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"WHO ARE YOU TO SAY WHAT MY BEST INTEREST IS?" MINORS' DUE PROCESS RIGHTS WHEN ADMITTED BY PARENTS FOR INPATIENT MENTAL HEALTH TREATMENT

Kelli Schmidt

Abstract: In State ex rel. T.B. v. CPC Fairfax Hospital, the Washington Supreme Court determined that minors who refuse to consent to inpatient mental health treatment, but are admitted by their parents nonetheless, have a statutory right to a prompt judicial review of the admission decision. This Comment argues that confining mature minors in mental hospitals against their will is a deprivation of both liberty and privacy interests and, as such, stringent due process protections are required, not only by Washington's current statutory scheme, but also by the U.S. and Washington Constitutions. It concludes by stating that the current statutory scheme meets the standards of both the substantive and procedural requirements of constitutional due process but that any statutory amendments that lower these standards are likely to fail to pass constitutional muster.

In State ex rel. T.B. v. CPC Fairfax Hospital,¹ the Washington Supreme Court determined that a minor's² due process rights were violated when her parents and hospital staff failed to seek judicial oversight of their decision to commit her to an inpatient mental health facility without her consent.³ The court based its opinion on the specific facts in the case and the intent and language of the 1995 “Becca Bill” amendments⁴ to the Mental Health Care and Treatment for Minors Act.⁵ Because the case was resolved on statutory grounds, the court avoided explicitly reaching the constitutional issue⁶ of the process due to minors

2. For the purposes of this Comment, the terms “minor(s),” “juveniles,” “youths,” and “mature minors” will be used to refer to youth between the ages of thirteen and eighteen, unless otherwise indicated.
3. CPC Fairfax, 129 Wash. 2d at 451, 918 P.2d at 503. A second statutory violation occurred when she was denied immediate access to counsel and subsequent access to her medical records. Id.
5. Wash. Rev. Code ch. 71.34.
6. CPC Fairfax, 129 Wash. 2d at 441, 918 P.2d at 498. The majority claims to avoid addressing the constitutional issues posed by the case. However, the minority opinion accurately criticizes the majority for nonetheless making strong statements that condemn the “massive curtailment of liberty” caused by the minor's admission to an inpatient Hospital as unconstitutional. Id. at 454, 918 P.2d at 505 (Dolliver, J., concurring and dissenting) (citing majority opinion at 453, 918 P.2d at 504).
who refuse to consent to inpatient mental health treatment after they have been presented to a facility for evaluation and treatment by their parents.\footnote{7}

This Comment examines minors' constitutional rights when facing forced inpatient psychiatric treatment, under both the U.S.\footnote{8} and Washington State Constitutions.\footnote{9} It then argues that unconsenting minors not only have statutory rights to specific due process protections\footnote{10} but also fundamental constitutional rights to these processes under the Due Process clauses of both constitutions. These rights inure because minors, like adults, have significant liberty and privacy interests in refusing forced inpatient mental health treatment. The need for stringent processes to protect these interests is indeed stronger when parents, rather than state agents, admit their minor children to private, as opposed to public, mental health facilities.

Part I of this Comment provides a brief history of minors' rights\footnote{11} in regard to mental and medical health treatment.\footnote{12} Part II argues that minors, in common with adults, have constitutional rights to due process protections when they refuse to provide consent for inpatient mental health treatment. It examines the applicable sections of the Federal and Washington State Constitutions\footnote{13} and the various interests implicated by the state's current statutory scheme for the mental commitment of minors. This Comment concludes that unconsenting minors have significant liberty and privacy interests that are threatened by forced

\footnote{7} Prior to the Becca Bill amendments, a minor could be admitted by a parent only if the parent's admission application included the "written consent, knowingly and voluntarily given, of the minor." Wash. Rev. Code § 71.34.030(2)(b) (1994) (amended 1995).
\footnote{8} U.S. Const. amend. XIV.
\footnote{9} Wash. Const. art. I, §§ 3, 7.
\footnote{10} Due process safeguards for forced institutionalization have traditionally included the following rights: to be informed of the reasons for commitment, to judicial oversight of the commitment decision, to be present at the commitment determination, to representation, to be heard, to be confronted with adverse witnesses, to cross-examine, and to offer evidence of one's own. See Wolff v. McDonnell, 418 U.S. 539 (1974); Morrissey v. Brewer, 408 U.S. 471 (1972); McNeil v. Director, Patuxent Inst., 407 U.S. 245 (1972); Specht v. Patterson, 386 U.S. 605, 610 (1967); see also Goldberg v. Kelly, 397 U.S. 254, 269–71 (1970); In re Harris, 98 Wash. 2d 276, 654 P.2d 109 (1982).
\footnote{11} The author's inquiry into minors' due process rights in mental health decisions began with the passage of the Becca Bill by the Washington State Legislature. However, this Comment does not attempt to address the procedural and substantive due process rights of minors implicated by other portions of the legislation including: the creation of locked crisis residential facilities for runaway youth; statutory authority for parents to place their unconsenting minor children in drug and alcohol treatment facilities; and court proceedings for truancy.
\footnote{12} Parham v. J.R., 442 U.S. 584 (1979); see infra part I.A.
\footnote{13} See infra part II.A.
Minors’ Due Process Rights

confinement in mental health institutions. To safeguard these interests, Washington State’s current statutory due process protections must continue to be applied to minors admitted by their parents when minors refuse to provide consent for their own inpatient mental health treatment.

I. BACKGROUND

A. Brief History of Minors’ Rights in Treatment Decisions

Traditionally, the judiciary had accorded great deference to parental authority, with parental duties giving rise to parental powers. Children’s rights were viewed as coextensive with the rights of the parent. This deference was based primarily on “children’s rights” cases from early in this century. This trend continued until 1967 when the U.S. Supreme Court expressly recognized that minors are “persons” who possess fundamental constitutional rights independent from those of their parents.

Under common law, parental consent traditionally was required before a doctor could legally treat a minor. This requirement reflected the assumption that, under normal circumstances, there is an identity of interests between parent and child. A “mature minor” exception to the parental consent requirement exists, however, and it has been upheld by the U.S. Supreme Court and lower courts. The “mature minor”

14. For an enumeration of these rights, see infra notes 189–199 and accompanying text.
16. Id.
19. Two other exceptions to this general rule are the emergency exception, when immediate care is required due to a serious threat to the life and health of the minor, and an exception for emancipated minors. Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1951); Wells v. McGehee, 39 So. 2d 196 (La. 1949); Moss v. Rishworth, 222 S.W. 225 (Tex. 1920).
exception is recognized in some states by common law, and it has been codified in several other states.22

The "mature minor" exception is applied when a parent is unfit, or unable, to provide consent and when there is a recognition that mature minors are capable of making independent decisions concerning some types of medical treatment.23 Mature minor exceptions either set a low minimum age of consent for any type of treatment24 or allow minors to consent to specific types of medical treatment.25 Such policies are consistent with social science studies that show that the medical decision-making process employed by minors over the age of thirteen is generally indistinguishable from the process employed by adults.26 The Washington Legislature endorsed a mature minor statute when it passed the Mental Health Care and Treatment for Minors Act,27 which determined that minors, age thirteen or older, may consent for their own inpatient, mental health treatment, without obtaining parental approval if certain requirements are met.28

22. See Fay A. Rozovsky, Consent to Treatment: A Practical Guide (2d ed. 1990), for a review of different states' consent laws.
25. These typically allow for treatment of sexually-transmitted disease, contraception services, diagnosis of pregnancy, treatment for alcohol and drug abuse, and mental health treatment. Supra note 22. Although the U.S. Supreme Court has upheld the rights of mature minors to obtain abortions without parental consent, it has also upheld the constitutionality of state statutes that require parent notification and/or a judicial determination of sufficient maturity before allowing the abortion. Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502 (1990); Hodgson v. Minnesota, 497 U.S. 417 (1990); H.L. v. Matheson, 450 U.S. 398 (1981).
27. See supra note 5.
28. Requirements include notice of the minor's admission to the parent. At the parent's request for release, the minor must be released to the parent unless the Hospital administrator files a petition with superior court stating that it is the facility's belief that the minor is in need of inpatient treatment and release would constitute a threat to the minor's health or safety. Additionally, the minor's voluntary written consent for inpatient treatment must be renewed every twelve months and the minor's need for inpatient treatment must be reviewed and documented no less than every 180 days. Wash. Rev. Code § 71.34.030(2).
B. Parham v. J.R.

