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POST-PARHAM REMEDIES: THE INVOLUNTARY
COMMITMENT OF MINORS IN VIRGINIA AFTER
PARHAM v. J.R.

Willis J. Spaulding*

I. INTRODUCTION

[T]his case raises the most important question of every child's constitutional right to liberty, not only the liberty that includes freedom from bodily restraint [citation omitted], but also the liberty that includes the freedom of an ordinary, every-day child in these United States of America—the freedom to live with mothers, fathers, brothers, and sisters in whatever the family abode may be; the freedom to be loved and to be spanked; the freedom to go in and out the door, to run and play, to laugh and cry, to fight and fuss, to stand up and fall down, to play childish games; the freedom to go to school and to frolic with school mates; to go to Sunday school and church; the freedom to watch and listen or not to watch and listen to television; the freedom to buy candy at the corner store, the freedom to be a normal child in a normal household cared for by normal parents.¹

No court could go further than the three-judge district court in *J.L. v. Parham*² in recognizing the liberty interests of persons under the age of majority,³ and extending to them the full procedural and

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1. *J.L. v. Parham*, 412 F. Supp. 112, 136 (M.D. Ga. 1976), *rev'd sub nom.* *Parham v. J.R.*, 99 S. Ct. 2493 (1979).

2. *Id.*

3. In Georgia the age of majority was eighteen. GA. CODE ANN. § 74-104 (1973). The challenged statute, § 88-503.1, independently specified eighteen as the age under which a person was subject to parental commitment. While § 88-503.1(b) permitted children fourteen years of age and older to admit themselves, only their parents (or the hospital) could discharge them unless they were eighteen or older. This is a striking example of how a person might lose one legal disability of childhood, the inability to consent to treatment, at a different age than another, the inability to refuse treatment. See generally Katz, Schroeder, and Sedman, *Emancipating Our Children—Coming of Legal Age in America*, 7 FAM. L.Q. 211 (1973). Throughout this article "children" or "minors" will be used interchangeably to describe persons under 18, the Virginia age of majority specified by VA. CODE ANN. § 1-13.42(b) (Cum. Supp. 1979).

substantive protection of due process under the fourteenth amendment. The decision struck down a Georgia statute⁴ which had permitted parents or guardians to admit children to state mental hospitals without a pre-admission hearing.⁵ The state was ordered to release children so admitted within 60 days, unless they were recommitted pursuant to an existing juvenile court procedure,⁶ or its equivalent, which afforded the basic procedural due process safeguards of notice, an opportunity to be heard, and counsel.

While seven months earlier another three-judge district court in *Bartley v. Kremens*⁷ had set forth with greater specificity the procedural safeguards which Pennsylvania must afford minors institutionalized or proposed to be institutionalized in mental health and mental retardation facilities, that court did not have occasion to consider substantive due process limitations on the state's authority to confine children in institutions.⁸ By contrast, the district court in *J.L. v. Parham* found in the fourteenth amendment a restriction on state authority which, although this point was to be overlooked in the Supreme Court,⁹ would exist regardless of the procedure followed in committing children. Relying on data provided by the defendants, the district court found that about forty-six of the plaintiff children could be treated in "a less drastic non-hospital environment if such an environment were only available."¹⁰ The district court ordered the defendants to build or otherwise provide such treatment for those children.¹¹ This constituted a major devel-

4. GA. CODE ANN. § 88-503.1 (1979). For comparable statutes in other states see *Parham v. J.R.*, 99 S. Ct. 2493, 2509 n.20; for state-by-state analysis see J. WILSON, *THE RIGHTS OF MINORS IN THE MENTAL HEALTH SYSTEM*, Appendix B (1978). But see *infra* note 14 for decisions overturning or modifying some of these statutes.

5. This form of voluntary entry into a mental hospital will be referred to as a "parental commitment," to distinguish it from a voluntary commitment based on the patient's consent, and an involuntary commitment which generally requires a judicial or administrative order. Such parental commitments are sometimes sought by guardians of adult wards and raise similar constitutional issues. See, e.g., *Pima County Public Fiduciary v. Superior Ct.*, 26 Ariz. Ct. App. 85, 546 P.2d 354 (1976).

6. Provided by GA. CODE ANN. § 24A-2601 (1976).

7. *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded as moot* 431 U.S. 119 (1977), *on remand sub. nom. Institutionalized Juveniles v. Secretary of Public Welfare*, 459 F. Supp. 30 (E.D. Pa. 1977), *rev'd*, 99 S. Ct. 2523 (1979).

8. *Id.* at 1042 n.4.

9. See *Parham v. J.R.*, 99 S. Ct. 2493, 2513 n.23 (1979).

10. *J.L. v. Parham*, 412 F. Supp. at 139.

11. *Id.* Similar results were reached using different rationales in *Halderman v. Pennhurst*,

opment in the doctrine of the "less restrictive alternative" which previously had been interpreted to prohibit a state from confining a person in a mental hospital only if a less restrictive alternative was currently available, rather than possible only with a reallocation of public funds.¹²

The impact of *J.L. v. Parham* and *Bartley v. Kremens* was felt almost immediately in the courts and legislatures of Virginia¹³ and other jurisdictions,¹⁴ and received extensive comment from scholars.¹⁵ The Supreme Court's recent reversal of those decisions in *Parham v. J.R.*¹⁶ and *Secretary of Public Welfare v. Institutionalized Juveniles*¹⁷ can be expected to have no less of an effect, partic-

446 F. Supp. 1295 (E.D. Pa. 1977), and *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

12. See generally Hoffman and Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100 (1977). Hoffman and Foust surveyed Virginia judges confronted with an involuntary commitment statute, VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979), which, like that of most other states, prohibits commitment to a hospital when a less restrictive form of treatment would suffice, but does not indicate whether the court should consider less restrictive alternatives which are appropriate, but presently unavailable. Not surprisingly, a majority of the judges indicated that they would order hospitalization where a less restrictive alternative was appropriate but unavailable, even if they thought hospitalization would present a risk to the defendant. *Id.* at 1128.

13. Discussed *infra* at text accompanying note 29.

14. *Poe v. Califano*, Civ. Act 74-1800 (D.D.C. Sept. 25, 1978); *Kidd v. Schmidt*, 399 F. Supp. 301 (E.D. Wis. 1975); *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974); *Pima County Public Fiduciary v. Superior Court*, 26 Ariz. Ct. App. 85, 546 P.2d 354 (1976); *In re Roger S.*, 19 Cal.3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977); *In re Long*, 25 N.C. App. 702, 214 S.E.2d 626 (1975).

15. A. HOLDER, LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE 256 (1977); J. WILSON, THE RIGHTS OF MINORS IN THE MENTAL HEALTH SYSTEM 193 (1978); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 940 (1974); Hoffman, *The "Due Process" Rights of Minors in Mental Hospitals*, 13 U. OF S.F. L. REV. 63 (1978); Holladay, *Due Process Limitations on Parental Rights to Commit Children to Mental Institutions*, 48 U. COLO. L. REV. 235 (1977); McCarr, *Commitment of Minors to Mental Institutions*, 1978 ANN. SURVEY OF AM. L. 653; Panneton, *Children, Commitment and Consent: A Constitutional Crisis*, 10 FAM. L.Q. 295 (1977); Teitelbaum and Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 FAM. L. Q. 153 (1978); Note, *"Voluntary" Admission of Children to Mental Hospitals: A Conflict of Interest Between Parent and Child*, 36 MD. L. REV. 153 (1976); Note, *Minors' Right to Due Process: Does it Extend to Commitment to Mental Institutions?*, 52 NOTRE DAME LAW. 136 (1976); Note, *The Mental Hospitalization of Children and the Limits of Parental Authority*, 88 YALE L.J. 186 (1958); Comment, *Parents, Children, and the Institutionalization Process, A Constitutional Analysis*, 83 DICK L. REV. 261 (1979).

16. 99 S. Ct. 2493 (1979).

17. 99 S. Ct. 2523 (1979). Since most of the Supreme Court's reasoning is contained within *Parham v. J.R.*, this article will focus primarily on it.

ularly on legislatures which may be tempted to dismantle reforms wrought in response to the district court decisions. In *Parham v. J.R.*, all nine justices agreed that a state could at least initially confine a child in a state hospital at a parent's request, assuming the state employed adequate medical screening procedures.¹⁸ The majority opinion by Chief Justice Burger went further to say that a state agency having custody of a child could also, at least initially, "volunteer" a child into a state hospital without a prior hearing.¹⁹ Justice Stewart, in a concurring opinion, found no state action in, and thus no application of the fourteenth amendment to, either kind of commitment.²⁰ Justice Brennan, in an opinion joined by Justices Marshall and Stevens, agreed that a child could be confined in a hospital without a prior hearing, but argued that the Court ought to have reached the question of the necessity of a hearing for continued confinement, which he would have answered by requiring at least one post-admission hearing.²¹ Justices Brennan, Marshall, and Stevens also dissented from the majority in insisting that, where a state agency rather than a parent was seeking admission of a child in its custody, a pre-admission hearing be provided.²²

This article evaluates the current Virginia procedure for committing children to mental hospitals against the due process standards delineated by the Supreme Court in *Parham v. J.R.*,²³ and its companion case, *Secretary of Public Welfare v. Institutionalized Juveniles*.²⁴ It will be argued that those decisions ought to lead to augmentation, rather than replacement, of existing procedural safeguards with the systematic screening process endorsed by the Supreme Court.²⁵

18. *Parham v. J.R.*, 99 S. Ct. at 2506.

19. *Id.* at 2512.

20. *Id.* at 2515 (Stewart, J., concurring).

21. *Id.* at 2520 (Brennan, J., concurring in part and dissenting in part).

22. *Id.* at 2522.

23. 99 S. Ct. 2493 (1979).

24. 99 S. Ct. 2523 (1979).

25. The Court's paradigm of medical screening is cited in full *infra* at text accompanying note 193.

II. CURRENT VIRGINIA PROCEDURE

A. Informal Voluntary Admission

Virginia statute now provides: "Any hospital may admit as a patient any person requesting admission who, having been examined by a physician on the staff of such hospital, is deemed to be in need of hospitalization for mental illness or mental retardation."²⁶

Until it was revised in 1976,²⁷ this statute also permitted the admission of "[a]ny person under eighteen years of age. . . on the request of the parent or any person standing *in loco parentis* to such infant."²⁸ In the interim period between the General Assembly's passage of House Bill 1256 which repealed this parental admission provision and its effective date, July 1, 1976, parental admissions were enjoined in Virginia by the consent order in *Brown v. Allerton*.²⁹

The State of Georgia argued in *Parham v. J.R.* that without such a provision for admission of minors at the request of parents, a child could not have access to mental health services on a voluntary basis, because they were legally incapable of consenting to treatment.³⁰ The consent order in *Brown v. Allerton*, however, permitted the voluntary admission of children who were determined by the staff to be capable of consenting, had received an explanation of the nature of the admission and their right to object, and who in fact had given a voluntary consent.³¹

While this order was in effect only from April 19, 1976, until July 1, 1976, its guidelines for the informal voluntary admission of minors were adopted by the Virginia Department of Mental Health and Mental Retardation almost verbatim as a departmental instruction governing practices in its facilities. Like the final order in *Brown v. Allerton*, Departmental Instruction No. 60 is based on the premise that "[t]he age of a minor does not control his ability to give informed consent to his voluntary admission."³² Unlike the

26. VA. CODE ANN. § 37.1-65 (Repl. Vol. 1976).

27. 1976 Va. Acts ch. 671, at 978.

28. VA. CODE ANN. § 37.1-65 (1972).

29. Civ. No. 75-0450-R (E.D. Va. April 19, 1976).

30. Jurisdictional Statement of Appellants at 18, *Parham v. J.R.*, 99 S. Ct. 2493 (1979).

31. Civ. No. 75-0450-R (E.D. Va. April 19, 1976).

32. Departmental Instruction No. 60 of the Virginia Department of Mental Health and Mental Retardation at 1 (January 22, 1979).

order, however, Departmental Instruction No. 60 requires facilities to obtain the consent of the parent or guardian to admission of a minor even where the minor has given informed consent. This additional requirement is at odds with the Department's position that some minors on their own can give valid, informed consent to inpatient admission.³³

Presumably, if a parent withholds consent to inpatient mental health treatment sought by a minor who is willing and capable of giving informed consent, and is in need of treatment, and the hospital adheres to current departmental policy, the minor would be forced to seek from a juvenile and domestic relations district court either a protective order based on a finding of neglect,³⁴ or a judicial consent in lieu of parental consent.³⁵

Minors in the custody of state agencies may also seek informal voluntary admission under section 37.1-65, except to such facilities, known as treatment centers, as the Virginia Treatment Center for Children in Richmond. Admission to treatment centers is limited by statute to children under the age of sixteen. Children in the custody

33. If age does not affect ability to consent, then the Department might with equal justification require the parental consent to the voluntary admission of adults. Departmental policy on this point is unlikely to change in light of the Joint Commission on Accreditation of Hospitals (JCAH) Consolidated Standard 10.5.1, discussed briefly *infra* at note 102, which presently requires for the voluntary admission of a child over 12 years of age both the patient's and the parent's informed consent.

