Kids in the Cuckoo's Nest

BY HOLLY METZ

Kristina B., seventeen, was placed in the locked ward of a psychiatric hospital in California, alongside patients suffering from serious mental illness. The hospital's eight-page, single-spaced evaluation of her found "no evidence of thought disorder, impairment in reality testing, [or] depression." What was wrong with her? According to Kristina's lawyer, it was "having a twenty-two-year-old boyfriend her parents didn't like" and repeatedly denying that she needed to be hospitalized.

Although they suffer from no significant psychopathology, an alarming number of teenagers are being sent off to locked psychiatric wards in private hospitals. "Voluntarily" committed by their parents, most often denied the due-process rights granted adults in similar circumstances, these "troublesome" minors are diagnosed with such juvenile-specific mental problems as "conduct disorder" or "oppositional-defiant disorder," the symptoms of which, developmental researchers suggest, may really be signs of normal adolescent development.

Kristina's attorney, Sidney Sue Hollar of San Francisco's Legal Services for Children, Inc., quotes from her client's psychological evaluation, which asserts that the adolescent is "disobedient" and manifests "negative and rebellious behavior"—behaviors which often lead to a diagnosis of oppositional-defiant disorder.

Kristina demanded a hearing upon admission, but private hospitals in California—unlike its state facilities—are not required by law to provide precommitment hearings to juveniles unwillingly admitted at their parents' request. A bill recently passed by the California legislature outlines how minors may be privately hospitalized by their parents, but, says Hollar, it "provides very few protections against unnecessary hospitalization" of those minors.

"These kids are in a kind of legal twilight zone," says Barbara Demming Lurie, a Los Angeles County patients'-rights advocate. "Even if they don't want to be there, they're considered voluntary patients because their parents have volunteered them." These minors also differ from voluntary adult patients because "kids can't pack up and leave," adds Lurie. They must wait for parents' and psychiatrists' consent, and "hospitals are quite aware of that." Some advocates say their clients remain locked up for months.

Securing Kristina's permanent release from the hospital proved impossible for her attorney. At an early stage in the legal battle, the hospital neglected to file a response with the court, initiating the teenager's release to her family home. But her parents promptly had her readmitted to the psychiatric ward. Kristina's "voluntary" treatment ended when she reached eighteen and thus acquired the rights of adult patients who cannot be held against their will unless they prove to be dangerous to themselves or others.

Unfortunately, experiences like Kristina's are not unusual. Nationwide surveys estimate the increase in rates of adolescent psychiatric admission since 1980 at 250 to 400 per cent, with most teens admitted to privately owned general hospitals or to free-standing private psychiatric facilities. A Children's Defense Fund study suggests at least 40 per cent of these juvenile admissions are inappropriate. In some states, such as Minnesota, the figure is closer to 50 per cent, according to University of Michigan professor Ira Schwartz, who warned a Congressional committee in 1985 that the hospitalization of disobedient youths had become "a hidden system of juvenile control."

Paradoxically, the beginnings of this "hidden system" can be traced, in part, to legal attempts in the 1970s to remove rebellious minors from the purview of another inhospitable system: juvenile justice. Previously categorized as status offenders, these "incorrigible" teens were held in secure detention centers or jails because of certain noncriminal behaviors—including violating curfew or running away—which were considered punishable because of the child's status as a minor.

The Juvenile Justice and Delinquency Prevention Act of 1974 encouraged deinstitutionalization of status offenders, and states began to enact legislation prohibiting their detention. "But now that the incorrigibles could no longer be locked up in juvenile facilities, there was a kind of social-control vacuum," says Patty Gilbert, a Los Angeles County mental-health program reviewer whose doctoral dissertation analyzed factors in the hospitalization of California youth. "Private psychiatric facilities," she says, "came in to fill the vacuum. Very aggressively."

Long-time child advocates say the labeling of many disobedient adolescents simply shifted from "bad" to "sick." Today, a teenager may be hospitalized with a "disorder" because of "problem behaviors" that sound an awful lot like status offenses, including rebelliousness at home, truancy, and experimentation with sex, drugs, or alcohol.

"What we're talking about are basically pain-in-the-ass kids," says Bill Johnson, president of the National Association for Rights Protection and Advocacy. "I would question the appropriateness of the medical model being used to handle a significant percentage of their problems." Hospitalized teenagers, he adds, are often blamed as the source of family problems,