*Parham v. J.R.* was the first, and only, U.S. Supreme Court case to consider minors' due process rights when presented for admission by a parent to a state-run psychiatric hospital against the minor's will. The Court held that a Georgia statute authorizing a parent to admit initially a minor to a state inpatient facility, against the minor’s will, and without a prior judicial commitment hearing, was not per se unconstitutional. The Court did not determine, however, the full extent to which a mature minor’s federal substantive due process right to refuse forced hospitalization may be legitimately restricted.

The *Parham* Court acknowledged that "it is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment." The Court recognized that protectable privacy and liberty interests exist and applied the traditional *Mathews v. Eldridge* test, which guides decisions regarding state procedures for due process.

After balancing the private interests of both the parent and the minor pursuant to the *Mathews* test, the Court stated, "[T]he child’s rights and the nature of the commitment decision are such that parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized." The Court acknowledged that the risk of error inherent in the parental decision to have a child institutionalized for mental health care was sufficiently great that some kind of inquiry by a "neutral factfinder" should be made to determine whether statutory requirements for admission were satisfied. The Court then concluded that due process was satisfied, at initial admission, if that factfinder was also the admitting physician at a state hospital.

A number of questions were left unanswered by the Court. The Court specifically did not determine "what process might be required if a child

30. *Id.* at 616–17.
31. *Id.* at 600.
34. *Id.* at 606.
35. *Id.* at 609.
contests his confinement by requesting a release." Furthermore, the Court did not specify any requirements for review of the initial admission decision nor did it discuss whether Georgia's state hospitals had adequate review procedures. Additionally, the Court did not determine what due process protections are necessary when a parent seeks to admit the minor to a private, rather than public, mental health hospital. Finally, the Court did not address whether initial admission by a single parent was constitutional if the other parent, as well as the child, refused to provide consent for the admission to an inpatient facility.

C. The Becca Bill

The Becca Bill was initiated by an organization of parents who were frustrated by poor police, social service, and mental health service responses to parents' requests for assistance in controlling their "out-of-control" children. The plight of these parents' groups came to the forefront of the legislative agenda when the Washington media extensively covered the murder of thirteen year-old Rebecca Hedman, who later became the namesake of the "Becca Bill." Many of the news media reports and legislation were inspired by the tragic circumstances surrounding Rebecca Hedman's death.

36. Id. at 617. The Washington Supreme Court answered this question based on statutory grounds in State ex rel. T.B. v. CPC Fairfax Hospital and, therefore, avoided determining the issue as a constitutional matter. 129 Wash. 2d 439, 918 P.2d 497 (1996); see infra part I.D.

37. Parham, 442 U.S. at 617.

38. Id.

39. Application of constitutional principles and due process protections are required by private, as well as public, hospitals when the admission is governed by a state enabling statute such as title 71, chapter 34 of the Washington Revised Code. As the Washington Supreme Court noted, "once a state has granted a liberty interest by statute... 'due process protections are necessary to insure that the state-created right is not arbitrarily abrogated.'" CPC Fairfax, 129 Wash. 2d at 453, 918 P.2d at 504 (quoting Vitek v. Jones, 445 U.S. 480, 489 (1980)).

Because the U.S. Supreme Court has recognized that involuntary commitment represents a "massive curtailment of liberty" that implicates fundamental constitutional rights, Humphrey v. Cady, 405 U.S. 504, 509 (1972), any involuntary, mental health commitment to a private institution with a nexus to state actors is likely still governed by the state and federal due process clauses, regardless of whether an enabling statute exists. But see R.J.D. v. The Vaughan Clinic, P.C., 572 So. 2d 1225 (Ala. 1990) (granting partial summary judgment for private psychiatric hospital sued by emancipated child and her father; finding that, as custodial parent, mother was empowered to request involuntary admission for her child and admission had not been conducted under color of state law).

40. See Vaughan Clinic, 572 So. 2d 1225.

41. The Becca Bill was initiated by a number of groups including the Parents Coalition, founded by King County Prosecutor Norm Maleng. Steven Goldsmith, Can Laws Rein in Kids Who Take Off?, Seattle Post-Intelligencer, Feb. 10, 1995, at A1. The Runaway Alliance, a grassroots organization started by the mother of a runaway, also did extensive lobbying for the passage of the Becca Bill.
accounts chronicled Rebecca Hedman’s life as a runaway from her Tacoma, Washington home and her life on the streets as “Misty,” a crack-smoking prostitute whose nude body was discovered in Spokane, Washington on October 18, 1993. Many subsequent newspaper articles on “out-of-control” youth referred to Rebecca Hedman’s brutal murder. Few articles addressed the issues that cause youth to be “out-of-control,” and only one documented Rebecca Hedman’s pre-runaway life of alleged abuse as an infant, foster-care placement before the age of two, sexual abuse by an older brother in her adoptive home, and repeated placement in group homes and drug-abuse treatment programs.

The combination of the “Becca” stories, extensive media accounts of children “out-of-control,” and parents’ impassioned requests for assistance from the legislature resulted in the Becca Bill amendments to the Mental Health Care and Treatment for Minors Act (MHCTMA) and the Family Reconciliation Act, which provide legal processes for parents of at-risk youth and children who need state services.

The Becca Bill amended the voluntary admissions and involuntary commitment statute for minors, the MHCTMA. Most significantly, these amendments allow minors, ages thirteen and older, to be “voluntarily” admitted to mental health facilities upon application of a parent. Such admissions differ from the prior statutory scheme that


45. The Becca Bill legislative intent states, “The legislature recognizes there is a need for services and assistance for parents and children who are in conflict. These conflicts are manifested by children who exhibit various behaviors including: Running away, substance abuse, serious acting out problems, mental health needs, and other behaviors that endanger themselves or others.” 1995 Wash. Laws ch. 312, § 1 (codified at Wash. Rev. Code § 13.32.010 (1996)).

46. See supra note 4.

47. Traditionally, evaluation and treatment that a minor consents to have been considered “voluntary” whereas evaluation and treatment that are not consented to have been considered “involuntary” which requires “commitment.” “Commitment” is statutorily defined as “a determination by a judge or court commissioner, made after a commitment hearing, that the minor is in need of inpatient diagnosis, evaluation, or treatment or . . . less restrictive alternative treatment.” Wash. Rev. Code § 71.34.020(3).