34. The court may order treatment without evidence of neglect under VA. CODE ANN. § 16.1-275 (Cum. Supp. 1979), discussed at note 90 *infra* and accompanying text. A preliminary, *ex parte* proceeding to obtain treatment services might be made under § 16.1-253 (A)(2) (Cum. Supp. 1979). An order requiring both parents and, for example, a community mental health clinic, to provide services for a child found to be neglected might be entered under § 16.1-279(1) and (2) (Cum. Supp. 1979). A "neglected child" is defined by statute in Virginia to mean "any child whose parents or other person responsible for his care . . . [n]eglects or refuses to provide care necessary for his health . . ." VA. CODE ANN. § 16.1-228(A) (Cum. Supp. 1979). Since under this definition it is possible that a child in a state hospital who does not receive "care necessary for his health" might be neglected, neglect proceedings might be initiated by anyone, including the child, usually by making a complaint to the local Department of Welfare office, to terminate mental health services as well as to obtain them.

35. Other than by those procedures referred to in note 34 *supra*, the court has authority to give consent to treatment for a minor "separated from the custody of his parents" or where the parent cannot be consulted with reasonable promptness. VA. CODE ANN. § 54-325.2 (Cum. Supp. 1979). But § 16.1-241(D) (iv) (Cum. Supp. 1979) expands this authority, at least with respect to emergency treatment, to empower the court to give consent as well where a parent "fails to give such consent or provide such treatment when requested by the judge to do so."

of state agencies must be admitted to treatment centers through the commitment process, on either a formal voluntary or involuntary basis.³⁶

The current Code of Virginia, which explicitly provides that, for the purposes of obtaining outpatient mental health care, a minor is deemed to be an adult,³⁷ and requires the same involuntary commitment procedure to be followed for both minors and adults,³⁸ offers no support for the present insistence in Departmental Instruction No. 60 on parental consent to the informal voluntary admission of minors. This requirement may be attributed to a traditional deference to the rights of parents who, regardless of the admission status of the child, may be financially responsible for all or part of the cost of care and treatment, at least for the first five years of institutionalization.³⁹

If the admission is necessary to provide an appropriate education for the child, then it must be provided without cost to the parent or the child.⁴⁰ This would also be true if an appropriate education required admission to a private facility.⁴¹ While in cases of informal, voluntary admissions of children, the issue of educational necessity

36. VA. CODE ANN. § 37.1-61 (Repl. Vol. 1976).

37. VA. CODE ANN. § 54.325.2(D)(4) (Cum. Supp. 1979). For a discussion of this provision, see, Comment, 13 U. RICH. L. REV. 915 (1979).

38. VA. CODE ANN. § 16.1-241(B) (Cum. Supp. 1979).

39. VA. CODE ANN. § 37.1-105 (Repl. Vol. 1976) (regarding state hospital services only). The juvenile and domestic relations district court has even broader power under § 16.1-275 to compel parents to pay for any treatment of the child: nonpayment may be punished as contempt or nonsupport.

40. VA. CODE ANN. § 22-10.5 (Cum. Supp. 1979). Both state and federal law define "seriously emotionally disturbed" rather than "mentally ill" children as handicapped and thus entitled to a free and appropriate education at public expense. VA. CODE ANN. § 22-10.3 (Cum. Supp. 1979); 20 U.S.C. § 1401(1) (1970).

41. VA. CODE ANN. § 22-10.8(a) (Cum. Supp. 1979). Federal regulations require states receiving federal assistance to pay for all costs of residential placement "including non-medical care and room and board," as well as education, if the placement is necessitated for whatever reason by the child's handicap, regardless of educational considerations. 45 C.F.R. § 84.33(c)(3) (1977). Appendix A to this regulation explains: "When residential care is necessitated not by the student's handicap but by factors such as the student's home conditions, the recipient [the state receiving funds] is not required to pay the cost of room and board."

Nonetheless, some courts have read this regulation to impose liability on the state for all costs of residential placement only when the placement is "for the purpose of providing . . . a free and appropriate public education," rather than meeting other needs occasioned by the child's handicap. See, e.g., *Guempel v. State*, 159 N.J. Super. 166, 387 A.2d 399, 408 (1978).

primarily raises questions about financial responsibility for the cost of care and treatment, in formal voluntary admissions and involuntary commitments, it raises more serious questions about the denial of due process, since those procedures also ignore educational considerations.⁴²

B. *Formal Voluntary Admission*

Formal voluntary admissions are not truly voluntary.⁴³ They are a consequence of someone other than the patient obtaining, after a hearing before a judge,⁴⁴ a consent order, under section 37.1-67.2,

42. The state board of education must "prescribe procedures to afford due process to handicapped children and their parents or guardians and to school divisions in resolving disputes as to program placement, individualized education program, tuition eligibility and other matters as defined in state and federal law or regulations." VA. CODE ANN. § 22-10.4(B) (Cum. Supp. 1979); see also 20 U.S.C. § 1415 (1976). These state and federal statutes give "any party aggrieved" by those proceedings a right to be heard, as was required in *Mills v. Board of Education of District of Columbia*, 348 F. Supp. 866 (D.D.C. 1972). Although presently the state provides notice and hearing only to the parents, or in their absence, a surrogate, and not the child, the statutes clearly intend procedural protection for the child as well. Thus a commitment of a child to a state hospital, even on petition of the parent, which ignores the child's loss of educational opportunity, denies the procedural protection required by this statute to the child, and perhaps also to the board of education, which has an affirmative duty to provide a free and appropriate education to the child, a duty which cannot be waived by the parent.

Both J. L. (who died while the case was pending review by the Supreme Court) and J. R., the plaintiff class representatives, had been expelled from school prior to hospitalization because they were "uncontrollable" or "disruptive and incorrigible." *Parham v. J.R.*, 99 S. Ct. 2493, 2497-98 (1979). Such expulsions today would probably violate the educational rights of a mentally ill child, see *Stuart v. Nappi*, 443 F. Supp. 1235 (D. Conn. 1978), and provide a basis for seeking deinstitutionalization independent from those relied on in *J.L. v. Parham*.

43. See note 5 *supra*.

44. In cases involving adults, the judge may be either a regular or substitute general district court judge, or he may be an attorney appointed by the senior circuit court judge to serve as a "special justice," who may order temporary detention orders under § 37.1-67.1 (Repl. Vol. 1976), formal voluntary admission under § 37.1-67.2 (Cum. Supp. 1979), or involuntary commitment under § 37.1-67.3 (Cum. Supp. 1979). VA. CODE ANN. § 37.1-10(11) (Cum. Supp. 1979). A special justice receives no fee for issuing or refusing to issue a temporary detention order, but if he does issue one, he can expect to preside over at least a preliminary hearing, for which he will receive \$25.00, and, if in that preliminary hearing he finds the defendant unwilling or unable to seek voluntary admission, he will preside over the involuntary commitment hearing, for which he will receive an additional \$25.00. VA. CODE ANN. § 37.1-89 (Repl. Vol. 1976). This raises questions about the impartiality of a special justice who issues a temporary detention order, resulting in the defendant's seizure, or who denies a defendant an opportunity to seek voluntary admission. See *Ward v. Village of Monroeville*, 409 U.S. 57 (1972). Where a defendant is a minor, orders under §§ 37.1-65.1, 37.1-67.1, 37.1-67.2, or 37.1-67.3 must be issued by a juvenile and domestic relations district court judge. VA. CODE ANN. § 16.1-241(B) (Cum. Supp. 1979).

enforcing the agreement of the patient to a minimum period of treatment for mental illness. This "voluntary" procedure is in sharp contrast with that provided under section 37.1-65.1 for the "voluntary" admission of mentally retarded persons who are found incapable of consenting to treatment.

This latter procedure, known as "judicial certification of eligibility for admission," is worth examining here, since it contains procedural and substantive safeguards which are missing from the formal voluntary admission procedure to mental health facilities.⁴⁵

Section 37.1-65.1 authorizes the court to empower a parent or guardian or any "responsible person" to admit someone to a facility for the mentally retarded for an indefinite period of time. This is not an involuntary commitment only because the order does not compel admission but simply authorizes the parents or someone else to sign the mentally retarded person into the institution, if they so desire. If they had not decided on institutionalization, they would not be before the court in the first place, so the effect is the same as an involuntary commitment.

To certify a mentally retarded person as eligible for admission the court must provide that person with roughly the same procedural rights as in the commitment of the mentally ill, including a right to notice, a hearing, and an opportunity to present witnesses and cross-examine adverse witnesses.⁴⁶ There is a right to appeal certification within thirty days of the order in a trial *de novo*, before a jury, if the defendant requests one. The appeal is heard in the circuit court in the jurisdiction either where the certification was made, or where the mental retardation facility to which the defendant was admitted is located.⁴⁷

45. The judicial certification procedure in § 37.1-65.1 replaced, at least for mentally retarded children, the parental commitment authorized by § 37.1-65 until its revision in 1976. The Board of Mental Health and Mental Retardation has the authority, which it has yet to exercise, to issue regulations permitting the judicial certification procedure to be avoided for short term emergency or respite admission of the mentally retarded. VA. CODE ANN. § 37.1-65.2 (Cum. Supp. 1979).

46. VA. CODE ANN. § 37.1-65.1 (Cum. Supp. 1979). But this statute in effect allows the defense attorney to waive the defendant's right to be present at the hearing, and to waive the right to cross-examine the court-appointed expert witness.

47. VA. CODE ANN. § 37.1-67.6 (Cum. Supp. 1979).

The substantive requirements for certification are:

- (i) that such person is not capable of requesting his own admission,
- (ii) that the facility has approved the proposed admission. . . ,
- (iii) that there is no less restrictive alternative to institutional confinement, consistent with the best interests of the [defendant],
- (iv) that [the defendant] is mentally retarded and in need of institutional training or treatment. . .⁴⁸

The court appoints a physician or clinical psychologist to testify as to (i) and (iv), and for (ii) depends on the state facility, whose refusal to approve admission may be appealed administratively but is not reviewed by the court hearing the issue of certification. While the statute apparently places the burden of proving (iii) on the petitioner, the court is not directed to appoint an expert on this issue, or otherwise investigate alternatives to institutionalization.⁴⁹ The court is not required to consider the educational needs of the defendant, so it is entirely possible that the educational propriety of institutionalizing a child will be considered, if ever, only when the state seeks reimbursement from the parents.⁵⁰

By contrast, the formal voluntary admission of the mentally ill child under section 37.1-67.2 is for a finite period of time and requires a judicial determination that the child, in addition to being willing to seek voluntary admission on the terms offered by the court,⁵¹ is capable of giving consent to such admission. While Departmental Instruction No. 60⁵² certainly permits state facilities to accept formal voluntary admissions of minors under section 37.1-67.2, it is conceivable that some Virginia courts, without statutory or precedential guidance, might find minors incapable of seeking voluntary admission solely because of age. This is perhaps less likely to occur now that juvenile and domestic relations district courts

48. VA. CODE ANN. § 37.1-65.1(C)(3) (Cum. Supp. 1979).

49. The defendant may at his own expense call expert witnesses on this point. VA. CODE ANN. § 37.1-65.1(C)(2) (Cum. Supp. 1979).

50. See note 42 *supra*.

51. The only terms explicitly authorized by statute are hospitalization for a period not to exceed two days and seventy-two hour notice to the hospital by the patient of intention to leave. It is conceivable, however, that a defendant who agreed to accept those conditions, but who otherwise seemed uncooperative, might nonetheless be found "unwilling."

52. See notes 32 & 33 *supra* and accompanying text.

have been given exclusive original jurisdiction of both the certification of mentally retarded minors and commitment, including formal voluntary admission, of mentally ill minors.⁵³

The formal voluntary admission of a mentally ill minor begins with the temporary detention order, authorized by section 37.1-67.1. This is issued by a juvenile and domestic relations district court judge rather than by a magistrate. The judge must have probable cause to believe that the child is "mentally ill and in need of hospitalization."⁵⁴ He may base this finding either upon a sworn petition or upon his own motion.⁵⁵

This order permits detention for forty-eight hours, or if that period terminates on a weekend or holiday, seventy-two hours. It also authorizes the institution holding the defendant to render whatever emergency medical and psychiatric services it determines are in the best interests of the defendant.⁵⁶

Section 37.1-67.1 permits the judge to release the defendant prior to the expiration of the order if the judge finds "from all evidence readily available that such release will not pose an imminent danger to [the defendant] or others" and the defendant agrees to appear.