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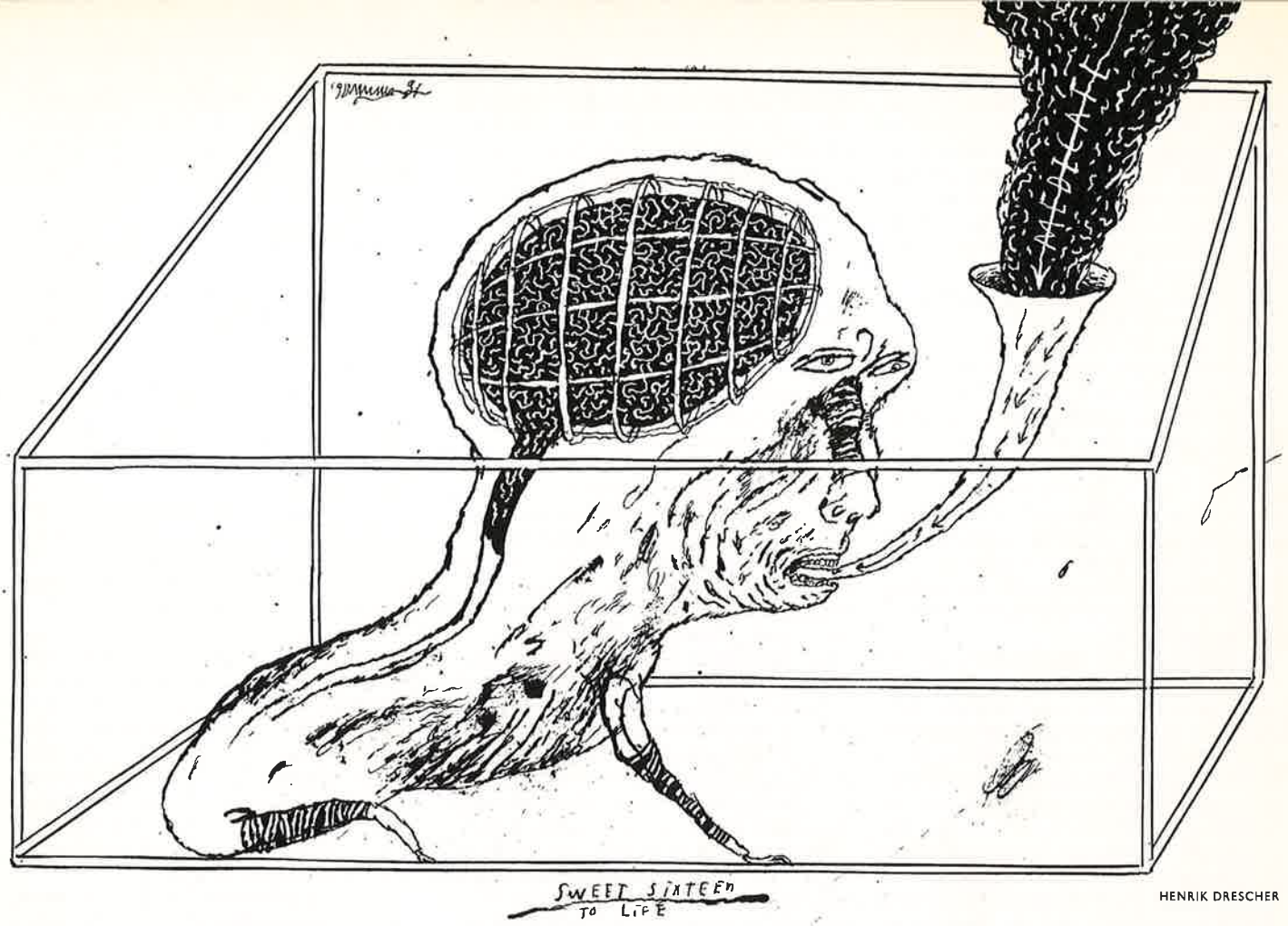

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but their treatment programs rarely involve purposeful therapeutic intervention with family members. Johnson recalls that the parents of one troublesome Minnesota teen dropped him off at a psychiatric hospital, then took the rest of the family to Hawaii on vacation.

Patients' representatives do not deny that there are psychotic and clinically depressed kids, many of whom, they say, might benefit from inpatient care. But, they warn, in many states, teenagers facing "voluntary" psychiatric hospitalizations—appropriately or inappropriately—are not guaranteed adequate protection of their liberty interests.

What rights do kids have in these circumstances? As a result of a 1979 Supreme Court case, *Parham v. J.R.*, the due-process rights of voluntarily committed minors vary from state to state. The Court declined to *require* states to extend to minors procedural protections established for adults facing institutionalization. As long as there are no signs of abuse or neglect, the Court held, parents may be relied on to act in their children's best interests. The Court did find that children have the right to have a "neutral fact-finder" review their records upon admission, but that reviewer is usually the hospital's admitting psychiatrist.

The *Parham* ruling has failed children and adolescents, critics say, for the availability of rights now depends on geography: Minors in Virginia who object to their placement in a private psychiatric facility receive a preadmission judicial hearing; similarly placed California youths may request a review only after admission, and their reviewer is a psychiatrist from the very facility they are trying to leave.

Child advocates criticize admissions criteria for their imprecision. Lois Weithorn, former professor of law and psychology at the University of Virginia, asserts that there are no commonly accepted guidelines for juvenile mental-hospital admissions. Although licensing and professional organizations have developed assorted standards, hospital psychiatrists admit standards vary from hospital to hospital. One California psychiatrist quit work at a hospital after learning that nonmedical staff were admitting juveniles and pretending she had signed them in.