48. “A minor may be voluntarily admitted by application of the parent. The consent of the minor is not required for the minor to be evaluated and admitted as appropriate.” Wash. Rev. Code § 71.34.030(2)(a).
required minors, thirteen years of age or older, be admitted to a facility voluntarily by a parent only if the parent’s application included the “knowingly and voluntarily” provided written consent of the minor.49 Prior to the Becca Bill only a county-designated mental health professional (CDMHP)50 could file a petition with the court for initial detention of an unconsenting minor in an inpatient mental health facility. CDMHPs were required to follow stringent statutory guidelines regarding admission for evaluation and continued detention for treatment when the minor failed to provide consent to treatment.51

Language in the “Becca Bill,” which stated that parents could “voluntarily” admit their minor children without the minors’ consent,52 caused a great deal of confusion regarding the effect of the Becca Bill amendments on minors’ due process rights. Many people believed this amendment meant that a single parents’ consent for their nature minor’s admission vitiated the need for a minor’s consent to inpatient evaluation and treatment.53 Extending the reasoning used in Parham far beyond the limits conceived by the Court, advocates of this position maintained that, because parents have a legal right to admit their mature minor children to mental hospitals against their will, parents and the admitting hospitals have no duty to seek review of the decision to admit, evaluate, provide treatment, or continue confinement.54

Youth rights advocates and civil libertarians were extremely concerned by this interpretation55 because, if accurate, the only procedure available under the statute to guard against the inappropriate confinement of a “voluntarily admitted” minor is a review by a CDMHP within sixty

49. See supra note 7.
50. “County-designated mental health professionals” are qualified psychiatrists, psychologists, psychiatric nurses, or social workers designated by one or more counties. Wash. Rev. Code § 71.34.020.
51. The duties and obligations of CDMHPs who seek admission of unconsenting minors was not changed by the amendments. Wash. Rev. Code §§ 71.34.050–.100. See infra notes 189–199 for a more thorough discussion of the current commitment scheme.
52. See supra note 48.
53. This was the position maintained by the mental health facility, the minor’s parents, and the judge who first heard the minor’s position in State ex rel. T.B. v. CPC Fairfax Hosp., 198 Wash. 2d 439, 918 P.2d 497 (1996). See infra note 69 and accompanying text.
54. CPC Fairfax, 198 Wash. 2d at 441, 918 P.2d at 500.
55. See Amicus Curiae Brief of American Civil Liberties Union & Seattle Displacement Coalition at 1, CPC Fairfax (No. 63389-4).
days of admission. According to the statutory scheme, if treatment of a “voluntary” admittee is not appropriate, the CDMHP is required to notify the facility, the child, the child’s parents, and the Department of Social and Health Services (DSHS). However, the statute fails to indicate specifically any procedural or substantive due process rights that accrue with a CDMHP determination that inpatient treatment is not appropriate when the admission is “voluntary.” Additionally, DSHS is required to select randomly and review the information of children who are initially admitted to inpatient treatment by their parents. But again, the Becca Bill does not identify any specific judicial procedures that would insure minors’ release if this systematic review reveals that individual minors are being held against their will.

D. State ex rel. T.B. v. CPC Fairfax Hospital

The plaintiff in the Washington Supreme Court case State ex rel. T.B. v. CPC Fairfax Hospital challenged the view that the Becca Bill’s amendments to the MHCTMA vitiated the need for judicial due process proceedings when unconsenting minors are admitted by their parents for inpatient mental health treatment. The controversy underlying the case involved the tension between parents’ rights to family autonomy and minors’ rights to constitutionally required judicial due process proceedings in mental commitment decisions.

At the time of the case, T.B. was a fifteen-year-old girl with a history of family difficulties. In 1994, her mother called the CDMHP to have T.B. involuntarily committed to a mental hospital; the CDMHP, however, found T.B. ineligible for commitment because she was neither a threat to herself or others as a result of a mental disorder. T.B.’s behavior and school performance deteriorated: she ran away from home, she failed to show up to an at-risk youth court hearing, and she was

56. CDMHPs may, on their own initiative, review the “voluntary” admission of any child between 15 and 30 days after admission. Wash. Rev. Code § 71.34.025(1). However, the statute requires DSHS to conduct a review no later than 60 days after admission. Wash. Rev. Code § 71.34.025(2).
57. Wash. Rev. Code § 71.34.020(5).
58. Wash. Rev. Code § 71.34.035.
59. Wash. Rev. Code § 71.34.025(3).
61. Id. at 450, 918 P.2d at 503.
62. Id. at 441, 918 P.2d at 498.
63. Id. at 442, 918 P.2d at 498.
arrested and placed in detention. While in detention, T.B. was seen by a psychiatrist but T.B. was uncooperative and left after about ten minutes. Based on this brief meeting, the psychiatrist determined, “T.B. probably did not meet the requirements for involuntary commitment but [the psychiatrist] reported [T.B.] suffered from reactive attachment disorder, conduct disorder, bipolar II disorder manic type, and attention deficit disorder.” T.B.’s parents then approached Fairfax Hospital seeking admission of T.B., and the private mental hospital admitted T.B. in absentia. Upon release from detention, T.B. was transported to the hospital by a private ambulance while strapped to a gurney in five-point restraints.

T.B. immediately requested release, but Fairfax refused either to release her or provide for a judicial hearing to authorize her continued confinement. T.B.’s attorneys filed a writ of habeas corpus and had a hearing two days after her admission. The trial court determined that T.B.’s parents had a legal right to place her at Fairfax, and T.B.’s demand for release did not trigger any duty to seek review by the court. In addition, the trial court judge determined that the procedures utilized by T.B’s parents and the hospital met the requirements of due process.

The Washington Supreme Court directly accepted T.B.’s appeal from the denial of her petition for writ of habeas corpus. The nine members of the court were unanimous in the case’s result: because T.B. was a minor who refused to consent to her inpatient treatment, the hospital was required to release her within twenty-four hours of her admission or file an application or petition for initial detention the next judicial day. The court also determined that statutory violations occurred when the minor was denied immediate access to counsel and subsequent access to her medical records. Because the case could be decided on statutory

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64. Id.
65. Id., 918 P.2d at 499.
66. Id.
67. Id. at 444, 918 P.2d at 499–500.
68. Id., 918 P.2d at 500.
69. Id. The trial court’s decision, as a sealed opinion, is unavailable.
70. Id. at 441, 918 P.2d at 498. The court of appeals provided the Washington Supreme Court with certification of the child’s appeal.
71. Id. at 451, 918 P.2d at 503. In so holding, the court implicitly indicated its unanimous rejection of the interpretation set forth by CPC Fairfax and T.B.’s parents who argued that the legislature intended to allow parents’ consent for the minor’s admission to ultimately vitiate the need for the minor’s consent to treatment.
72. Id.
grounds, the court did not recognize explicitly the fundamental constitutional right to due process that was implicated in this case.\textsuperscript{73} Although unanimous in result, the justices had different analyses of the facts and legal arguments.\textsuperscript{74}

The majority reached its conclusion based on its interpretation of the statute's language that characterized T.B. as a "voluntary" admittee, and as such, they determined she was entitled to be released when she requested or have a judicial due process hearing to continue confinement against her will.\textsuperscript{75} Because she was not released when she requested, her parents were required to file an application for initial detention the next judicial day after T.B.'s initial detention.\textsuperscript{76} For involuntary patients, initial detention always starts at the time of arrival at the facility; as a "voluntary" patient, however, "start of initial detention" begins at the time a patient fails to provide consent for treatment or rescinds consent.\textsuperscript{77} While claiming to avoid the constitutional issues of the case,\textsuperscript{78} the majority nonetheless used strident language stating:

Deprivation of these statutory rights in the context of such a massive curtailment of liberty as commitment to a mental institution also constitutes a deprivation of that process due under the Fourteenth Amendment to the United States Constitution . . . .\textsuperscript{79}

The concurring minority vociferously challenges the majority's reading of the statute and argues that the majority exceeded the scope of its authority by "underhandedly" reaching the constitutional issue.\textsuperscript{80} The minority argues that the statutory language referring to an unconsenting minor's admission as "voluntary," was merely an error due to oversight by the drafters.\textsuperscript{81} Despite calling the majority's reading "Orwellian" and violative of general statutory principles, the minority nonetheless emphatically states, "A child admitted against her will cannot be other