But whether the defendant is detained or released prior to the hearing, the current statutory language requires both the preliminary hearing described in section 37.1-67.2 and, if necessary, the involuntary commitment hearing under section 37.1-67.3, to be held within the forty-eight or seventy-two hour period, beginning with the execution of the temporary detention order. Furthermore, although section 37.1-67.3 gives the defendant the right to "an opportunity to prepare any defenses he may have," it does not specifically give him a right to a continuance or authorize hearings beyond the

53. VA. CODE ANN. § 16.1-241(B) (Cum. Supp. 1979).

54. VA. CODE ANN. § 37.1-67.1 (Repl. Vol. 1976). "Mentally ill" is defined as "any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment . . ." § 37.1-1(15). The subject of a temporary detention order must not only need care and treatment, but a particular kind of care and treatment, hospitalization.

55. VA. CODE ANN. § 37.1-67.1 (Repl. Vol. 1976). Some Virginia judges have refused to issue temporary detention orders on their own motions, because they believe this disqualifies them from, in effect, hearing that motion in a hearing under § 37.1-67.3.

56. VA. CODE ANN. § 37.1-67.4 (Repl. Vol. 1976).

forty-eight or seventy-two hour period beginning with the execution of the temporary detention order.

It is in the preliminary hearing that formal voluntary admission may occur, if the defendant is willing and capable of consenting to voluntary admission on the terms offered by the judge. The judge need not appoint an examining physician until the involuntary commitment hearing. There is no statutory requirement that counsel be appointed for unrepresented defendants in the preliminary hearing, although at least prior to *Parham v. J.R.*,⁵⁷ it was assumed that the Constitution required appointed counsel, since the preliminary hearing was a critical stage in the proceedings.⁵⁸ If the judge does appoint counsel for an unrepresented defendant, section 37.1-89 contemplates paying the attorney twenty-five dollars for the preliminary hearing as well as twenty-five dollars for the voluntary commitment hearing.

It is therefore possible under section 37.1-67.2 that the formal voluntary admission of a minor might occur without the benefit of counsel or a court-appointed physician. Furthermore, no showing is necessary that the state hospital has accepted the child, that there are no less restrictive alternatives to the state hospital, or that his educational rights are not in jeopardy. The possibility that the state hospital will turn away the defendant after an order of formal voluntary admission under section 37.1-67.2 may incline the court to proceed to an involuntary commitment. If the defendant wishes to contest the allegations of mental illness, dangerousness or inability to care for himself, or if he desires non-hospital treatment, he must decline formal voluntary admission and take his chances in the involuntary commitment hearing under section 37.1-67.3.

The formal voluntary admission under section 37.1-67.2, requires the defendant both to accept a "minimum period of treatment . . . not to exceed seventy-two hours," and thereafter to "give the hospital at least forty-eight hours notice prior to leaving the hospital," unless the hospital itself discharges him earlier.

57. 99 S. Ct. 2493 (1979).

58. See, e.g., *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968) (civil commitment of nine-year-old to state facility for mentally retarded required defense counsel at every step of the proceedings).

It is not at all clear what recourse the court or the hospital has if the defendant disregards the conditions of his admission. The only certain authority the hospital staff has is to seek a temporary detention order under section 37.1-67.1, beginning the commitment process anew. This is also the staff's sole remedy if it wants to detain the defendant beyond the minimum period ordered and after proper notice by the defendant.

Whether the child enters the hospital through an informal voluntary admission under section 37.1-65, or through a formal voluntary admission under section 37.1-67.2, he has the unconditional right to refuse psychotropic medication. If the staff wants to provide such treatment over the child's protests, it must obtain a temporary detention order and seek involuntary commitment.⁵⁹

C. *Involuntary Commitment*

If the judge finds the defendant lacks either the capacity or willingness to seek formal voluntary admission, he proceeds, usually without delay, to an involuntary commitment hearing authorized by 37.1-67.3, at which stage he must appoint a physician⁶⁰ and, if the defendant is unrepresented, a defense attorney.⁶¹ Often the preliminary hearing under section 37.1-67.2 and the involuntary commitment hearing under section 37.1-67.3 are consolidated into one hearing.⁶² The procedural requirements for the involuntary commitment hearing are the same as those of the certification hearing.⁶³

Substantively, section 37.1-67.3 requires the judge, after observing the defendant, obtaining a "positive certification"⁶⁴ from the court-appointed physician, and considering all other relevant

59. This is one indication of the way in which the patient's liberty is impaired by involuntary commitment.

60. VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979) requires only that the court appoint a physician "who is licensed in Virginia and who is skilled in the diagnosis of mental illness." It does not require that the physician be a board-certified psychiatrist, or even a physician who holds himself out to the public as a psychiatrist.

61. Appointment of both the physician and the defense attorney is left entirely to the discretion of the judge who may appoint the same individuals in case after case.

62. Practice varies from judge to judge as to whether a payment voucher is submitted to the Department of Mental Health and Mental Retardation for a \$25.00 or \$50.00 fee each for both the defense attorney and the special justice for such a "combined" hearing.

63. See note 48 *supra* and accompanying text.

64. See note 72 *infra* and accompanying text.

evidence in a full adversarial hearing, to specifically find that the defendant:

- a) presents an imminent danger to himself or others as a result of mental illness,⁶⁵ or
- b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself,⁶⁶ and
- c) that there is no less restrictive alternative to institutional confinement and treatment and that alternatives to institutional hospitalization were deemed not suitable.⁶⁷

The court is required to find by clear and convincing evidence⁶⁸ either a) and c), or b) and c), in order to justify a commitment to the state hospital. If the court finds a) or b), but does not find c), that is, if the absence of a less restrictive alternative is not proved, the court's authority is limited to ordering "out-patient treatment, day treatment in a hospital, referral to a community mental health clinic, or other such appropriate treatment modalities as may be necessary to meet the needs of the individual."⁶⁹

There is no provision in section 37.1-67.3 that permits the court to retain jurisdiction over a defendant who is ordered, but does not seek, out-patient treatment, so that short of judicially-innovated remedies,⁷⁰ the adult defendant can only be brought before the court again on a new temporary detention order issued under section 37.1-67.1. Similarly, the court is given no authority in section 37.1-67.3

65. The distinctly different problems of defining and predicting danger to self or others have generated a large volume of literature. See, e.g., DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH (C. Frederick ed. 1978); S. PFOHL, PREDICTING DANGEROUSNESS (1978).

66. This vague catch-all criterion is based entirely on the state's *parens patriae* power, and is distinguished from that of dangerousness to self, by exclusion of the suicidal. The only real limitation on commitments based on this criterion is the requirement that there be no less restrictive alternative.

67. See note 12 *supra* and accompanying text.

68. *Addington v. Texas*, 99 S. Ct. 1804 (1979). What difference this standard of proof makes with a statute which permits great judicial freedom in interpreting such words as "imminent danger," "substantially unable," and "not suitable" is questionable, as the Supreme Court recognized.

69. VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979).

70. Such as a commitment hearing that is adjourned or continued for a period of treatment, or a commitment to the state hospital with the provision that the defendant be furloughed to a community program.

to modify its order committing the defendant to a state hospital when an alternative to hospitalization later becomes available because of a reduced waiting list at a community mental health clinic, the control of the defendant's symptoms by psychotropic medication, or the like. Where the defendant is a minor, however, the court may retain jurisdiction over the defendant under section 16.1-242,⁷¹ and make modifications in the commitment order as circumstances change.

The court-appointed physician is required by section 37.1-67.3 to examine the defendant and certify that he has probable cause to believe that "he is or is not mentally ill . . . does or does not present an imminent danger to himself or others, and requires or does not require involuntary hospitalization." A "positive certification" by the court-appointed physician is made a necessary condition of a commitment order by section 37.1-67.3. Just what is meant by a "positive certification" is not apparent from the Code, but presumably it includes a probable cause determination of mental illness and a need for voluntary hospitalization, but not necessarily dangerousness.⁷²

As in the certification procedure for mentally retarded persons,⁷³ current statutory language does not allocate responsibility for investigating less restrictive alternatives. The burden is clearly not on the defendant to establish that there is a less restrictive alternative,⁷⁴ although his counsel just as clearly has an ethical duty to explore those alternatives.⁷⁵ The Code also fails to require the court to assess

71. VA. CODE ANN. § 16.1-242 (Cum. Supp. 1979).

72. If a positive certification of "dangerousness" were required, the court could not commit a person on the grounds that he was unable to care for himself because of mental illness. It is also possible to read the statute to require only that the physician's certification makes probable cause findings one way or the other on the issues of mental illness, dangerousness, or need for hospitalization, although if the physician were in this sense "positive" that, for example, the defendant was not mentally ill, there would be no expert evidence to support an order of involuntary commitment.

73. VA. CODE ANN. § 37.1-65.1 (Cum. Supp. 1979), discussed at notes 45 & 46 *supra* and accompanying text.

74. See, Hoffman and Foust, *supra* n.12, at 1109.

75. In at least one state such an investigation is required by statute. See ARIZ. REV. STAT. ANN. § 36-537 (1974). Neither VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979) nor the VA. CODE OF PROFESSIONAL RESPONSIBILITY II:EC:7-12 gives the defense attorney much guidance as to when in a commitment hearing the attorney may begin to act as a guardian *ad litem* and advocate what the attorney thinks is best for the client, rather than what the client thinks is

the adverse educational impact of institutionalization on the child, but defense counsel might nonetheless raise the issue.⁷⁶

While section 37.1-67.3 permits the court to order treatment in, for example, a community mental health clinic, it does not require the court to consult with that clinic prior to deciding whether treatment is or is not available and appropriate. Even where the defendant is a child, and the juvenile and domestic relations district court can order a clinic operated by a community mental health and mental retardation services board⁷⁷ to provide services to the defendant (in addition to ordering the defendant to seek them), the clinic is entitled to prior notice and hearing.⁷⁸

No time limitation is placed on an order directing out-patient therapy, or some other treatment modality less restrictive than institutional confinement. The order of commitment to a hospital, in contrast, may not authorize confinement for longer than 180 days, after which the defendant must be served with a new temporary detention order or released.⁷⁹ The commitment order, it is important

best. However, either as attorney or guardian *ad litem*, an investigation of less restrictive alternatives is mandatory. See generally Slobogin, *The Role of the Attorney in Civil Commitment*, U. RICH. MENTAL HEALTH LEGAL STUDIES NEWSLETTER (March 1979).

76. See note 42 *supra*.

77. VA. CODE ANN. § 37.1-194 (Cum. Supp. 1979) permits the state to make the matching grants to cities and counties to establish and operate local mental health and mental retardation programs. These programs are directed by boards of from five to fifteen members appointed by local government. VA. CODE ANN. § 37.1-195 (Cum. Supp. 1979). (The boards authorized by Chapter 10 of Title 37.1 are commonly referred to as "Chapter 10 Boards.") These programs follow the model of the "community mental health center" set forth in § 201 of the Community Mental Health Center Act, 42 U.S.C. § 2689 (1976 & Supp. 1979) (amended 1978), and while the entire state is served by Chapter 10 programs, not all of them receive federal funds. While both state and federal programs require services to courts, absent a specific agreement between the court and the Chapter 10 Board, a court-ordered evaluation or treatment could be refused, or at least denied preference over other prospective clients on a waiting list.

78. To the extent that a specific contract with the court, Chapter 10 policy, or the fee schedule, requires a program to provide court-ordered evaluation or treatment, VA. CODE ANN. § 16.1-278 (Cum. Supp. 1979) still entitles the program to notice and opportunity to be heard before a juvenile and domestic relations district court issues an order compelling the provision of such evaluation or services.

79. VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979). Recommitment will usually occur in a hearing held on the hospital grounds, often a great distance from the defendant's home. The physician appointed by the judge is usually on the staff of the hospital. Under such circumstances, it is even less likely that community alternatives to institutional confinement will

to note, only fixes a maximum period of confinement, and does not usually limit the hospital director's discretion to release the defendant earlier.⁸⁰ After the commitment order is entered, the defendant is taken to the state hospital. Prior to formal admission and within twenty-four hours, he must be screened by a physician to determine whether there is "sufficient cause to believe . . . [he] is mentally ill," the only condition of admission after an involuntary commitment.⁸¹

Once an involuntarily committed patient is admitted, however, the hospital director may unconditionally release him if he determines that the patient is "recovered," "not mentally ill," or that his "discharge . . . will not be detrimental to the public welfare, or injurious to the patient."⁸² The director also has broad authority to grant convalescent leave to a patient who does not meet the statutory criteria for unconditional discharge.⁸³

Although the State Board of Mental Health and Mental Retardation is authorized "to develop and institute pre-admission screening to prevent inappropriate admissions to the facilities and programs under its control,"⁸⁴ it has not yet done so. Such regulations might require, as a condition of admission after a commitment order, that the parent obtain the approval of the state hospital or the local school board prior to obtaining a temporary detention order. Or these regulations might require the judge to order commitments initially to a local mental health center, and permit state hospital admission only by referral. Neither sort of regulation would be entirely consistent with existing statutory language,⁸⁵ so that it is diffi-

receive proper consideration, since neither the judge, physician, nor appointed counsel will have contacts with the defendant's community.

80. Of course the director lacks such discretion to release patients, usually confined to forensic units, who are being held for a mental status evaluation prior to criminal trial pursuant to VA. CODE ANN. § 19.2-169 (Repl. Vol. 1975), after an acquittal by reason of insanity pursuant to VA. CODE ANN. § 19.2-181 (Cum. Supp. 1979), or transfer after civil commitment from the correctional system, or who are subject to virtually any judicial order other than one under VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979).

81. VA. CODE ANN. § 37.1-70 (Repl. Vol. 1976).

82. VA. CODE ANN. § 37.1-98 (Cum. Supp. 1979).

83. VA. CODE ANN. § 37.1-98(d) (Cum. Supp. 1979); § 37.1-126 (Repl. Vol. 1976).

84. VA. CODE ANN. § 37.1-70 (Repl. Vol. 1976).

85. Such mandatory screening regulations would limit the power of judges and deny access to judges by petitioners contrary to the provisions of VA. CODE ANN. §§ 37.1-67.1 (Repl. Vol. 1976), 37.1-67.2 (Cum. Supp. 1979), and 37.1-67.3 (Cum. Supp. 1979).

cult to see how effective mandatory pre-admission screening could be implemented without statutory amendment.⁸⁶

The juvenile and domestic relations district court in Virginia, with its exclusive original jurisdiction over the commitment of mentally ill children and certification of mentally retarded children, must adhere to the same procedures established for the commitment and certification of adults in Title 37.1,⁸⁷ even after the court has adjudicated a child "delinquent" or "in need of services."⁸⁸ In apparent contradiction to this restriction on the court, section 16.1-275 gives the court almost unlimited discretion to order that a child be subjected to mental health examination and treatment by a local mental health center,⁸⁹ or if that is not available, by any physician, or clinical psychologist (the latter being permitted to only examine the child). Solely on the basis of a physician's written recommendation, the court may summarily send a child to a state mental hospital for up to thirty days "for the purpose of obtaining a recommendation for the treatment of the child."⁹⁰ While the primary purpose of this thirty day commitment is evaluation, physician-directed treatment would also seem to be permitted. Unlike an involuntary commitment, the hospital probably may not release the child prior to the expiration of the thirty days or whatever lesser period the court has ordered without prior court approval.⁹¹

An order of involuntary commitment may be appealed to a circuit court within thirty days.⁹² Additionally state habeas corpus relief may be sought at any time by an involuntarily committed patient who cannot informally persuade the director to release him prior to the expiration of the commitment order.⁹³

86. Such an amendment is proposed *infra* at notes 222-230 and accompanying text.

87. VA. CODE ANN. § 16.1-241 (Cum. Supp. 1979).

88. VA. CODE ANN. § 16.1-280 (Cum. Supp. 1979).

89. By "local mental health center," this statute apparently means a Chapter 10 mental health program, which is intended to be consulted first by the court. *See note 77 supra*.

90. VA. CODE ANN. § 16.1-275 (Cum. Supp. 1979).

91. If the court intended to make the state hospital's cooperation mandatory, however, VA. CODE ANN. § 16.1-278 (Cum. Supp. 1979) would require prior notice and an opportunity to be heard.

92. VA. CODE ANN. § 37.1-67.6 (Cum. Supp. 1979).

93. VA. CODE ANN. § 37.1-103 (Repl. Vol. 1976).

D. *Rights of Children in State Hospitals*

Admission to a state hospital, whether on an informal or formal voluntary basis, or on an order of involuntary commitment, does not, in Virginia, raise a presumption of legal incapacity or incompetency.⁹⁴ In theory, then, the patient should retain all of his legal rights unless he is subsequently adjudicated incompetent,⁹⁵ except that patients admitted on an involuntary commitment order may be arrested if they "escape."⁹⁶ In reality, however, a patient gains some rights and loses others after admission. Particularly where the patient is a child, the exercise of those rights may also be impaired or enhanced by the staff, depending on their widely varying perceptions of those rights.⁹⁷

94. VA. CODE ANN. § 37.1-87 (Repl. Vol. 1976).

95. VA. CODE ANN. § 37.1-128.02 (Repl. Vol. 1976) sets forth the procedure for determining "legal incompetency." Sections 37.1-128.1 and 37.1-132 (Repl. Vol. 1976) establish alternative procedures to create partial guardianships for persons "incapacitated" by mental disability or impaired health, respectively.

96. VA. CODE ANN. § 37.1-76 (Repl. Vol. 1976).

97. In February, 1979, the author surveyed 452 Chapter 10 Board-employed mental health professionals. Their responses to a question regarding the rights of children suggest their deference to those rights during treatment of children: Under present Virginia law, a mentally ill juvenile

	No. of responses	% of responses
(1) has the same rights as any other juvenile	86	20.6
(2) has the same rights as a mentally ill adult	37	8.9
(3) has the same rights as any adult		2.4
(4) must legally obey the wishes of his or her parents or anyone standing in the place of a parent	29	7.0
(5) may be involuntarily committed by a judge, if the parents do not object to the hospitalization	28	6.7
(6) Both (4) and (5) are true.	136	32.6
(7) (1), (2), and (3) are true.	91	21.8

In *Wyatt v. Stickney*,⁹⁸ patients involuntarily committed to Alabama's Bryce Hospital, once in the hospital, were determined to have certain specific rights protected by the United States Constitution.⁹⁹ Many states, such as Virginia, subsequently enacted statutory "bills of rights" for patients in state mental hospitals and residents in state mental retardation facilities which closely tracked Judge Johnson's findings in *Wyatt v. Stickney*. Thus, it has been often unnecessary, for example, for a court to determine whether there is a constitutional right, once admitted to a hospital, to treatment in the least restrictive setting, since there is a clear statutory right to treatment.¹⁰⁰

While the *Wyatt* opinion concerned itself with involuntarily confined patients in state hospitals,¹⁰¹ the Virginia statutory "bill of rights" applies to patients or residents regardless of their status in any facilities "operated, funded, or licensed by the Department of Mental Health and Mental Retardation," and does not on its face make any distinction between patients because of minority.¹⁰²

A child in a state hospital would therefore be entitled on the same basis as an adult to "[b]e treated under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation."¹⁰³ As in the involuntary com-

98. 325 F. Supp. 781, 784 (M.D. Ala. 1971). See also 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), and 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

99. 344 F. Supp. at 379-86 ("minimum constitutional standards for adequate treatment of the mentally ill"); 344 F. Supp. at 395-407 ("minimum constitutional standards for adequate habilitation of the mentally retarded").

100. See, e.g., *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

101. The class of plaintiffs was originally comprised of all persons involuntarily confined for mental treatment in Alabama's Bryce Hospital. The class was later enlarged to include involuntary patients at Searcy Hospital and at Partlow State School and Hospital for the mentally retarded, both in Alabama. 344 F. Supp. at 374. Voluntarily admitted patients might also be in a position to complain about a denial of equal protection if similar benefits were not extended to them.

102. By contrast, some states, such as North Carolina, specifically enumerate by statute the rights of minors in state hospitals. See N.C. GEN. STAT. § 122-55.14 (Cum. Supp. 1977). To be accredited by the Joint Commission on Accreditation of Hospitals (JCAH), and thus eligible for Medicaid reimbursement for services to children, the facility must accord children over the age of 12 an elaborate array of "patient rights," although generally the parents or guardians of all children and adolescents must also give informed consent to most aspects of treatment. JCAH CONSOLIDATED STANDARDS FOR CHILD, ADOLESCENT, AND ADULT PSYCHIATRIC, ALCOHOLISM, AND DRUG ABUSE PROGRAMS 31 (April 1979).

mitment procedure itself, there is a question here whether the right compels the state to create less restrictive conditions where none exist, or permits the state to resort to the least restrictive setting currently available.¹⁰⁴

Similarly, the patient, adult or child, is guaranteed "prompt evaluation and treatment or training about which he is informed insofar as he is capable of understanding." These so-called rights to treatment are gained once a person becomes a patient, but by their very wording suggest the loss of another right, the right to be subjected to treatment only after informed consent.¹⁰⁵ It is on this point that the existing statutes,¹⁰⁶ regulations implementing the statutory "bill of rights,"¹⁰⁷ and departmental instructions,¹⁰⁸ make a clumsy attempt to distinguish between the consent required from adults and minor patients, and between the consent required for psychiatric and non-psychiatric treatment.

The Virginia statutory "bill of rights" of patients and residents, despite its assurance that all state and federal legal rights are retained after admission,¹⁰⁹ only gives patients a limited right to be informed about treatment,¹¹⁰ only requires informed consent to experimental or investigational research, and permits even this consent to be given by a surrogate.¹¹¹ A patient subject to "hazardous treatment or irreversible surgical procedures" may have "upon request, [a prior] impartial review," which may be dispensed with

103. VA. CODE ANN. § 37.1-84.1(6) (Repl. Vol. 1976).

104. See note 12 *supra*.

105. Violations of this right are redressed in Virginia by actions in negligence requiring expert testimony as to the nature of the consent that would be obtained by a reasonable practitioner. *Bly v. Rhoads*, 216 Va. 645, 650-51, 222 S.E.2d 783, 788 (1976). Such action at the election of either party must be preceded by screening by a medical malpractice review panel. VA. CODE ANN. § 8.01-581.12 (Repl. Vol. 1977). See generally Stone, *Informed Consent: Special Problems for Psychiatry*, 30 HOSP. & COMM. PSYCHIATRY 321 (1979).

106. VA. CODE ANN. §§ 37.1-84.1 (Repl. Vol. 1976) and 54-325.2 (Cum. Supp. 1979).

107. Rules and Regulations to Assure the Rights of Patients and Residents of Hospitals and Other Facilities Operated By the [Virginia] Department of Mental Health and Mental Retardation (April 15, 1978) (hereinafter "Patient's Rights Regulations").

108. Departmental Instruction No. 60 [admission of minor] and No. 55 [refusal of treatment] of the Virginia Department of Mental Health and Mental Retardation (January 22, 1979 and August 8, 1978, respectively).

109. VA. CODE ANN. § 37.1-84.1(1) (Repl. Vol. 1976).

110. VA. CODE ANN. § 37.1-84.1(2) (Repl. Vol. 1976).

111. VA. CODE ANN. § 37.1-84.1(4) (Repl. Vol. 1976).

“in case of emergency procedures required for preservation of his health.”¹¹² Obviously these are not really rights of patients in state facilities, but diminutions of rights that would ordinarily be enjoyed by patients admitted to a general hospital for, say, an appendectomy.¹¹³

The regulations which implement the statutory “bill of rights” in state facilities further diminish the child’s control over treatment by permitting the consent of the child’s “legally authorized representative”¹¹⁴ to those few forms of treatment requiring consent. This is consistent with other Virginia statutes addressing the general issue of consent to the treatment of minors,¹¹⁵ but is in conflict with Departmental Instruction No. 60 which requires the informed consent of both the voluntarily admitted child and his parent, or guardian, prior to psychotropic medication. In the case of an involuntarily committed child, just the consent of the parent or guardian is required.¹¹⁶

The regulations specifically deny the right to refuse treatment to patients civilly committed,¹¹⁷ or committed after an acquittal in a criminal trial by reason of insanity.¹¹⁸ But, again, departmental policy is to permit the involuntarily committed adult and child to refuse treatment on religious grounds and, in other cases, to insist on a second opinion before medication.¹¹⁹ Since this policy is not

112. VA. CODE ANN. § 37.1-84.1(5) (Repl. Vol. 1976).

113. In *Parham v. J.R.*, the majority continually analogized admission of a child to a mental hospital to admission for procedures such as appendectomy. See, e.g., 99 S. Ct. at 2504-05, or 99 S. Ct. at 2515 (Stewart, J., concurring). The authors they cite in support of this analogy are careful to distinguish the legal effects of hospitalization of a child for physical treatment from that for psychiatric treatment. See, e.g., Bennett, *Allocation of Child Medical Care Decision-making Authority: A Suggested Interest Analysis*, 62 VA. L. REV. 285, 286 n.2 (1976).

