to the constitution (39).

Further, "Racial segregation of any state-operated facility is unconstitutional" (39).

And, "The defendants have advanced no legitimate state interest, much less a compelling interest that is served by the reading or censoring of incoming or outgoing mail or by limitation of the persons with whom inmates may correspond" (39).

Also, the Provo Canyon School is restrained from subjecting juveniles to the "administration of polygraph examinations for any purpose whatsoever" (38).

Further, "Requiring inmates to maintain silence during periods of the day merely for purpose of punishment, and to perform repetitive, non-functional, degrading, and unnecessary tasks for many hours . . . constitutes cruel and unusual punishment" (39).

- Also, "The beatings employed by defendants are disproportionate to the offenses for which they are used, and do not measure up to contemporary standards of decency in our contemporary society" (41).

And, "Our concern is with actual and potential abuses under policies where . . . drugs are administered to juveniles intramuscularly by staff, without trying medication short of drugs and without adequate medical guidance and prescription" (41).

- Controls on the Use of Isolation and Restraints

For example, "Students may not be placed in the [isolation unit except when there is substantial evidence that they constitute an immediate threat to the physical well-being of themselves or others;

confinement may not exceed 24 hours and must be approved within one hour by [four officials are specified]; the [isolation unit] must be visited at least once every three hours during the day . . . [students] must be permitted to sleep a reasonable time during the day. . . must receive daily at least an hour's physical exercise outside of the [isolation unit]. . . and they must be allowed to eat their meals outside of their cells" (40).

Another institution was enjoined from violating its own regulations governing room confinement and the use of restraints. Confinement and use of physical restraints were not to be used unless the child constituted "a serious and evident danger to himself or others", and physical restraints were not to remain in use longer than 30 minutes. Except in extreme circumstances, isolation was not to last longer than six hours, and isolated children were to be checked at least hourly (44).

- Right to Privacy

The Constitution does not explicitly mention a right to privacy. U.S. Supreme Court cases, however, have found the roots of this right in the First, Fourth, Fifth, Ninth, and Fourteenth Amendments (49). The Morales case had ordered that a constitutionally adequate treatment plan must include freedom from unnecessary or arbitrary invasions of privacy and a physical plan designed to maximize the child's security, privacy, and dignity.

The right to privacy was extended to a juvenile in a public junior high school who successfully enjoined the administration of a questionnaire whose stated purpose was to aid school authorities in identifying potential drug abusers. The questionnaire was of a highly personal nature and the means used to inform the students and their parents about the program's methods and goals did not approach the status of "informed consent" (35). There could be application of this principle to delinquency institutions where questionnaires are administered by institutional officials or by outside researchers seeking to obtain personal information that may not be relevant to the course of care at the facility.

A right to privacy was applied by a federal court in voiding the voluntary consent of an involuntarily detained mental patient who had agreed to subject himself to an experiment testing the relative merits of psychosurgery and a particular drug on the control of aggression. "Government has no power or right to control man's minds, thoughts, and expression. This is the command of the First Amendment and we adhere to it in holding an involuntarily detained mental patient may not consent to experimental psychosurgery" (25). the right to privacy argument may be applicable to other more intrusive modes of treatment such as electroshock and the more severe applications of behavior modification and

psychopharmacology. Its acceptance at this time is doubtful as to psychotherapeutic intervention (Michael D. Wade, "The Right to Refuse Treatment: Mental Patients and the Law", 1 Detroit College Law Review:53 [1976]). However, a case that arose in a New Jersey institution should be cited. There, residents were required to participate in a guided group interaction program and to tell their life histories including "all problems with the law". Following a promise of confidentiality, a youth described a mugging in which he had been involved and his learning later that the victim may have died. This was not the offense for which the youth had been committed. The information was reported by the institution to the youth's probation officer and then to the police; the youth was subsequently adjudicated for robbery and murder. On appeal, the violation of confidentiality was held inconsistent with due process and fundamental fairness and the case was reversed (19).