\textsuperscript{73} Id. at 441, 918 P.2d at 498.
\textsuperscript{74} The majority opinion, penned by Justice Sanders, was signed by Justices Durham, Smith, and Alexander, with Justice Madsen concurring in the result. The minority concurrence, written by Justice Dolliver, was signed by Justices Guy, Talmadge, and Johnson. See id at 454–63, 918 P.2d at 505–08 (Dolliver, J., concurring and dissenting in part).
\textsuperscript{75} Id. at 450–51, 918 P.2d at 503.
\textsuperscript{76} Id. at 451, 918 P.2d at 503.
\textsuperscript{77} Id. at 450, 918 P.2d at 503 (citing statutory definition of "start of initial detention," Wash. Rev. Code § 71.34.020(23)).
\textsuperscript{78} See supra note 6.
\textsuperscript{79} CPC Fairfax, 129 Wash. 2d at 452–53, 918 P.2d at 504.
\textsuperscript{80} See supra note 6.
\textsuperscript{81} CPC Fairfax, 129 Wash. 2d. at 459, 912 P.2d at 507.
than an involuntary admittee... Unwilling children admitted by their parents cannot be voluntary admittees.\textsuperscript{82} The minority's concurrence states that the statutory provisions governing involuntary admittees must be applied, and those standards are the same for admitting and detaining unwilling minors regardless of whether a parent or the state (via a CDMHP) initiates admission.\textsuperscript{83}

In effect, both the majority's and minority's positions clearly posit that unconsenting minors have a statutory right to judicial due process when they are admitted by their parents to inpatient mental health facilities. Furthermore, regardless of the appropriateness of doing so, the majority's opinion also recognizes that minors have a constitutional right to due process.

Neither \textit{Parham} nor \textit{State ex rel. T.B. v. CPC Fairfax Hospital} explicitly articulate the processes required, by the U.S. and Washington Constitutions, to safeguard the liberty and privacy interests of minors who refuse to consent to inpatient mental health treatment at either a public or private facility. \textit{Parham} merely maintains that parents initially may admit their minor children for inpatient evaluation purposes but goes no further to explain minors' due process rights.\textsuperscript{84} \textit{State ex rel. T.B. v. CPC Fairfax Hospital} states that unconsenting minors in Washington have a statutory right to due process when being presented for mental health commitment against their will and the majority highlights the constitutionally recognized interests of minors facing unwanted inpatient mental health treatment.

\section*{II. CONFINING MATURE MINORS TO MENTAL INSTITUTIONS AGAINST THEIR WILL WITHOUT JUDICIAL DUE PROCESS PROCEEDINGS RESULTS IN LIBERTY AND PRIVACY DEPRIVATIONS THAT VIOLATE THE WASHINGTON AND U.S. CONSTITUTIONS}

Because current case law fails to state explicitly that minors who refuse to consent to inpatient mental health treatment have fundamental constitutional rights to judicial due process, parents' rights advocates and members of the legislature may erroneously believe that minors' due process...
Minors' Due Process Rights

process rights may be further limited by simply amending the MHCTMA. This Comment explains the processes due when a minor's constitutionally recognized liberty and privacy interests are threatened by treatment in an inpatient mental hospital against the minor's will. Unconsenting minors admitted for inpatient treatment by their parents have a right to the same due process as all other adults and minors. These rights and the interests they safeguard must be clearly elucidated.85

A. The Constitutional Right to Due Process When Consent Is Not Granted for Inpatient Psychiatric Treatment

The U.S. Supreme Court frequently has held that minors, as well as adults, are entitled to constitutional protections and possess constitutional rights.86 The Fourteenth Amendment to the U.S. Constitution provides that, "No state . . . shall . . . deprive any person of life, liberty, or property, without due process of law."87 The Washington Constitution has been interpreted to provide broader protection for due process rights than its federal counterpart.88

The Washington Constitution also provides broader protections than the U.S. Constitution regarding the rights to privacy and freedom from governmental intrusion into citizens' private affairs. Unlike the U.S. Constitution, which simply infers the right of privacy from other constitutional clauses, the Washington State Constitution provides an explicit right to privacy.89 This right to privacy has been recognized as a fundamental right with regard to autonomous decision-making.90

Particularly in the context of involuntary institutionalization, the Washington Constitution has been interpreted to provide more expansive

85. See supra note 10.


protections of privacy than its federal counterpart and it has been deemed to protect the right to refuse medical and psychiatric treatment. Additionally, Washington State's courts and legislatures have been ahead of their federal counterparts in extending more expansive due process protections to both minors and adults facing forcible hospitalization. This has also been true in the case of upholding mature minors' rights to autonomy in medical decision-making.

There is no question that both the U.S. and Washington Constitutions require that due process must accompany involuntary commitment for mental disorders. The U.S. Supreme Court has described forcible detention in a psychiatric institution as "a massive curtailment of liberty." To commit individuals to mental institutions, the Due Process Clause requires that the State prove by clear and convincing evidence that the individuals are both mentally ill and dangerous to themselves or others. Involuntary commitment entails greater deprivations of liberty than mere confinement and can be imposed indefinitely. Consequently, it can constitute a more intrusive exercise of state power than imprisonment for a criminal conviction. Forced hospitalization encroaches on liberty interests by affecting patients' rights of freedom from unwanted bodily intrusion via physical restraints or forced


93. State v. Koome, 84 Wash. 2d 901, 904, 530 P.2d 260, 263 (1975) (holding mature minors' rights to autonomy in medical decision-making derives from article 1, section. 3 of Washington Constitution).


98. In Youngberg v. Romeo, 457 U.S. 307 (1982) the Supreme Court affirmed that "[l]iberty from bodily restraint always has been recognized as the core of the liberty protected by the due process
Minors' Due Process Rights

medications,99 freedom from coercion, and the exercise of autonomy in medical decisions inherent in the "right to privacy."100 The Washington Supreme Court has held that the full guarantee of due process is necessary in civil commitment proceedings, and even a guardian ad litem cannot waive the fundamental due process rights of an incompetent adult without knowing consent by the accused.101

B. Applying the Mathews/Harris Test for Due Process Procedures

The current statutory provisions governing involuntary admittees must be applied when an unconsenting minor is admitted by his or her parents to a mental health facility.102 Both the U.S. and Washington Supreme Courts use the same balancing test to determine whether due process requirements have been met when the State's procedures have the potential to deprive individuals of constitutionally recognized interests.103 This test balances the government's interests, the private interests affected by State action, and the risk of erroneous deprivation of private interests.104 Each of these factors will be considered separately in the context of Washington State's current procedures for mental health commitment of minors by their parents.


102. State ex rel. T.B. v. CPC Fairfax Hosp., 129 Wash. 2d 439, 448–49, 918 P.2d 497, 502, 507 (1996). The statutory provisions include Washington Revised Code sections 71.34.030(3)(d) and 71.34.050(2).

103. Mathews v. Eldridge, 424 U.S. 319, 332–35 (1976); In re Harris, 98 Wash. 2d 276, 285, 654 P.2d 109, 113 (1982); see supra note 32 and accompanying text. While the U.S. and Washington Supreme Courts use the same test to balance interests, the weight given to those interests will differ as the Washington Constitution provides broader protections than its U.S. counterpart. See Amicus Curiae Brief of American Civil Liberties Union & Seattle Displacement Coalition at 5, CPC Fairfax (No. 63389-4); supra notes 86–91.

104. Mathews, 424 U.S. at 335. Because in this instance the government's interest is the least consequential and easily dealt with first, the author has changed the order of analysis.
1. The Government's Interest

Washington State has an obligation under the MHCTMA to protect the child's liberty interest and guard against the needless hospitalization of its youngest and most vulnerable citizens. Furthermore, due process clauses of the Washington and U.S. Constitutions require that the nature of involuntary commitment bear some reasonable relation to the purpose for which the individual is committed. Thus, even if the State uses fair procedures, there is still a substantive constitutional obligation, which cannot be abrogated by statute, to bar arbitrary and wrongful government actions. Such arbitrary government action would include the involuntary commitment of minors to mental hospitals as punitive and rehabilitative measures to address the problems of youth who are perceived to be "out-of-control," but not mentally ill and dangerous.