114. Patient’s Rights Regulations, *supra* note 107, at 2.

115. VA. CODE ANN. §§ 37.1-84.1 (Repl. Vol. 1976) and 54-325.2 (Cum. Supp. 1979).

116. Departmental Instruction No. 60, *supra* note 108, at 4.

117. Patient’s Rights Regulations, *supra* note 107, at 3. See in particular, Gaughan and LaRue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution*, 4 LAW & PSYCHOLOGY REV. 43 (1978). See also Gonzáles, *For Mental Patients, The Cure May Be Worse*, 242 J.A.M.A. 226 (1979), for a brief, recent survey of medical opinion on the adverse side-effects of antipsychotic drugs.

118. See note 80 *supra*.

119. Departmental Instruction No. 60, *supra* note 108, at 4; Departmental Instruction No. 55, *supra* note 108, at 3.

formalized in a statute or regulation, and since this limited "right to refuse treatment" depends on the patient's assertion of it, rather than a requirement that the hospital obtain informed consent, it is of dubious value to liberty interests of the patient.

The regulations for implementing the statutory "bill of rights" in Virginia also provide a three-tiered system of administrative relief, for adult and child alike, through a patient advocate, local human rights committee and state human rights committee.¹²⁰ There is no requirement that this process be exhausted before seeking injunctive relief, or damages on a statutory tort theory, in a state court for an abridgment of these rights provided by statute.

III. *Parham v. J.R.*

A. *The State Action in Parental Commitments*

In taking the case of *Parham v. J.R.*, the Supreme Court asked the parties in particular to argue the threshold issue of whether, when a parent in Georgia signed his child into a state hospital, there was sufficient state action to subject that admission to constitutional restraints.¹²¹ If the state was not "significantly involved" in these parental commitments, the due process requirements of the fourteenth amendment would not apply.¹²² The state of Georgia claimed that they were only providing services to parents, who in turn were acting on behalf of their children; the child was a "voluntary patient."¹²³ The attorneys for the plaintiff class of children pointed out that even though the parents initiated the commitment process, the state hospital decided whom to admit. It was difficult for Georgia to deny this involvement since elsewhere it argued that it was providing due process by assuring that a physician at the state hospital made "the ultimate determination that a child is to be admitted" after a multi-disciplinary screening proce-

120. Patient's Rights Regulations, *supra* note 107, at 18. For a careful analysis of this review process by one of its creators, the late Dr. Browning Hoffman, see Hoffman and Dunn, *Beyond Rouse and Wyatt: An Administrative-Law Model for Expanding and Implementing the Mental Patient's Right to Treatment*, 61 VA. L. REV. 297 (1975).

121. *Parham v. J.L.*, 431 U.S. 936 (1977).

122. *Reitman v. Mulkey*, 387 U.S. 369, 370 (1967). See also *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 172 (1972); *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 349-51 (1974).

123. Brief for Appellants at 26, *Parham v. J.R.*, 99 S. Ct. 2493 (1979).

dure.¹²⁴ Moreover, there was even greater state involvement where the state itself requested the admission of a child who had become, as J.R. had, a ward of the state through a neglect proceeding. Finally, it could hardly be denied that regardless of what route the child had taken to the hospital, it was the state who detained him there.¹²⁵

Chief Justice Burger, writing for the majority, devoted less than a sentence to the issue of state action: "It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment and that the State's involvement in the commitment decision constitutes state action under the Fourteenth Amendment."¹²⁶

Justice Stewart, however, adopted the position of the State of Georgia, that "it has been a canon of the common law that parents speak for their minor children."¹²⁷ As long as the state recognizes a reasonable definition of minority, it may thereby constitutionally authorize parents to make medical decisions on behalf of their children. There is no constitutional difference between an adult voluntarily admitting himself to a state mental hospital and a parent "volunteering" on behalf of his child. There is no constitutional difference between a parent confining his child in a state hospital for an appendectomy and confining his child for mental health services, although, Justice Stewart admitted, the latter "results in a far greater loss of liberty."¹²⁸

124. *Id.* at 33.

125. The same might also be said for a child in a private hospital, although the Court did not reach that question in *Parham v. J.R.* or *Secretary of Public Welfare v. Institutionalized Juveniles*, 99 S. Ct. 2523 (1979). For a recent decision that did find state action in a private hospital commitment by a private physician, see *Kay v. Benson*, Civ. No. 77-86 (D. N.H., July 6, 1979) where the court found that since commitment was a power normally exercised by government, a physician who signed a certificate leading to the detention of the plaintiff was clothed with state authority for the purposes of a § 1983 action. See also, *Ruffler v. Phelps Memorial Hospital*, 453 F. Supp. 1062 (S.D. N.Y. 1978) holding that the civil commitment and treatment of the mentally ill was a public function even when performed by a private hospital; thus there was sufficient state action to subject a private hospital to a civil rights action. But see *Campbell v. Glenwood Hills Hospital, Inc.*, 224 F. Supp. 27 (D. Minn. 1963); *Spampinato v. M. Breger & Co.*, 270 F.2d 46 (2d Cir. 1959), *cert. denied*, 361 U.S. 944 (1960).

126. *Parham v. J.R.*, 99 S. Ct. at 2503. See also *Addington v. Texas*, 99 S. Ct. 1804, 1809 (1979); *In re Gault*, 387 U.S. 1, 27 (1967); *Sprecht v. Patterson*, 386 U.S. 605 (1967).

127. 99 S. Ct. at 2513 (Stewart, J., concurring).

128. *Id.* at 2515 (Stewart, J., concurring).

Justice Stewart attempted to distinguish *Planned Parenthood of Missouri v. Danforth*¹²⁹ which divested parents of absolute medical decision-making authority where the minor sought an abortion during the first trimester of pregnancy. He reasoned that the right to an abortion is a substantive constitutional right,¹³⁰ but that the children in *Parham* "had no substantive constitutional right not to be hospitalized for psychiatric treatment."¹³¹ This statement is difficult to reconcile with Justice Stewart's own often-cited finding in *O'Connor v. Donaldson*¹³² that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."¹³³

But in *Danforth*, although the parent's decision-making authority was enforced by criminal sanction against doctors who performed abortions without parental consent,¹³⁴ the Court had nonetheless viewed the parent's authority itself as an attempted delegation by the state of an authority which it lacked.¹³⁵ Thus, the critical and impermissible state action in *Danforth* was the parent's exercise of state authority over the child's decision whether to seek an abortion. Similar state authority is also exercised by parents in committing the child.

Even if the parent within the meaning of *Danforth* depended on a delegation of state authority to admit his child to a state hospital, Justice Stewart would continue to deny that sufficient state action existed. In his concurring opinion, he went so far as to assert that when a guardian (such as a state agency of which J.R. was a ward) admitted a child to a state hospital he too should be presumed to be acting in the best interests of the person legally incapable of acting for himself, thus rendering the commitment voluntary.¹³⁶ Justice Brennan, characterizing this unprecedented approach to the

129. 428 U.S. 52 (1976).

130. Stewart probably perceived this right to be founded upon notions of substantive due process under the fourteenth amendment.

131. *Parham v. J.R.*, 99 S. Ct. at 2515, n.6 (Stewart, J., concurring).

132. 422 U.S. 563 (1975).

133. *Id.* at 576.

134. 428 U.S. at 57.

135. *Id.* at 75.

136. *Parham v. J.R.*, 99 S. Ct. at 2514 (Stewart, J., concurring).

concept of state action as "particularly unpersuasive," remarked that "[w]ith equal logic it could be argued that criminal trials are unnecessary since prosecutors are not supposed to prosecute innocent persons."¹³⁷

Justice Stewart seemed to consider the parent's authority in committing the child, if not wholly state-created, then at least constitutionally subject to state restrictions, such as a pre-admission hearing for children whose parents seek to commit them.¹³⁸ He denied children protected rights in avoiding institutionalization. He also denied to their parents a protected autonomy in the care and control of their children to the extent that that requires institutionalization. Justice Stewart's opinion, therefore, depends not upon any constitutional distinctions between the adult and the child, but upon a conviction that a state may create such distinctions as it pleases, without invoking the protection, for adult or child, of the fourteenth amendment.¹³⁹

All members of the Court, with the notable exception of Justice Stewart, had no trouble finding state action in parental commitment. However it is unfortunate that they failed to articulate the basis for doing so, since it would have clarified the balance that the decision struck between the state, the parent, and the child if the Court had established whether the state derived its power from the parent, or the parent from the state. If the Court was inclined to the latter position, it would seem to entitle the child to due process protection even where the commitment was to a private hospital, a question the Court had no occasion to address in *Parham*¹⁴⁰ or *Institutionalized Juveniles*.¹⁴¹

137. *Id.* at 2522 (Brennan, J., concurring in part and dissenting in part).

138. *Id.* at 2515 (Stewart, J., concurring): "This is not to say that in this area the Constitution compels a State to respect the traditional authority of a parent, as in the *Meyer* and *Pierce* cases. I believe as in *Prince v. Massachusetts*, 321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645, that the Constitution would tolerate intervention by the State."

139. *But see id.* at 2515, n.8, which cites *Prince* to suggest that if the state impairs parental authority by requiring pre-admission hearings for children, this hearing "would, of course, be subject to the limitations imposed by the Fourteenth Amendment."

140. 99 S. Ct. 2493 (1979).

141. 99 S. Ct. 2523 (1979).

B. *Parental Due Process: Protecting Parent, Child, and State in a Single Proceeding*

After determining that a child committed by his parent or guardian has a liberty interest protected by the due process clause of the fourteenth amendment,¹⁴² the question remained: "what process is due?"¹⁴³ Conceding that the child possessed a protected liberty interest of some kind, Chief Justice Burger cited his earlier opinion for the unanimous Court in *Addington v. Texas*,¹⁴⁴ as well as *In re Gault*¹⁴⁵ and *Specht v. Patterson*.¹⁴⁶ Nonetheless, these cases proved to be unreliable guides as to the kinds of procedural safeguards the Court would extend to the children in parental commitments.

In *Addington v. Texas*, Chief Justice Burger had implemented a belief expressed four years earlier in *O'Connor v. Donaldson*:

There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. [Citation omitted.] Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding.¹⁴⁷

When Frank Addington's mother had asked the court to commit him to a mental hospital indefinitely, in addition to a full adversarial hearing before a jury with court-appointed counsel, the Chief Justice held that the grounds for commitment must be proved by "clear and convincing evidence."

The Court in *In re Winship*,¹⁴⁸ had disregarded "civil labels and good intentions" to require proof beyond a reasonable doubt in juvenile delinquency proceedings. Surprisingly, however, in *Addington v. Texas* both the noncriminal nature of the commitment process

142. *Parham v. J.R.*, 99 S. Ct. at 2503.

143. *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972) ("due process is flexible and calls for such procedural protections as the particular situation demands").

144. 99 S. Ct. 1804 (1979).

145. 387 U.S. 1 (1967).

146. 386 U.S. 605 (1967).

147. 422 U.S. at 580 (Burger, C.J., concurring).

148. 397 U.S. 358 (1970).

and the nonpunitive purposes of commitment were used to justify a somewhat lower standard.¹⁴⁹ The Court was also influenced by the possibility that freedom was not much better than commitment for someone who was "genuinely mentally ill."¹⁵⁰ Presumably, freedom was always much better for the defendant than confinement after a criminal conviction or an adjudication of delinquency. Chief Justice Burger even doubted that an unconfined mentally ill person in need of treatment was "wholly at liberty"¹⁵¹ despite his remarks to the contrary in *O'Connor v. Donaldson*.¹⁵²

The unreliability of psychiatric diagnosis¹⁵³ did not lead the Court to impose greater procedural safeguards in order to reduce the risk of error in commitment decisions. Instead, the Court was persuaded by the "subtleties and nuances of psychiatric diagnosis" to lower the standard of proof from that used in criminal proceedings to facilitate commitments.¹⁵⁴ This deference to medical expertise and the medical model of mental illness, unrelated to precedent, is perhaps the most satisfactory explanation for the varying approaches taken by the Court to civil commitment and juvenile delinquency proceedings.

Yet the standard of proof required in *Addington v. Texas* is higher than that of a mere preponderance of the evidence used in most civil proceedings, and is accompanied by the full panoply of procedural due process safeguards provided in criminal proceedings. In *Parham*, where a child was the subject of the commitment, Chief Justice Burger viewed all of these safeguards as "time-consuming procedural minuets."¹⁵⁵ How did the Court, beginning from the same assumption, that commitment could not be accomplished without due process, arrive at such different conclusions as to what process was due?