- Right to Treatment with Juvenile Mental Health Services

Having ruled that a constitutional right to treatment exists, in a case that did not challenge the conditions of confinement, a federal court incorporated the least restrictive alternative requirement with the doctrine and then proceeded to apply this directive to the Maryland Juvenile Code. "But the imperative that least drastic means be considered does not imply a constitutional right on the part of every individual to a personal judicial determination that the means being employed to improve his condition are the best possible or the least restrictive conceivable. What is required is that the state give thoughtful consideration to the needs of the individual, treating him constructively and in accordance with his own situation, rather than automatically placing in institutions, perhaps far from home and perhaps forever, all for whom families cannot care and all who are rejected by family or society . . . logic, economics, and the scarcity of human resources make it impossible to supply the finest to everyone. Nor are courts, or child rehabilitation experts, however skilled, equipped to determine infallibly what is optimum. The quid pro quo the state must provide is treatment based on expert advice recently designed to affect the purposes of state action" (24).

A related case which ruled on challenges to placement of Louisiana mentally retarded, physically handicapped, and delinquent children in Texas institutions held that "The constitutional right to treatment is a right to a program of treatment that affords the individual a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capacities permit with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency" (12).

Petition for Writ of Habeas Corpus

This historic proceeding may be initiated by anyone claiming that his confinement is unlawful. For example, a habeas corpus proceeding was the route by which three juveniles successfully claimed that their hospitalization, initiated by a parent or the juvenile court, failed to meet statutory or constitutional standards. With one, who objected to his parent's confining him, the failure to provide post-admission procedures and review consistent with due process safeguards, comparable to those provided persons hospitalized involuntarily, was found to constitute unconstitutional confinement (30). With a second parental admission case, the fourteen year old who objected to confinement was held entitled to a preadmission administrative hearing as to whether evidence supported statutory requirements for confinement (50). In a third case, the writ was issued when a juvenile court had wrongly confined a delinquent youth in a mental hospital although the legislature had expressly repealed the court's authority to enter such a disposition (36).

Institutionalized youths do not always have access to legal counsel, a situation which reduces the number of habeas corpus cases initiated to challenge unlawful confinements.

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CHAPTER III

DIRECTIONS FOR THE FUTURE

This review has indicated the growth in due process safeguards provided youths along both juvenile justice and mental health tracks and general findings of the application of the right to treatment with both systems. The greater incorporation of the least restrictive alternative doctrine and a requirement of periodic court review is substantially more extensive for youngsters involuntarily committed to mental illness facilities. Curbs on the unbridled discretion to act in the best interest of youngsters, in both systems, are evident. Concern with the "double curse" of both badness and madness was noted together with several implications of recent federal initiatives that should influence future directions toward the least restrictive alternative, right to treatment, and right to education. Implications for the future suggest positive values with the following:

Legislative Revisions

Involuntary mental hospitalization of children, delinquent or otherwise, should be regulated by procedures that adhere to due process safeguards generally set out in civil mental illness proceedings. Juvenile court codes that presently authorize mental hospitalization as a delinquency disposition should be redrawn to comport with civil mental illness standards and procedures. This would involve a separate proceeding, an acceptable definition of mental illness and dangerousness, use of the least restrictive alternative, mandatory counsel, mandatory periodic review hearings, and other safeguards. Hospital procedures which permit voluntary parent admission should thereafter be followed by court findings and periodic reviews similar to those set out in the North Carolina statute.

Reduced Juvenile Court and Executive Agency Reliance upon the "Medical Model"

The historic as well as present overemphasis on the psychological/psychiatric evaluation of delinquent children in the application of counseling and treatment modalities has not served us or our children very well. The expanded use of mild punishment alternatives, such as money restitution, community service restitution, victim service restitution, fines, and other community level sanctions for offending behaviors, even with emotionally troubled youngsters, can reduce the blurring of badness with madness.