The State also has an interest in reinforcing family autonomy and the rights of parents. The MHCTMA recognizes that parents have a right to participate in treatment decisions, and the Becca Bill amendments created several new mechanisms that assist parents in getting treatment for their children. Parents now can start the procedure for the involuntary commitment of an unwilling child, and parents can seek review if the CDMHP refuses to file the petition for initial detention or

105. Wash. Rev. Code § 71.34.010. The section states:
It is the purpose of this chapter to ensure that minors in need of mental health care and treatment receive an appropriate continuum of culturally relevant care and treatment, from prevention and early intervention to involuntary treatment.

It is also the purpose of this chapter to protect the rights of minors against needless Hospitalization and deprivations of liberty and to enable treatment decisions to be made in response to clinical needs and in accordance with sound professional judgment. The mental health care and treatment providers shall encourage the use of voluntary services and, whenever clinically appropriate . . . offer less restrictive alternatives to inpatient treatment.

Additionally, . . . providers shall ensure that minors' parents are given an opportunity to participate in the treatment decisions for their minor children. The . . . providers shall, to the extent possible, offer services that involve minors' parents and family.

§ 71.34.010.


108. Supra note 103.


110. Wash. Rev. Code § 71.34.050(1).
if a hospital refuses to file a petition for fourteen day commitment. By intervening immediately after a minor has been initially admitted by a parent, the State can best achieve its goal of promoting family unity by interjecting itself between the conflicting parent and child regarding the commitment decision. Minors and their parents will be assured that the commitment decision is an objective one and that inpatient treatment is truly necessary. Judicial oversight of involuntary commitment proceedings first began in the early part of this century. As a consequence, judges, lawyers, social workers, and guardians ad litem who participate in involuntary commitment proceedings are well trained in handling delicate family and mental health issues. There is no reason to suspect that when parents make the admission decision, judicial participants are less likely to conduct their inquiries in a professional manner that continues to balance respect for family privacy and autonomy with a minor's right not to be deprived of liberty unnecessarily. Indeed, by having trained judicial participants in the admission and treatment decision processes families of mentally-ill children will have an exposure to a greater number of resources if outpatient treatment is deemed the most appropriate level of care. When admission is appropriate, the family can work with trained judicial participants, not just hospital staff, toward developing appropriate less restrictive treatment options when inpatient treatment is no longer appropriate.

The State has an additional interest in protecting its youth from unethical marketing and abuses of psychiatric diagnoses that might be inappropriate. The State also has an interest in protecting its own mental health and legal resources, and those of private and state insurers, by refusing to allow its adolescents to be "recruited" by companies with a well-documented history of unethical practices and insurance fraud. In addition to congressional hearings, several lawsuits and costly investigations have already been undertaken at the federal level. In the early 1990s National Medical Enterprises, which ran a nationwide chain of for-profit psychiatric hospitals for children, paid a $379 million settlement to the federal government over a fraud investigation involving its psychiatric services. Federal government reviews have shown that,

111. Wash. Rev. Code § 71.34.070(1).
112. See infra part II.B.3.
114. The settlement has been described as the largest settlement ever with the federal government. See Elyse Tanouye, Smithcline Is Close to Settling Billing Charges, Wall St. J., Sept. 6, 1996, at B1.
because the military offers its members rich medical benefits, private psychiatric hospital abuses of teenagers and young children from military families may have cost American taxpayers hundreds of millions of dollars.115

The Legislature's intent with the Becca Bill amendments was to assist parents in procuring mental health treatment for their children, not to cut financial or administrative costs incurred by the then-existing due process procedures.116 Nonetheless, the State's interest in conserving its judiciary's financial and administrative resources should be addressed. There should be no increase in judicial costs as a result of requiring hearings when parents admit their unconsenting minor children. Prior to the Becca Bill, all unconsenting minors admitted by CDMHPs were entitled to a hearing. Initial admission criterion and standards were not changed by the Becca Bill, and they are the same regardless of whether parents or CDMHPs make the admission decisions. If admission criterion is being applied as required by statute, allowing parents to circumvent the CDMHP process, and make admissions decisions on their own, should not in and of itself cause an increase in the number of hearings required.117

2. Analysis of the Private Interests Affected by the Washington Civil Commitment Statute for Minors

a. The Minor's Interests

Significant liberty, privacy, equal protection, and due process rights of minors are affected when minors attempt to make autonomous decisions about their own medical care and oppose commitment to mental institutions.

115. See Peter Kerr, U.S. Study of Mental Care Finds Widespread Abuses, N.Y. Times, Apr. 29, 1992, at D1 (stating that federal review of private psychiatric cases, mostly involving children in military families, has determined that "in 64 percent of the cases patients never should have been admitted, were kept longer than necessary, or had medical records for which their Hospitals could not justify treatment")

116. As evidence, nowhere in the bill did the legislature state that the Becca B 11 was designed to cure budgetary woes or amend financial obligations by the State.

117. There is the risk that costs will increase if unconsenting minors are being admitted inappropriately. Any such increase in costs must not be attributed to the processes due after admission. Instead, they should be attributed to abuses of admitting physicians who have an ethical and professional responsibility to safeguard minors rights. See infra note 179 and accompanying text.
Even beneficial commitment involves deprivations that have accompanying harmful effects that can be manifested in a very short time. \(^\text{118}\) Within the hospital, freedom of movement often is closely regulated. \(^\text{119}\) Contact with the world outside the institution is highly regulated and can be denied by staff for lack of treatment progress or acting-out behavior. These contacts include visits from friends and family and trips outside the hospital setting. Upon release, the stigma of being a former "mental patient" can affect job prospects and reintegration into the community. These deprivations, if even for a short time, may have grave and lasting consequences for the rest of the person's life. \(^\text{120}\)

Children may have a stronger liberty interest than adults, as the consequences of erroneous commitment decisions are more tragic for children. Children, on average, are committed for longer periods than adults. \(^\text{121}\) The primary purpose of psychiatric treatment is to alter the patient's thoughts and behaviors, which has profound implications for adolescents in the critical stages of identity formation. \(^\text{122}\) Also, the problem of "institutionalization," whereby patients who have been subject to the total control of an institutional authority become unable to "cope" in the community, may be particularly acute for minors due to long inpatient stays. \(^\text{123}\) Moreover, the use of psychotropic medications can have a grave impact on an adolescent's physical development. \(^\text{124}\)

\(^{118}\) In re Harris, 98 Wash. 2d 276, 279, 654 P.2d 109, 111 (1982); see also Redding, supra note 26, at 3–4.


\(^{120}\) Colyar, 469 F. Supp. at 430; see also Lessard v. Schmidt, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972).

\(^{121}\) Jackson-Beeck et al., supra note 100, at 157.

\(^{122}\) Tremper & Kelly, supra note 26, at 114.

Failure to arrive at any psychosocial self-definition plagues some individuals, particularly those who find decision-making a threatening and conflict-ridden experience or lack opportunity to exercise choice. Such failure tends to fuel a sense of isolation, shame, apathy, personal alienation, and perceptions of being manipulated by others.

Id.