149. See note 68 *supra*.

150. *Id.* at 1811.

151. *Id.*

152. 422 U.S. at 580 (Burger, C.J., concurring).

153. Chief Justice Burger acknowledged the unreliability of psychiatric diagnosis in *O'Connor v. Donaldson*, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring) and cited Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 697-719 (1974), and Livermore, Malmquist, and Meshl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968).

154. *Addington v. Texas*, 99 S. Ct. at 1811.

155. *Parham v. J.R.*, 99 S. Ct. at 2506.

In both *Addington v. Texas*¹⁵⁶ and *Parham v. J.R.*¹⁵⁷ the Court turned to a deceptively simple test developed in *Mathews v. Eldridge* to determine the procedural requirements of due process. The Court considered:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.¹⁵⁸

In *Addington v. Texas*, although the commitment of Addington, an adult, was sought by his mother, the Court ignored her interest in the proceeding altogether. It was not the mother, but the state, as *parens patriae*, which had an interest in "providing care to its citizens who are unable because of emotional disorders to care for themselves" and the state which had the "police power to protect the community from the dangerous tendencies of some who are mentally ill."¹⁵⁹ The Court, therefore, simply weighed these interests of the state and Addington's interest in avoiding commitment, determined that the latter was greater than the former, and adjusted the burden of proof in the commitment hearing accordingly.

In *Parham v. J.R.*, the Court's recognition of parental interest, based on the Constitution, tradition, and state statute, distorted judicial analysis at each of the three levels of the *Mathews v. Eldridge* test. As a consequence, *Parham v. J.R.* is an intelligible, doctrinal exposition of neither due process nor children's rights. Nonetheless, in distinguishing this case from that line of cases beginning with *Danforth*¹⁶⁰ and leading most recently to *Belotti v. Baird (Belotti II)*,¹⁶¹ it is essential to note the impact that parental

156. 99 S. Ct. 1804 (1979).

157. 99 S. Ct. 2493 (1979).

158. 424 U.S. 319, 335 (1976). See also, *Parham v. J.R.*, 99 S. Ct. at 2502; *Addington v. Texas*, 99 S. Ct. at 1809; *Smith v. OFFER*, 431 U.S. 816 (1977).

159. 99 S. Ct. at 1809.

160. 428 U.S. 52 (1976).

161. 99 S. Ct. 3035 (1979), [hereinafter cited as *Bellotti II*, to differentiate it from *Bellotti v. Baird*, 428 U.S. 132 (1976)]. In *Bellotti I* the Supreme Court directed the district court to

interest had on the Court, as it worked its way through the *Mathews v. Eldridge* formula.

The Court first conceded that the child had a "protectible interest not only in being free of unnecessary bodily restraints, but also in not being labeled erroneously because of an improper decision by the state hospital superintendent."¹⁶² The Court then added that this interest was "inextricably linked with the parents' interest in and obligation for the welfare and health of the child."¹⁶³ Due process, then, required that any procedure used by the state must accommodate at the same time the private interests of both the parent and the child. In this sense, the parents' interests were given a constitutional status comparable to that of the child. The Court found yet another source of parental authority over children. It was alluded to by Chief Justice Burger in such expressions as "the parents' traditional interests," "Western Civilization concepts of the family," and "American tradition."¹⁶⁴ This parental interest received substantive due process protection, as the Court suggested it could only be burdened by preadmission hearings where the state "perceives that parents and a child may be at odds, but nothing in the constitution compels such procedures."¹⁶⁵ Consequently, the child's interest was negated by the recognition of a countervailing private interest at the first step of the *Mathews v. Eldridge* test.

The second step of the *Mathews* formula is a determination of the "risk of erroneous deprivation" of the child's liberty through parental commitment without judicial involvement, the Court relied again on "those pages of human experience that teach that parents generally do act in the child's best interests."¹⁶⁶ This presumption permitted the Court to relax, if not remove entirely, any due process

certify to the Supreme Judicial Court of Massachusetts questions concerning the meaning of the abortion consent statute, because of the possibility that the court might interpret the statute in a way which rendered it constitutional. The Massachusetts Supreme Judicial Court's opinion appears in *Baird v. Attorney General*, 371 Mass. 741, 360 N.E.2d 288 (1977). In *Bellotti II* the United States Supreme Court found the statute, as interpreted by the Massachusetts court, unconstitutional.

162. *Parham v. J.R.*, 99 S. Ct. at 2503-04.

163. *Id.* at 2503.

164. *Id.* at 2504.

165. *Id.* at 2508 n.18.

166. *Id.* at 2504.

protection from potential parental despotism. The Court added that an adversarial hearing prior to the admission of the child, apart from being presumably unnecessary to protect the child, would also trespass on or inhibit the exercise of the parental prerogative to seek treatment for the child.¹⁶⁷ Children in the custody of a state agency were determined by the majority to be subject to an analagous presumption that the agency will act in their best interests, and therefore, the risk of inappropriate hospitalization was negligible.¹⁶⁸

Third, the state has a "*parens patriae* interest in helping parents care for the mental health of their children," which would be in jeopardy "if the parents are unwilling to take advantage of opportunities because the admission process is too onerous, too embarrassing or too contentious."¹⁶⁹ It is at this point that parental authority was handled by the Court in a manner roughly consistent with *Danforth* and *Belotti II*. The Court found that the state has a legitimate interest in fostering parental authority and that interest must be weighed against the child's private interests in avoiding the confinement and stigma of commitment. Justices Brennan, Marshall, and Stevens found this state interest alone sufficient to allow parents initially to admit their children to state hospitals without a hearing. The district court, in requiring a pre-admission hearing had also viewed parental commitment as an exercise of state authority. It also made a factual determination that the risk of injury to the child in a parental commitment was greater than one might suppose from just a study of Blackstone, or "those pages of human experience," cited by Chief Justice Burger,¹⁷⁰ and required a pre-admission hearing. Justices Brennan, Marshall, and Stevens would have required a similar hearing both at the pre-admission stage, where the state interest in maintaining family harmony is not present, as in commitments of children by state agencies, and at the post-admission stage where the family was intact.¹⁷¹

167. *Id.* at 2505. Since the parents were not really parties to the action, it should not have been necessary for the Court to reach this issue.

168. *Id.* at 2512. The Court's decision might have been much different if it had first analyzed commitments of children by agencies and then had analogized them to commitments by parents.

169. *Id.* at 2505.

170. *Id.* at 2504.

171. *Id.* at 2522 (Brennan, J., concurring in part and dissenting in part).

In *Belotti II*,¹⁷² decided subsequent to *Parham v. J.R.*, the Court examined a Massachusetts statute¹⁷³ which required that a minor seeking an abortion obtain either (1) parental consent, or (2) judicial consent if parental consent was requested and denied and notice was given to the parents. Judicial consent could be withheld regardless of the minor's maturity. The Court, with the exception of Justice White, thought the judicial consent procedure violated the due process clause because it did not provide access to the court without notice to the parents, and it permitted the court to deny an abortion to a minor it found mature and competent enough to decide for herself whether abortion was in her best interests.

Admitting that abortion is a "constitutional right . . . of unique character,"¹⁷⁴ it is still surprising that the Court in *Parham v. J.R.* failed to employ that approach to the problems of minority status. This approach recognized a state authority by a statutory definition of minority and other enactments to apportion decision-making power between parents and minors so defined. Justice Powell remarked in an illuminating footnote to the *Belotti II* opinion:

The nature of both the State's interest in fostering parental authority and the problem of determining "maturity" makes clear why the State generally may resort to objective, though inevitably arbitrary, criteria such as age limits, marital status, or membership in the armed forces for lifting some or all of the legal disabilities of minority. Not only is it difficult to define, let alone determine, maturity, but the fact that a minor may be very much an adult in some respects does not mean that his need and opportunity for growth under parental guidance and discipline have ended. As discussed in the text, however, the peculiar nature of the abortion decision requires the opportunity for case-by-case evaluations of the maturity of pregnant minors.¹⁷⁵

Applying this perspective to the problem of parental commitment, the Court might well have reached the conclusion that there

172. 99 S. Ct. 3035 (1979).

173. MASS. ANN. LAWS, ch. 112, § 12S. (Cum. Supp. 1978), cited in pertinent part at 99 S. Ct. 3039.

174. 99 S. Ct. at 3047.

175. *Id.* at 3048 n.23.

must be a case-by-case determination of maturity in state hospital admissions of minors. Furthermore, where the child is determined to be mature enough to refuse consent to admission, the state must either respect that decision, regardless of what it or the parents determine to be in the "best interests" of the child, or seek to involuntarily commit the child on the same standards as an adult. This conclusion is not by any means compelled by *Belotti II*, but it certainly is more consistent with that opinion. Moreover, it is conceivable that just such a case-by-case determination of maturity will be required by the Court if, in a future case, it considers the question not of what the procedure the child is entitled to before being admitted to the hospital, but of what procedure the child is entitled to justify his continued detention.

A critical distinction, then, between *Parham v. J.R.* and the *Danforth-Belotti II* line of cases is the Court's curious application in *Parham v. J.R.* of the *Mathews v. Eldridge* test, factoring in at every stage, a parental interest distinct, at least in part, from any governmental interest in promoting family integrity. This distinction contributed to, but does not wholly account for, the apparently different outcomes of these cases. Probably that difference cannot be explained entirely, but it is further elucidated by examining the Court's view of the role of the physician, who with the child decides on an abortion, and with the parent decides on the child's institutionalization.

C. *Medical Due Process: The Physician as Neutral Factfinder*

Despite the Court's paen to parental supremacy in *Parham v. J.R.*, it did conclude that,

the risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a "neutral factfinder" to determine whether the statutory requirements for admission are satisfied. [Citations omitted.] That inquiry must carefully probe the child's background using all available sources, including, but not limited to, parents, schools and other social agencies. Of course, the review must also include an interview with the child. It is necessary that the decisionmaker have the authority to refuse to admit any child who does not satisfy the medical standards for admission. Finally, it is

necessary that the child's continuing need for commitment be reviewed periodically by a similarly independent procedure. [Footnote omitted.]¹⁷⁶

This in itself was not very controversial. The pre-admission hearing after notice to the child, required by the district court,¹⁷⁷ would involve much the same "inquiry." But not only did the Chief Justice find a pre-admission hearing unnecessary, he also carefully emphasized that the neutral factfinder could be, and perhaps ought to be, a staff physician at the state hospital "so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment" and refuse inappropriate admissions.¹⁷⁸

The Court did not justify the designation of the staff physician as decisionmaker by the low risk of error it perceived in parental commitments. Instead, it seemed to say that a physician provided more protection to the child than a judge could. The Court based this conclusion on the assumptions that in commitment "the questions are essentially medical in character" and that the "mode and procedure of medical diagnostic procedures is not the business of judges." Furthermore, the presence of a judge at a commitment hearing provided no real protection to the person proposed for a commitment.¹⁷⁹

The first assumption, that commitment is merely a medical issue, is far from universally accepted. One author has usefully summarized a different and equally respectable perspective on mental illness:

No single bit of behavior (or symptom) can be considered deviant or mentally ill. The crucial factor is the social context in which the behavior occurs. The same behavior may, depending upon the situation, be considered socially acceptable, mentally ill, or criminal (indicating another method of social control.)

For example, an adolescent who commits a car theft may confess to a policeman, be called a juvenile delinquent and be jailed. He may instead consult a psychiatrist and then he is likely to be labeled

176. *Parham v. J.R.*, 99 S. Ct. at 2506.

177. *J.L. v. Parham*, 412 F. Supp. 112, 140 (M.D. Ga. 1976).

178. *Parham v. J.R.*, 99 S. Ct. at 2507.