The Least Restrictive Alternative

This doctrine can be applied practicably and effectively in both systems. Its application would reduce unnecessary pretrial or prolonged detention, inpatient evaluations, interminably long probation durations, and costly private residential and state institutional confinement. Further emphasis would be placed on home detention, outpatient and community alternatives, day treatment, regional resources, in-state services, and periodic court reviews. Effective networking approaches and brokerage linkages need to be developed since no one agency, however broadly empowered, can perform all necessary services to all children.

Time Frame Standards

Just as speedy trial is a requirement of due process, the development of time standards to achieve processing or treatment events, monitored regularly, focuses organizational practices more on children's needs than organizational needs in reducing anxiety and inaction during waiting periods and can result in some diminution of institutional stays.

The Right to Counsel

Though no guarantor of effective representation of children, well-prepared attorneys who clearly perceive their advocacy function in behalf of children provide an important tension that helps make the system function as it should. Preferably, waiver of counsel should not be possible at any stage of either system. Access to counsel should readily be available at institutional levels, as well.

Juvenile Court Review Hearings

A recent and extensive requirement of juvenile court review hearings with dependent and neglected children merits application with our present concern. Delinquent children placed in private residential facilities should be reviewed at hearings each six months, a procedure gaining currency in a number of states at present. Further, where delinquency proceedings are adjourned in place of voluntary mental hospitalization of a youngster, the juvenile court can monitor this course of developments by review hearings even in the absence of a statutory requirement.

Executive Agency Review Procedures

Regularized, periodic internal monitoring as to the status and need for services of each youngster within the jurisdiction of an agency and according to relatively clear criteria can facilitate the agency's fulfilling its responsibilities to its youngsters and making the best uses of its own resources.

Development of Mental Health Services within State Youth Agencies

It appears more efficient and more humanitarian for delinquency agencies to program more extensively for emotionally disturbed delinquents within their own facilities. Transfers of these youngsters to mental hospitals are increasingly beset with either civil mental illness proceedings or more rigorous administrative hearings which require time and resource expenditures in expanding the "double curse". Operationally, this means effective psychotherapeutic services to maintain all youngsters, to the extent feasible, in their regular delinquency institution settings. In more populous states, specialized facilities for distrubed delinquents within state youth systems may be desirable, nonetheless. In the latter instance, executive agencies can provide more checks on themselves through internal review of individual cases at regular time frames and according to approved criteria, or these agencies can volunteer to have the committing juvenile court review and advise them at hearings as to the status of the child and his continuation in a particular program. Within an institution, all youngsters should receive individualized evaluations and treatment plans.

Voluntary Use of Involuntary Civil Proceedings or Administrative Hearings for Juveniles Transferred from Delinquency to Mental Health Institutions

In states where transfer does not require the return to court for a civil mental illness proceeding, such a procedure can nonetheless be initiated. The time and resource requirements necessitated in obtaining this protection for youngsters may be offset by fewer youngsters eligible for transfer under the stricter requirements of mental illness proceedings and by reduced institutional time for transferred youngsters occasioned by periodic court reviews. Short of this, executive agencies would be well served by implementing the opportunity for full administrative hearing upon transfer.

Interagency Agreements

A number of states will find value in negotiating formal interagency agreements that guideline particular responsibilities of the state youth and mental health agencies and incorporate other state agencies in assisting these youngsters. These agreements appear useful in specifying particular agency responsibilities, procedures, criteria, consultations, resolution of disagreements, and interagency relationships with joint programs.

Regulations Relating to Civil and Legal Rights of Youths

It is important to specify and guideline permissible and impermissible procedures relating to the care of confined youngsters. This is critical both to secure fundamental fairness for youngsters while

institutionalized and to direct what staff members must do and must not do. A useful model here is the Massachusetts Department of Mental Health Program Regulations for Regional Adolescent Programs that specifies such rights as communication, visitation, personal possessions and personal space, protections relating to body searches, regulates access to records, and constrains restraint and seclusion.

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