\(^{124}\) One court described the potentially disastrous effects of tranquilizing drugs to control behavior, including "collapse of the cardiovascular system, the closing of the patient's throat with consequent asphyxiation, a depressant effect on the production of bone marrow, jaundice from an affected liver, drowsiness, hematological disorders, sore throat, and ocular changes." Nelson v. Heyne, 491 F.2d 352, 357 (7th Cir. 1974); see also Peter Breggin & Ginger Ross, The War Against Children 85–86 (1994) (discussing neurological damage and growth inhibition caused by ritalin, medication frequently prescribed for children with attention deficit and hyperactivity disorders).
Finally, the stigma of having been committed to a mental institution can affect an adolescent’s future educational and employment opportunities.\textsuperscript{125}

The Washington Legislature recognized the privacy and liberty interests of minors in creating the MHCTMA. It has been determined that minors age thirteen or older are mature enough to consent to mental health treatment and can commit themselves for inpatient treatment without obtaining parental approval.\textsuperscript{126}

Allowing minors to be committed by a parent against their will can alienate minors from voluntarily seeking mental health treatment in the future. If commitment is associated with force and deprivation of decision-making power, minors who might need less restrictive help, such as outpatient treatment, are likely to avoid seeking treatment for fear they will be confined against their will. Similarly, youth who are confined unnecessarily now are likely to view the mental health system with fear and distrust in the future.\textsuperscript{127}

\textit{b. Parent's Interest}

The U.S. Supreme Court traditionally has permitted broad parental authority over minor children. It has viewed decisions regarding the child’s best interest as the right of the parents which, absent a compelling state interest, typically has been protected from state interference.\textsuperscript{128}

In \textit{Parham}, the Court presumed that parents “possess what a child lacks in maturity, experience, and capacity for judgment” in making

\begin{itemize}
  \item \textsuperscript{125} “Because of such Hospitalization, they will be prevented from getting state employment, federal employment, running for public office, climates [sic] their ability to get future medical insurance, and labels them with a diagnosis forever.” Hearings, \textit{supra} note 113, at 156 (statement of Walter E. Afield, M.D.) (documenting investigation that found thousands of adolescents, children, and adults have been Hospitalized for treatment they didn’t need); \textit{see also} Parham v. J.R., 442 U.S. 584, 626-27 (1979) (Brennan J., concurring and dissenting in part).
  \item \textsuperscript{127} \textit{See In re Harris}, 98 Wash. 2d 276, 288, 654 P.2d 109, 115 (1982) (“Ms. Harris’ only previous commitment experience was involuntary, and it left her with a lasting fear of commitment. It is not surprising that she became a fugitive when ordered to report to the Hospital.”).
  \item \textsuperscript{128} \textit{See supra} notes 14–16 and accompanying text; \textit{see also} Parham v. J.R., 442 U.S. 584, 602 (1979); Wisconsin v. Yoder, 406 U.S. 205 (1972) (unconstitutional to require Amish children to attend public high school).
\end{itemize}
mental health decisions. Legislative or judicial deference to parental authority when parents commit their mature minors to inpatient mental health hospitals is based implicitly on traditional assumptions about parent/child relationships: parents always act in their child’s best interests and are able to perceive accurately what those interests are; children are less capable of making life choices than are their parents and therefore need parental protection; and families are able to care effectively for their children’s needs without outside supports.

Unfortunately, these assumptions do not always prove correct, particularly in juvenile commitment cases where parents actively seek outside support and assistance in decision-making for their children. Because parents’ concerns must include the well-being of the entire family, commitment may be based upon these concerns and/or a misunderstanding of the child’s behaviors. A parent may have distorted perceptions and may blame all family problems on a child’s behavior, while the child’s behavior may be unrelated to mental illness but, instead, be in response to changes in the family structure, such as divorce, parental conflict, and family moves which sever social support networks. Not infrequently, the parent admitting the child for treatment, suffers from mental illness, or is experiencing extreme crisis that makes it difficult to cope with parenting responsibilities.

The Parham Court’s concern that parents would refuse to seek mental health treatment for their children because of their own privacy concerns is not resolved by allowing parents to admit their children. Physicians are required to conduct an investigation and medical inquiry when making admission diagnoses, so a family’s history will need to be investigated before admission one way or the other.

After admission, parent’s authority and the right to family autonomy is significantly diminished. Once parents have decided to surrender custody of their minor children to a state or private mental institution, the

129. 442 U.S. at 602.
133. Id. at 6; see also Lois A. Weithorn, Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates, 40 Stan. L. Rev. 773, 799–802 (1988).
134. See Melton, supra note 123, at 156–57.
136. See infra notes 190–193 and accompanying text.
child is no longer under the exclusive control of the parent. Thus, a parent’s right to autonomy should no longer serve as a barrier to the minor’s right to judicial due process.

3. The Risk of Erroneous Deprivations Is High

Like parents, clinicians frequently misperceive the need for inpatient psychiatric treatment for minors. Although most clinicians do not intentionally act contrary to the child’s best interests, pressures from parents, institutions, or diagnostic error may result in inappropriate treatment recommendations. Without looking into family history, it is often difficult for mental health clinicians to make accurate diagnoses regarding mental illness of minors. Further, other evidence suggests that clinicians tend to over-diagnose in the case of adolescents in general. This seems particularly likely at private, for-profit facilities and when mental health clinicians admit a child who has never previously undergone any thorough psychiatric evaluation.

a. Diagnoses at Admission Might Be Inaccurate

An assessment of an unconsenting minor who has been admitted by a parent as a result of physical force or coercion seems particularly likely to produce inaccurate results. Assessing adolescents at admission, in a stressful and unfamiliar environment, complicates the relatively unreliable nature of childhood psychiatric diagnosis.

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137. A parent unknowledgable about mental health care may simply defer to a clinician’s diagnosis and treatment program for their child. Weithorn, supra note 133, at 811–12. Despite their good intentions, in many instances parents are simply unaware that their child is being abused, medicated, or coerced into inappropriate treatment programs while in inpatient care. Hearings, supra note 113, at 298 (prepared statement of Louis Smith, J.D.).


139. Id.


141. Jackson-Beeck et al., supra note 100, at 157; Weithorn, supra note 133, at 785–87.

142. See infra parts II.B.3(a), (b).

143. See supra notes 131–134 and accompanying text.

The psychiatric profession’s bible, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, has received strong criticism for its increasing number of vague and elastic “diagnoses” of “disorders” that almost exclusively affect children and adolescents. The *DSM-IV* identifies many “disorders” that are likely to apply to most juveniles (and many adults) at some point during adolescence. There are no recommendations for “treatment” of these “mental disorders,” nor are there guidelines for when inpatient treatment is preferred over outpatient treatment. Additionally, there are few, if any, words of caution to a psychiatrist consulting the *DSM-IV* regarding the interplay of social, cultural, economic, and familial influences on adolescent behavior.

It is important to understand the *DSM-IV* adolescent diagnoses to explain why the involuntary commitment of juveniles, in particular, should undergo judicial scrutiny as a due process protection of fundamental liberty interests. According to some reports, about two-thirds of juvenile inpatients receive initial diagnoses of Conduct Disorder (CD), a personality or childhood disorder (which includes Oppositional-Defiant Disorder (ODD)), or transitional disorders.

CD is a diagnosis frequently applied to adolescents. The *DSM-IV* reports, “The prevalence of Conduct Disorder appears to have increased over the last decades and may be higher in urban than in rural settings.... Conduct Disorder is one of the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children.” CD is typified by a “repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.” Characteristic “symptoms” of CD include: stealing, lying, property destruction, running away from home, truancy, and aggression. The *DSM-IV* notes concerns that the diagnosis may be misapplied to individuals if the behavior occurs while living in

147. Weithorn, *supra* note 133, at 788, n.99 (suggesting that only one-third of juveniles admitted for inpatient treatment suffered from severe or acute mental disorders of the type typically associated with inpatient admission (such as psychotic, serious depressive, or organic disorders) and citing California study that revealed that about 53% of Hospitalized juveniles suffered from disorders defined by antisocial or runaway behavior or general personality problems, whereas those Hospitalized for depression comprised another 17%).
149. *Id.* at 85.
150. *Id.* at 86.
threatening, impoverished, or high-crime areas. The DSM-IV also reports the risk for CD is increased when a parent has CD, Antisocial Personality Disorder, alcohol problems, mood disorders, schizophrenia, or Attention Deficit/Hyperactivity Disorder (ADD/ADHD).