179. *Id.* at 2507-08.

mentally ill and receive psychotherapy, or he may tell only his friends and be considered a hero. The label and the social reactor to deviance depend greatly upon who observes the deviance.¹⁸⁰

J.L. and J.R., the plaintiff class representatives, had been admitted with diagnosis of "hyperkinetic reactions to childhood" and "unsocialized, aggressive reaction to childhood," respectively.¹⁸¹ The possibility that they could have been called "delinquents," "status offenders," or just playful boys instead makes the decision-maker's neutrality seem somewhat more important than his medical degree.¹⁸² The Court refused to find the medical profession *per se* lacking in neutrality regarding commitment and left the issue open to an individual determination on remand to the district court as to each member of the plaintiff class.¹⁸³

The assumption that judges in general have no business making medical decisions might also be made in adult commitment cases, personal injury suits, or patent litigation, but it is not. The assumption that judicial hearings provide less procedural protection than medical screenings might well be correct if the judges in those hearings gave as much credence to medical opinion as Chief Justice Burger did.¹⁸⁴

The weight given to medical judgment is the single point of resemblance between *Parham v. J.R.*, and the abortion opinions. In *Roe v. Wade*¹⁸⁵ and *Doe v. Bolton*,¹⁸⁶ the Court had not left the abortion decision in the first trimester entirely with the woman

180. Zusman, *Society and Mental Illness*, 15 ARCH. GEN. PSYCHIATRY, 635, 636 (1966).

181. *Parham v. J.R.*, 99 S. Ct. at 2497-98. The recently completed AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3rd ed. 1979) (DSM-III) would classify these "illnesses" as "314.0x Attention Disorder Hyperactivity" and "312.0x Undersocialized Conduct Disorder, Aggressive Type," respectively, without indicating why they are "illnesses" rather than misconduct.

182. And from Zusman's perspective, *supra* note 180, the fact that the decisionmaker is a physician alone precludes neutrality.

183. *Parham v. J.R.*, 99 S. Ct. at 2511.

184. The reluctance of defense counsel to cross-examine physician witnesses also contributes to both the ineffectiveness of the hearing and the heavy reliance by the courts on medical opinion. See, e.g., Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966) cited by the Court at 99 S. Ct. 2508, at n.17. See also Slobogin, *supra* note 75.

185. 410 U.S. 113 (1973).

186. 410 U.S. 179 (1973).

seeking it. In that stage of pregnancy the Court had only said that "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."¹⁸⁷ In *Danforth*, one constitutional defect in the challenged statute was that it imposed in all cases a parental consent provision "exercisable by a person other than the woman and her physician, as a prerequisite to a minor's termination of her pregnancy and [did] so without sufficient justification for the restriction."¹⁸⁸ In *Belotti II*, the Court, to the extent that it recognized the need for parental involvement in an immature minor's abortion decision, did so because of the danger that the child, because of her immaturity, might not select a competent physician.¹⁸⁹ When the minor was determined on a case-by-case basis to be mature, the abortion decision was hers to make, not alone, but "in consultation with her physician, independently of her parents' wishes."¹⁹⁰ The Supreme Court's opinions on abortion may be read loosely not as providing pregnant women with a substantive due process right to abortion in the first trimester but as appointing the private physician as the neutral decision-maker controlling the woman's access to an abortion. In this light, medical consultation becomes a substitute for procedural due process.

In *Parham v. J.R.*, the Court gave the physician no less autonomy in parental commitments than in abortion decisions. The Court in *Parham v. J.R.* ignored the real possibility that the physician's neutrality is endangered in commitment because of the necessity of serving three masters at once: the child, the parents, and the state—the last both as an employee and an agent of social control. Perhaps the Court ignored this possibility because the Court's "medical due process" required much more than just an assurance that the staff physician at the state hospital made the ultimate determination of "whether the child is mentally or emotionally ill and whether he can benefit from the treatment that is provided by the state."¹⁹¹ Due process required, in addition to the presence of a

187. *Roe v. Wade*, 410 U.S. at 164. See also, *id.* at 166 ("the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician").

188. 428 U.S. at 75.

189. 99 S. Ct. at 3047, n.21.

190. *Id.* at 3048.

191. *Parham v. J.R.*, 99 S. Ct. at 2507.

neutral factfinder at the gates of the state hospital, a lengthy screening process beginning in the community and continuing after admission to the hospital.

The narrow holding of *Parham v. J.R.* was only that "Georgia's general administrative and statutory scheme for the voluntary commitment of children is not *per se* unconstitutional."¹⁹² It is possible on remand that the district court will find that some members of the plaintiff class of children did not receive adequate medical screening before admission. And it is possible that the district court could find that, distinct from admission, continued detention requires more than medical screening.

The standard of screening which must be met by Georgia on remand or by another state with a similar parental commitment statute, was set forth with great care by the Court:

In the typical case the parents of a child initially conclude from the child's behavior that there is some emotional problem—in short, that "something is wrong." They may respond to the problem in various ways, but generally the first contact with the State occurs when they bring the child to be examined by psychologist or psychiatrist at a community mental health clinic.

Most often, the examination is followed by outpatient treatment at the community clinic. In addition, the child's parents are encouraged, and sometimes required, to participate in a family therapy program to obtain a better insight into the problem. In most instances, this is all the care a child requires. However, if, after a period of outpatient care, the child's abnormal emotional condition persists, he may be referred by the local clinic staff to an affiliated regional mental hospital.

At the regional hospital an admissions team composed of a psychiatrist and at least one other mental health professional examines and interviews the child—privately in most instances. This team then examines the medical records provided by the clinic staff and interviews the parents. Based on this information, and any additional background that can be obtained, the admissions team makes a diagnosis and determines whether the child will likely benefit from institutionalized care. If the team finds either condition not met, admission is refused.

192. *Id.* at 2511.

If the team admits a child as suited for hospitalization, the child's condition and continuing need for hospital care are reviewed periodically by at least one independent, medical review group. For the most part, the reviews are as frequent as weekly, but none are less often than once every two months. Moreover, as we noted earlier the superintendent of each hospital is charged with an affirmative statutory duty to discharge any child who is no longer mentally ill or in need of therapy.¹⁹³

To the extent that a state deviates from this standard, *Parham v. J.R.* provides no protection from due process challenges not even with regard to the initial admission of the child. To the extent that the Court seriously believes that "the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real,"¹⁹⁴ it is possible to argue that due process requires such a medical screening procedure, or its equivalent. This is possible even in states such as Virginia, where minors who are unable or unwilling to seek voluntary admission to a mental hospital cannot be detained without a judicial order based on probable cause, and in addition are entitled to a full adversarial hearing before a juvenile and domestic relations judge usually within forty-eight hours of initial detention.¹⁹⁵

The constitutional adequacy of the screening process adopted by the state seems unrelated to whether the state formally implements screening by statute. In Georgia, screening practices varied from hospital to hospital, and from case to case. Therefore, on remand, the district court is left with immense factual issues to resolve. Almost two years earlier, the California Supreme Court in *In re Roger S.*,¹⁹⁶ decided that a strong mandatory screening procedure¹⁹⁷

193. *Id.* at 2510.

194. *Id.* at 2508.

195. VA. CODE ANN. § 16.1-241(B) (Cum. Supp. 1979); *but see* § 16.1-275 (Cum. Supp. 1979), discussed *supra* at note 90 and accompanying text.

196. 19 Cal.3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977).

197. California's rough equivalent to Virginia's Chapter 10 of Title 37.1, discussed *supra* at note 77, provides that: "No mentally disordered person shall be admitted to a state hospital prior to screening and referral by an agency designated by the county Short-Doyle

provided inadequate procedural due process to a fourteen year old boy admitted pursuant to a parental commitment statute.¹⁹⁸ The California court found that

the present screening procedure does not offer an adequate forum in which to resolve either the disputed questions of fact, upon which the psychiatric diagnosis of mental illness or disorder may rest in part, or conflicting medical opinions as to whether the minor is mentally ill or disordered and in need of treatment.¹⁹⁹

During the pre-admission screening process in California a physician had concluded that Roger S. was "clearly not psychotic," but a psychologist had concluded that Roger S. was "psychotic." Two other physicians recommended that Roger S. not be confined. Nonetheless, he was placed in a building at the state hospital, described by the court as having "barred windows and locked doors in an open ward with 40 other minors some of whom are so severely disturbed that they are unable to dress themselves."²⁰⁰ While the state hospital performed post-admission evaluation of Roger S. after referral by the community mental health center, there was no "neutral factfinder" in the pre-admission screening who might have resolved conflicts of lay or expert facts. Had California's screening practices included the provision of a neutral factfinder at the pre-admission stage, it is possible that the *In re Roger S.* court would not have required a hearing before children of Roger's age or older were admitted on parental request.²⁰¹

The Supreme Court in *Parham v. J.R.* discovered constitutional

plan to provide this service." CAL. WELF. & INST. CODE § 5601 (Supp. 1978). This mandates a "single portal of entry" through the community mental health center to the state hospital.

198. 19 Cal.3d at 936, 569 P.2d at 1295, 141 Cal. Rptr. at 307.

199. *Id.*

200. *Id.*

201. The California Supreme Court carefully explained that children of the age of Roger S., unlike adults, and like parolees and probationers, were not entitled to a judicial hearing, because their liberty was conditional even outside the institution. Since the parent already controlled the child's liberty, when a parent sought to commit the child, an administrative hearing, with a lower burden of proof, and a standard of commitment less than that of "imminently dangerous" or "gravely disabled," would suffice constitutionally. *Id.* at 309. The real distinction between *Parham v. J.R.* and this case lies in the latter's requirement that counsel be provided for the minor in the administrative hearing. 19 Cal.3d at 938-39, 569 P.2d at 1296-97, 141 Cal. Rptr. at 308-09.

dimensions in a procedure which long has been the focus of federal financial support to state and local mental health programs. Screening persons proposed for placement in state hospitals is a condition of receiving Community Mental Health grants²⁰² and Public Health Service formula grants for manpower training.²⁰³ Enforcement of the condition by the federal government through its funding agency, the National Institute of Mental Health, is probably, however, nonexistent. If state legislatures follow Chief Justice Burger's lead, the screening of state hospital admissions, at least those of children, will become even more critical to the elimination of inappropriate admissions, a primary goal of this federal legislation, since the courts no longer will be interposed between the prospective patient and the hospital. Of course, in those states which permit parental commitments, the provision of pre-admission screening will be demanded not just by the fine print in a federal grant, but also by the due process clause of the fourteenth amendment.

There is no reason whatsoever to believe that the Chief Justice's program of pre-admission screening will divert fewer dollars from treatment, as he assumed it would, than the brief judicial hearing sought by the plaintiffs. Questions of fairness aside, the cost of a hearing, or even hundreds of hearings, is less than the economic and social cost of inappropriately institutionalizing a single child. Moreover, screening sufficient to satisfy the requirements of due process

202. The Community Mental Health Centers Act, 42 U.S.C. § 2689(b)(1)(A)(ii) (1978), provides in pertinent part:

Beginning on the date the community mental health center is established for the purposes of this title, the services provided through the center shall include—

. . . .

(ii) assistance to courts and other public agencies in screening residents of the center's catchment area who are being considered for referral to a State mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility

203. Public Health Service Act, 42 U.S.C. § 246(g)(2)(D)(iii) (1978), provides in pertinent part:

the State mental health authority will—

. . . .

(iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other appropriate entities) of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary

encompasses initial treatment, including family therapy, at a community mental health center, and then referral to "an admission team composed of a psychiatrist and at least one other mental health professional" at the state hospital who must at least interview the child, review records, and interview the parents, before making an admission decision. It is difficult to believe that this "medical due process" is less costly to the state than the judicial due process sought by the plaintiffs in *Parham v. J.R.*

D. Questions Unanswered in *Parham v. J.R.*

No less dismaying to lawyers representing children than the broad and imprecise rhetoric about parental rights in *Parham v. J.R.*, is the narrowness of the majority's holding. Assuming Georgia met the Court's standard of medical screening, then, the Court held, it could admit a child to a state hospital without a hearing. This much the Court had already suggested was constitutionally permissible, in its summary affirmance in *Briggs v. Arafah*.²⁰⁴ At least three members

204. 411 U.S. 911 (1973), *aff'g summarily* Logan v. Arafah, 346 F. Supp. 1265 (D. Conn. 1972) (upholding a statute which permitted involuntary hospitalization on a medical certification alone, provided that if the patient objected a judicial hearing would be held within forty-five days). See also, Coll v. Hyland, 411 F. Supp. 905, 911 (D. N.J. 1976) (three-judge court) (permitting twenty day delay in holding hearing); Saville v. Treadway, 404 F. Supp. 430, 437 (M.D. Tenn. 1974) (authorizing forty-five day respite care admission for mentally retarded children without hearing); Fhagen v. Miller, 29 N.Y.2d 348, 278 N.E.2d 615, *cert. denied*, 409 U.S. 845 (1972) (permitting up to twenty-five day delay in hearing). Recent statistics obtained from the Virginia Department of Mental Health and Mental Retardation suggest that most recent involuntary commitments in Virginia are of so short a term that a hearing might not be necessary if *Briggs* is good law and the statistics are accurate. For the fiscal year ending June 30, 1979, the mean length of stay in the state's institutions was:

	Age	Total Number of Admissions	Mean Length of Stay (In Days)
<i>MR Admissions Other Than By Self</i>	< 18	139	18.81
	≥ 18	71	14.93
<i>MH Involuntary Admissions by Civil Court Order</i>	< 18	201	27.86
	≥ 18	4154	14.59

This data also discloses 280 juvenile admissions during this period with an admitting legal status described by the Department as "Voluntary-Parent" with a mean length of stay of 20.15 days. Presumably these admissions were based on the consent of the parent and the

of the Court, Justices Brennan, Marshall, and Stevens, would require more than medical screening to continue the confinement of a child after admission.²⁰⁵ Justice Stewart would permit the state to avoid any procedural safeguard before or after admission.²⁰⁶ The remainder of the Court gave no dependable indication of when and how much post-admission procedural protection is required.