After CD, the second class of diagnosis frequently assigned to adolescent inpatients is that of the "personality disorders" generally and ODD specifically. An essential feature of ODD is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior. Negative behavior is characterized by the child frequently exhibiting least four of the following eight behaviors: (1) losing temper; (2) arguing with adults; (3) actively defying or refusing to comply with adult requests; (4) deliberately annoying people; (5) blaming others for mistakes or misbehavior; (6) overreacting or becoming easily annoyed by others; (7) acting angry and resentful; and (8) being spiteful or vindictive. According to the DSM-IV, ODD is more common in families in which there is serious marital discord or at least one parent has an emotional disorder (such as maternal depression), learning disability (such as ADD/ADHD) or a substance abuse problem. An associated feature of ODD may be "a vicious cycle in which the parent and child bring out the worst in each other." The DSM-IV describes the prevalence of this "cycle" in families in which child care is given by a succession of different caregivers or in which harsh, inconsistent, or neglectful child rearing practices are common. "Manifestations of the disorder are almost invariably present in the home setting, but may not be evident at school or in the community." Rates of ODD from two percent to sixteen percent of the juvenile population have been reported, depending

151. Id. at 88. This seems to indicate that adolescents from poor, urban cities might exhibit all the symptoms of CD but be "normal" given their social context. However, another youth should be diagnosed as having a "mental disorder" if he or she exhibits the same behavior, has a similar troubled family environment, but comes from a suburban or rural neighborhood and/or a higher economic class.

152. Id. at 89; see also id. at 78. ADD/ADHD is another common diagnosis used for adolescents. The essential feature of ADD/ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity more severe than in others at the same stage of development. Inattention may be manifested by failing to pay close attention to details, difficulty sustaining tasks, and failure to follow through on requests or instructions. Id.

153. Weithorn, supra note 133, at 790, n.98.

154. Id. at 91.

155. Id.

156. Id. at 93.

157. Id. at 92.

158. Id.
Minors’ Due Process Rights

on the “nature of the population sample and methods of ascertainmen.”

Identifying the behaviors described above as “mental disorders” serves to pathologize what is ordinarily seen as fairly common adolescent behavior. In an adult, the “Oppositional-Defiant” behaviors would, most likely be viewed as appropriate and healthy responses to neglect and maltreatment. Yet, these are the diagnoses that were most often used to admit juveniles to mental health hospitals in the 1980s when the most egregious admissions abuses were common. Indeed, initial diagnoses of these “disorders” continue to be grounds for involuntary inpatient admissions today.

b. Abuse in Juvenile Admissions by Private Psychiatric Hospitals Is Cause for Concern of an Erroneous Deprivation

The risk of an erroneous liberty deprivation is more likely to occur when minors are admitted by their parents to private, for-profit psychiatric facilities than when admitted by state agents or to state hospitals. In 1992, the U.S. House of Representatives held hearings regarding numerous reports of abuse in juvenile civil commitments by private psychiatric hospitals. The house hearings occurred after investigations by many individual states. The house and states’ investigations revealed a prevalence of fraudulent billing practices,

159. Id.
160. Armstrong, supra note 144, at 149.
161. In State ex rel. T.B. v. CPC Fairfax Hosp., 129 Wash. 2d 439, 442, 918 P.2d 497, 499 (1996) the minor was admitted against her will after a ten minute evaluation, during which she did not cooperate, that resulted in a diagnosis that included CD among other common disorders. See supra notes 65–67 and accompanying text.
162. See Hearings, supra note 113; Emerging Trends in Mental Health Care for Adolescents: Hearings Before the House Select Comm. on Children, Youth, and Families, 99th Cong., 1st Sess. 5 (1985) (citing data documenting four-fold increase in admissions of adolescents to private psychiatric Hospitals from 1980–84); Kerr, supra note 115.
163. In the early 1990s, the Texas Senate Interim Committee on Health and Human Services was particularly thorough in its investigation of private psychiatric Hospitals’ abuses due in large part to media attention to the plight of several adolescents. See Hearings, supra note 113, at 5–6.
insurance fraud,\footnote{Id. at 44-60 (prepared statement of Louis Parisi, Director, Fraud Div., NJ Dep't of Ins.); id. at 195-275 (documenting investigations of fraud on behalf of Civilian Health and Medical Program of the Uniform Services).} and intentional misdiagnoses of patients to match insurance coverage.\footnote{Id. at 61-77 (statement of Curtis L. Decker, Esq., Exec. Dir., Nat'l Assoc. of Protection & Advocacy Sys., Inc.) (documenting intentional misdiagnosis, abuse, and neglect in private psychiatric hospitals); id. at 120-26 (statement of Charles S. Arnold, M.D., Psychiatrist).}

The House of Representative’s hearings resulted in overwhelming evidence that juveniles were a particular “target” for inpatient mental health treatment “recruiters” during the 1980s\footnote{Id. at 362-521 (documenting marketing practices of psychiatric Hospitals); see also Joe Sharkey, Bedlam: Greed, Profiteering and Fraud in a Mental Health System (Gore Crazy) (1994).} when stockholders began suffering losses or decreases in profits due to empty beds and a dwindling number of adult patients due to insurance cut-backs. Companies responded by creating new marketing programs targeted at adolescents because this group typically has the longest stays, the lowest costs for care,\footnote{Cost for adolescent “treatment” is lower than that for adults because treatment for the most common “adolescent disorders” usually consists of group “therapy” and discussion groups. Hearings, supra note 113, at 96-107 (statement of Russel D. Durret, former employee, Psychiatric Hosp.).} the highest bills, and the best insurance coverage.\footnote{Id.}

The hearings also revealed that companies’ marketing departments specifically targeted concerned parents of “troubled youth” in their advertising campaigns. Due to highly lucrative insurance benefits for adolescents, one investigator estimated that in just two hospitals, hundreds of children with ODD, CD, ADD/ADHD, and adjustment disorders were admitted for lengthy inpatient stays\footnote{Id. at 68 (statement of Curtis L. Decker, Exec. Dir., Nat'l Assoc. of Protection & Advocacy Sys., Inc.).} as, “[t]his group was the easiest to place in the hospital as the parents made the decision for admission.”\footnote{Id. at 105 (emphasis added) (statement of Russel D. Durret, former employee, Psychiatric Hosp.).}

As part of “recruitment” efforts, these facilities offered “evaluations and services” to school districts, community groups, and crisis-intervention services.\footnote{Id. at 2, 437, 439.} In fact, one company frequently sent “free” counselors (recruiters) to the scenes of high-school tragedies to provide “support” to survivors.\footnote{Sharkey, supra note 166, at 259.} Hospitals frequently paid “bonuses” to hospital
staff, including crisis-line counselors and doctors, for referrals that resulted in admission.\textsuperscript{173}

Once minors were admitted, distressed families were routinely presented with a very misleading portrayal of services and benefits their child was receiving.\textsuperscript{174} Children’s insurance providers would frequently be billed for several hours of group therapy a day,\textsuperscript{175} although most professionals admit even one-on-one therapy cannot be effective after about two hours a day. Additionally, children's insurance companies were being billed daily for dosages and types of medications daily that, if actually taken, would have been lethal.\textsuperscript{176} With alarming frequency, adolescent patients were deemed “cured” the same day their insurance benefits ran out.\textsuperscript{177} As a result of these abuses, many of the discharged children’s behavioral problems were worse, rather than better, after their inpatient treatment.\textsuperscript{178}

The U.S. Supreme Court in \textit{Parham} upheld the initial admission of a minor against his or her will because of the independent medical decision-making process used by Georgia’s state hospitals. This process included a thorough psychiatric investigation by a “neutral decision-maker.”\textsuperscript{179} Unfortunately, when initial admission is not accompanied by a previous diagnosis made outside the inpatient mental health facility, there is a serious danger that such inquiry will not occur.

Washington State’s standards for a minor’s admission merely require that a person in charge of an evaluation and treatment facility have a reason to believe that a minor needs inpatient treatment because of a mental disorder, that the facility provides the evaluation and treatment needed by the minor, and that treatment in a less restrictive setting is not

\textsuperscript{173} Hearings, \textit{supra} note 113, at 2, 104–05.
\textsuperscript{174} \textit{Id.} at 285 (prepared statement of Corydon G. Clark, M.D.).
\textsuperscript{175} \textit{Id.} at 102.
\textsuperscript{176} \textit{Id.} at 9 (statement of Texas Senator Mike Moncrief, Chair, Tex. Senate Interim Comm. on Health & Human Servs.).
\textsuperscript{177} \textit{Id.} at 285 (prepared statement of Corydon G. Clark, M.D.); \textit{Weithorn, supra} note 133, at 818.
\textsuperscript{178} There are likely to be differences between state and private hospital admission standards and private hospitals are more likely to lack neutrality and competency in admission decisions. The State is likely to have more stringent hiring standards for its hospitals as is consistent with the State’s benevolent purpose of caring for its citizens. Conversely, private mental health institutions are typically run for profit and admissions staff are likely to have both a professional and financial incentive to admit minors who don’t necessarily meet more stringent state criteria.
feasible. However, evidence suggests that minors have been admitted to inpatient treatment inappropriately because there is a lack of available or adequate community mental health services or a lack of insurance coverage for community based services that may exist.

c. *Admissions Decisions Made Without a Prior Psychiatric Evaluation Increase the Risk of Erroneous Deprivation*

Evidence suggests that a "neutral" decision cannot be made by a single admitting clinician when a parent brings a child for treatment without a prior referral from a community mental health professional. Although the goal of the psychiatrist is supposed to be the best welfare of the child-patient, "[i]t is the parent who has come to seek help, whose situation seems most desperate, who seems the most reliable source of information about what is wrong, [and] who is closest to the psychiatrist in age and social outlook . . . ." Therefore, the admitting clinician is more likely to believe or side with a parent when the parent and child are in conflict about the decision to admit. Additionally, concern has been expressed that there can be no "neutrality" when an admitting clinician has any relationship with the hospital which could be characterized as a "financial interest" in the decision to admit. This concern is particularly compelling in regard to private for-profit hospitals. The intake staff at private hospitals working with the parents to achieve admission are usually strongly biased in favor of admission to the hospital and minimally knowledgeable about alternatives. Furthermore, there is no proof that inpatient treatment is any more effective than outpatient treatment for adolescents with CD and ODD disorders, the most frequent diagnoses for admission at private hospitals.

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180. Wash. Rev. Code § 71.34.030(2). The Becca Bill amendments did not alter this portion of the statute.
181. See Redding, supra note 26, at 6–7; Weithorn, supra note 133.
183. Redding, supra note 23, at 702 (citing Ellis, supra note 140, at 868).
184. Id.
185. Weithorn, supra note 133, at 816–21.
187. Melton, supra note 123, at 159.
188. See supra note 147.
C. **Current State Procedures Adequately Recognize Parents’ Interests and Safeguard Minors’ Rights**

Due process requires that admission decisions be based on sound clinical judgment, family history, a serious mental health need that can’t be met in a less restrictive environment, and the threat of danger to oneself or others. To ensure that this criterion is met in the case of minors, judicial review of admission decisions and continued treatment are required by both the Washington State and Federal Constitutions.

The current statutory scheme of the MHCTMA, as recognized by the Court in *State ex rel. T.B. v. CPC Fairfax Hospital*, safeguards minors’ due process rights while simultaneously allowing parents a role in the mental health decisions of their children. These protections begin with a petition for initial detention the next judicial day after admission. The procedures for this petition trigger a number of due process protections. First a determination must be made that the minor, “as a result of a mental disorder presents a likelihood of serious harm” or is gravely disabled.” When investigating whether or not the minor meets these defined standards, one must look into the specific facts alleged, the credibility of the person or persons providing the information, and the determination that voluntary admission for inpatient treatment is not possible.

If these requirements are met, one can petition for an “involuntary” seventy-two hour treatment period to approve an initial detention at a treatment facility providing inpatient assessment and treatment. The minor must be given a copy of the petition, notice of initial detention, and

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189. Wash. Rev. Code § 71.34.050.
190. “Mental disorder” pertains to organic, mental, or emotional impairment that has substantial adverse effects. “The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or mental retardation alone is insufficient to justify a finding of ‘mental disorder.’” § 71.34.020(12).
191. “Likelihood of serious harm” means either (a) a substantial risk that the individual will harm him or herself as evidenced by threats or attempts of suicide or physical harm; (b) a substantial risk that the individual will harm someone else, as evidenced by prior harms to others or a reasonable fear of harm by another; or (c) a substantial risk that an individual will harm other’s property, as evidenced by prior behavior causing substantial property loss or damage. § 71.34.020(11).
192. “Gravely disabled minor” means a minor with a mental disorder who is in danger of serious physical harm due to a failure to provide for his or her essential human needs of health or safety, or who, as a result of not receiving essential care for health and safety, manifests severe deterioration in functioning and repeated and escalating loss of cognitive or volitional control over his or her actions. § 71.34.020(8) (1996).
193. § 71.34.050(1) (1996).
194. § 71.34.050 (1996).
and a statement of his or her rights. The petition must be filed with the court on the next judicial day following initial detention and serve the petition and notice on the minor's attorney as soon as possible. Additionally, the minor must be informed, orally and in writing, that a probable cause commitment hearing will be held within seventy-hours; that the minor has a right to communicate with an attorney; and that the minor has the right to have an attorney appointed if the minor is indigent. Finally, the evaluation facility must evaluate the minor's condition within twenty-four hours and decide whether to admit or release the minor in accordance with the involuntary commitment procedures. After the initial seventy-two hour treatment period, a professional person in charge of the evaluation and treatment facility must again file a petition with the county superior court to have the minor committed for an additional fourteen days for diagnosis, evaluation, and treatment.

Any amendment of the current statutory scheme that would allow distraught parents and staff at private, for-profit, mental health facilities to detain minors who are not mentally ill and dangerous to themselves or others will certainly violate minors substantive due process rights. Similarly, any amendments that would allow for less stringent admission and detention standards, or do away with the right to judicial review of the detention and treatment decisions, will violate minors' rights to procedural due process.

III. CONCLUSION

Mature minors who have been admitted to mental health facilities against their will, and without their consent, are entitled to due process protections, regardless of whether parents or state agents are making admissions decisions. U.S. Supreme Court cases make clear that, when constitutionally protected interests are at stake, fundamental due process requires the opportunity to be heard at a meaningful time in a meaningful manner. Whenever prior hearings are impracticable, states must

195. § 71.34.050(2) (1996).
196. § 71.34.050(2).
197. § 71.34.050(3) (1996).
198. § 71.34.050(4) (1996).
199. § 71.34.070 (1996).

1216
provide prompt post-deprivation hearings. Given the significant liberty and privacy deprivations implicit when inpatient mental health treatment is against a person's will, minors' rights must be protected against erroneous commitment decisions made only by well-intentioned, but ill-informed, parents and admitting clinicians at private, for-profit facilities. Due process requires judicial review of admissions decisions and continued treatment as provided for under Washington's current statutory scheme in the MHCTMA. The current scheme safeguards minors' due process rights while simultaneously allowing parents a role in the mental health decisions of their children. Washington State's minors are guaranteed these specific due process procedures, not only because they are codified in the MHCTMA, but also because they are constitutionally required by both the Washington and U.S. Constitutions to protect against the very real threat of erroneous deprivations of liberty and privacy interests.

201. The Parham court determined that judicial hearings prior to admission were impracticable. See supra notes 33-35 and accompanying text. However, after admission, parents' interests cease to outweigh minors' rights to a post-deprivation hearing. See supra note 137 and accompanying text.