In approving Georgia's parental commitment procedure, the Court also ignored the issue of the mature minor. Apparently a parental admission need not be refused if the neutral factfinder determines that the child is mature enough to make the admissions decision himself, but it is less clear whether, in the Court's view, a mature minor has a right to admit himself to a hospital without parental consent,²⁰⁷ or whether after admission a mature minor may refuse (or consent to) any kind of treatment.²⁰⁸

It is difficult to believe from Chief Justice Burger's opinion and his reliance on *Meyer v. Nebraska*,²⁰⁹ *Pierce v. Society of Sisters*²¹⁰ and *Wisconsin v. Yoder*,²¹¹ that *Parham v. J.R.* was not a case of parents challenging a state statute which required a pre-admission hearing before they could put their child in a state hospital. In fact, however, the Court was quite ready to permit a state to interpose such hearings between the child and his institutionalization where the state "perceives that parents and a child may be at odds."²¹² And where this conflict rises to the level of abuse or neglect, it is certain that the Court's calculus of due process would produce a

child in compliance with Departmental Instruction No. 60, discussed at notes 32-33 *supra* and accompanying text.

205. *Parham v. J.R.*, 99 S. Ct. at 2515 (Brennan, J., concurring in part and dissenting in part).

206. *Id.* at 2515 (Stewart, J., concurring).

* 207. *In re Roger S.*, *supra* note 196, is an example of a decision that recognized rights which existed in a category of minors over a certain age, in that case 14 years of age, which did not exist in younger children. *Danforth* and *Bellotti II* contemplated the determination of maturity on a case-by-case basis, but there the Court was dealing with necessarily older children. The best exposition of the arguments made to and ignored by the Court for a mature minor rule, and its basis in developmental psychology, appears in Amicus Brief of the Child Welfare League of America at 71, *Parham v. J.R.*, 99 S. Ct. 2493 (1979).

208. Discussed briefly at note 94 *supra* and accompanying text.

209. 262 U.S. 390 (1923).

210. 268 U.S. 510 (1925).

211. 406 U.S. 205 (1972).

212. *Parham v. J.R.*, 99 S. Ct. at 2508 n.18.

different result, requiring without doubt little or no deference to parental interests in commitment, and probably more than medical screening. Thus, states that wish to continue parental commitments after *Parham v. J.R.*, and that meet the Court's high standards for medical screening, may continue to risk challenges to constitutional sufficiency of that process, where screening turns up evidence of abuse or neglect—a risk greatly increased by vague definitions of abuse and neglect and mandatory reporting requirements typical of most state statutes.²¹³

Finally, the Court in *Parham v. J.R.* declined to consider the doctrine of the least restrictive alternative. It misconstrued the district court's order that the state create a treatment alternative for some members of the plaintiff class who could be treated optimally outside of the state hospitals. The Supreme Court understood this measure as a response to the deprivation of procedural due process in admitting the children rather than, as it was, relief to those children who, independent of the way in which they reached the hospital were being harmed by this continued confinement there.²¹⁴ Since the Supreme Court found the admission procedure adequate, it reasoned that it need not consider the remedy of ordering less restrictive treatment, although it suggested that it would not in any case be appropriate for a procedural deprivation.²¹⁵ Presumably this issue is open for the district court on remand to consider independently of those regarding adequacy of medical screening.²¹⁶

Judge Broderick, it will be remembered, in dissenting from the district court opinion in *Bartley v. Kremens*, called the provision of procedural safeguards to children whom parents wanted to institutionalize an "overdose of due process," a dissent followed closely by

213. An argument might be made that inappropriate institutionalization alone could constitute neglect thus triggering reporting duties on the part of the hospital staff and court intervention.

214. Justice Brennan briefly alludes to the potential harm to the plaintiffs. *Parham v. J.R.*, 99 S. Ct. at 2517 (Brennan, J., concurring in part and dissenting in part).

215. *Id.* at 2513 n.23.

216. Chief Justice Burger complained that "the [district] court made no findings on this issue" while at the same time acknowledging that the 46 members of the plaintiff class were "found to be treatable in 'less drastic' settings." *Id.* One would think that, in the context of expert opinion, that failure to treat in the least restrictive setting is comparable to harming the children, and that this would be a sufficient finding.

Chief Justice Burger in *Parham v. J.R.*. Nonetheless, when Judge Broderick in *Halderman v. Pennhurst*²¹⁷ addressed the substantive rights of persons within a large institution for the mentally retarded in Pennsylvania, his response was to order community placement of all residents and the closing of the institution thereafter.²¹⁸ In *Parham v. J.R.* there are no reliable indications of how the Court would react if on remand the district court rather than prescribing an "overdose of due process," adopted the more far-reaching remedy fashioned by Judge Broderick in *Halderman v. Pennhurst*.

IV. NEW DIRECTIONS FOR VIRGINIA LAW

Examined in the light of *Parham v. J.R.*, current Virginia procedures for involuntary commitment are constitutionally sufficient, though susceptible to considerable improvement within the parameters implied by the Court. A wholesale replacement of existing statutory safeguards of notice, hearing, and appointed counsel with the Court's recommended medical screening process would not be an improvement. That screening process is of doubtful constitutional sufficiency in cases involving child abuse or neglect, continuing detention, mature minors, or deprivation of educational opportunities, all of which are circumstances the Court, perhaps incorrectly, felt were missing in *Parham v. J.R.* The introduction of any of these factors almost surely would alter the measure of procedural due process the Court would extend to a minor in commitment to a state hospital. Virginia legislators instead ought to retain the existing statutory procedures for informed voluntary,²¹⁹ formal voluntary,²²⁰ and involuntary²²¹ admissions of minors to state hospitals, but should preface those procedures with a medical screening process which would permit some children to be treated just on the consent of a parent or guardian, and without judicial involvement, and, for other children, for whom a hearing is appropriate, provide the court with better data on which to base a commitment decision.

217. 446 F. Supp. 1295 (E.D. Pa. 1977) (appeals argued before the Third Circuit (in banc) September 6, 1979).

218. *Id.* at 1327.

219. VA. CODE ANN. § 37.1-65 (Repl. Vol. 1976).

220. VA. CODE ANN. § 37.1-67.2 (Cum. Supp. 1979).

221. VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979).

The following statutory language might achieve both of those objectives:

§ 37.1-70.1 Admission of persons under the age of eighteen for screening.—

(a) Any community mental health and mental retardation services program established under § 37.1-194, or any other facility specifically authorized by regulations duly adopted by the Board,²²² may admit as an outpatient²²³ and treat any person under the age of eighteen, upon the request of his parent or legal guardian, provided that within twenty-four hours of admission, a physician or clinical psychologist²²⁴ certifies in writing that:

- (1) the person is mentally ill or mentally retarded and will benefit from services currently available in the program;
- (2) the person is incapable of making an informed decision to seek or refuse such services;²²⁵
- (3) there is no reason to believe after investigation that the person has been subjected to abuse or neglect as defined in § 16.1-228;²²⁶ and

222. The Virginia Department of Mental Health and Mental Retardation is controlled by a board of directors, called the State Mental Health and Mental Retardation Board. VA. CODE ANN. §§ 37.1-2 (Repl. Vol. 1976), 37.1-10 (Cum. Supp. 1979), and 37.1-39 (Repl. Vol. 1976). There are nine such directors, all unsalaried, and appointed by the governor. § 37.1-4 (Repl. Vol. 1976). The Board presently has broad authority to adopt regulations, § 37.1-20 (Repl. Vol. 1976), and specific authority to adopt pre-screening regulations, § 37.1-70 (Repl. Vol. 1976).

223. As in the final paragraph of VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979) regulations might broaden this to include "day treatment in a hospital, night treatment in a hospital . . . or other such appropriate treatment modalities" as are less restrictive than institutional confinement.

224. The Virginia Code already recognizes the propriety of such evaluations by clinical psychologists of persons alleged to be mentally retarded, VA. CODE ANN. § 37.1-65.1 (Cum. Supp. 1979), and children in general, VA. CODE ANN. § 16.1-275 (Cum. Supp. 1979).

225. There would seem to be no reason to suppose that the capacity to consent to treatment is not commensurate with the capacity to refuse. In *Melville v. Sabbatino*, 30 Conn. Supp. 320, 313 A.2d 886, 889 (1973) where the state authorized the voluntary admission of minors between the ages of 16 and 18, the court held that it followed logically that those minors could also sign themselves out of the hospital, regardless of parental wishes. The district court in *Danforth* had also reasoned that since parents could not force a minor to have an abortion, they also could not stop her from seeking an abortion. *Planned Parenthood v. Danforth*, 392 F. Supp. 1362, 1376 (E.D. Mo. 1975). Both these cases relied on *In re Smith*, 16 Md. App. 209, 295 A.2d 238 (1972). Nonetheless, legislatures continue to create room for distinguishing between the right to refuse treatment and the right to consent. See note 3 *supra*.

226. Evidence of abuse or neglect would take the detention of the child beyond the scope of *Parham v. J.R.* See note 213 *supra* and accompanying text.

(4) there is no reason to believe after consultation with school authorities that such services will deny the person an appropriate education.²²⁷

(b) Any hospital or training center may admit as an inpatient and treat for a period not to exceed fifteen consecutive days or thirty days within one year any person under the age of eighteen, upon the request of his parent or legal guardian, provided that prior to admission, a physician or clinical psychologist certifies that in addition to the foregoing conditions in (a), the following additional conditions are also met:

(1) the person has received within the last thirty days services including, where appropriate, family therapy in the program or approved facility, but requires further services (which shall be specified) available in no less restrictive setting than the hospital or the training center to which admission is sought;²²⁸

(2) the program or approved facility has recommended such inpatient admission and has prepared a plan for the eventual discharge of the person from the hospital or training center and the post-discharge provision of services to the person by that program or approved facility;

(3) another physician or clinical psychologist independently has reviewed all the foregoing conditions and found them to be satisfied.

(c) No judge shall issue an order regarding a person under the age of eighteen under § 37.1-65.1, § 37.1-67.1 or § 37.1-3,²²⁹ until he has received a written report from a community mental health and mental retardation services program, or approved facility which certifies that

(1) such person was admitted and treated pursuant to (a) and (b) and continues to be mentally ill or mentally retarded and in need of institutional services; or

227. See note 42 *supra*.

228. Such a requirement enables the court to make a better informed decision as to the existence of alternatives to institutional confinement in an involuntary commitment hearing under VA. CODE ANN. § 37.1-67.3 (Cum. Supp. 1979) or a certification hearing under § 37.1-65.1 (Cum. Supp. 1979).

229. This could perhaps be expanded to include any order resulting in detention under VA. CODE ANN. § 16.1-275 (Cum. Supp. 1979).

- (2) admission and treatment pursuant to both (a) and (b) were sought but denied or terminated because one or more conditions therein were not satisfied (which condition shall be specified); and
- (3) any additional pre-admission screening procedures required by regulations duly adopted by the Board pursuant to its authority in § 37.1-70 have been complied with.

Such a statute permits parents or a legal guardian to obtain outpatient or short term inpatient treatment for a child. Judicial intervention is triggered only where such treatment has failed, or for specified reasons, has been found inappropriate, at which point the court should be in a better position to weigh the merits of institutionalization. At the same time that such a procedure accommodates the parental interests elaborated in *Parham v. J.R.*, it also enhances the procedural protection provided to the child.²³⁰

V. CONCLUSION

The medical screening process endorsed by Chief Justice Burger in *Parham v. J.R.* permits states to relax, or at least delay, the provision of adversarial-style procedural safeguards for children whose parents or guardian seek to commit to a state hospital, absent indications of child abuse or neglect. This medical screening process can, in addition to facilitating parental access to hospital services, improve judicial decision-making in those cases where medical screening alone may not be sufficient to provide procedural due process protection to the liberty interests of a minor.

230. This is accomplished principally by insuring that the court, the defense counsel, and the court-appointed physician or clinical psychologist receives better data on the grounds for institutionalization.