Weithorn has also reproached the 300-member National Association of Private Psychiatric Hospitals (NAPPH) for producing "vague and overly broad" guidelines that list "sexual promiscuity" as a behavior requiring "immediate acute-care hospitalization." The guidelines make no direct link between mental problems and sexual conduct, nor is there any definition of "promiscuity," she writes in the *Stanford Law Review*. Admissions staff are left to apply their own moral standards.

"Certainly, it's a judgment call," says Doyle Carson, immediate past president of NAPPH and psychiatrist-in-chief at Timberlawn Psychiatric Hospital in Dallas. Asked to define sexual promiscuity, he remarks that "adolescents in particular show their problems behaviorally more than adults." Then he explains, "In terms of sexual promiscuity, the kind of thing we think of, to put someone in the hospital, is: A girl runs off. She gets out on the road and starts hitchhiking rides with truck drivers, goes into the sleaziest, most dangerous parts of the city, and offers herself up. Now the term 'sexual promiscuity' gets used, but it's really more serious self-destructive behavior, not just a girl who goes out and who's loose, in terms of her morals, with a number of people."

Could sexual promiscuity be attributed more frequently to teenage girls than teenage boys? "This is kind of crude," replies Bill Johnson, "but there are a couple of ways to get into psychiatric treatment, especially if you're a girl: Be good lookin', have big tits, and be sexually active." And patients'-rights advocate Barbara Lurie, who communicates with dozens of patients daily, says she has yet to hear the term applied to boys.

For diagnostic instruction, clinicians use the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R), which contains de-

scriptions of disorders, diagnostic criteria, and guidelines for assessing severity of manifestation. But child advocates say its definitions, which are commonly used for insurance-company payment, are too general. "Psychiatry is a soft science," warns Kathy Kosnoff, an attorney with Minnesota's Mental Health Law Project. "You can find yourself and most of your friends in the DSM-III-R."

How does the DSM-III-R describe oppositional-defiant disorder, the "symptoms" of which sent Kristina B. to the hospital? "The essential feature," the manual advises, "is a pattern of negativistic, hostile, and defiant behavior. . . . Children with this disorder are argumentative with adults, frequently lose their temper, swear, are often angry. . . . They frequently actively defy adult requests or rules. . . ." To many advocates, this sounds like routine family conflict, teens testing the limits of parental authority.

And, though the manual does say the "diagnosis is made only if the oppositional and defiant behavior is much more common than that seen in other people of the same mental age," that conclusion is often based exclusively on the testimony of persons the teens may consider antagonistic to their point of view—their parents. The text reads: "Typically, symptoms of the disorder are more evident in interactions with adults or peers whom the child knows well. Thus, children with the disorder are likely to show little or no signs of the disorder when examined clinically."

Using this manual, notes Weithorn, clinicians have admitted about two-thirds of juvenile inpatients with initial diagnoses of oppositional-defiant disorder, conduct disorder, or transitional disorder (which, by definition, excludes the disorder from categorization as a serious mental illness).

For hospital staff, "it's really a question of whether you can make a diagnosis that will pass muster with the payer," says Kosnoff. Until recently, insurance companies were quite liberal with third-party reimbursements, favoring inpatient over outpatient treatment with generous coverage. A 1981 study of factors in the hospitalization of 11,000 California adolescents found that those with insurance, placed in private psychiatric hospitals, stayed twice as long as uninsured teens admitted to public facilities.

But by 1988, Blue Cross and Blue Shield of Minnesota was declaring more than 50 per cent of adolescents' inpatient days in psychiatric and chemical-dependency units medically unwarranted. Insurance companies have begun to recognize the effectiveness, in cost and treatment, of outpatient care, yet alternative facilities are limited, especially in rural areas.

Instead, the insurance industry has improved its review processes. Insurers now require preadmission certification, whereby the patient's admission is theoretically subject to insurance-company approval prior to entry. But most often, the review actually occurs *after* admission for emergency-entry psychiatric patients. "The bottom line for me is that their liberty interests are not being considered," says Gilbert.

Child advocates across the country note that kids who are inappropriately hospitalized in private hospitals are overwhelmingly from the middle or upper classes; four out of five are white.

"Usually the rich have more protections than the poor," notes Lurie. "In this case, it's the reverse."

The scarcity of beds in state-financed psychiatric facilities is so acute, she says, that "to get a county bed, the poor have to be so needy, and are so screened, only the most disturbed kids end up in those beds." While unnecessary inpatient treatment is foisted upon disobedient kids with insurance, "acutely sick kids can't get the kind of intensive, inpatient treatment they need, for financial reasons," adds Kosnoff.

Recent studies have also found that while disobedient white youths are "medicalized" through placement in psychiatric facilities, black teens with similar behavioral problems are "criminalized" through placement in the juvenile-justice system. "Whether a child enters the juvenile-justice system or the mental-health system may have more to do with minority status and socioeconomic status than with degree of psychopathology," asserts a 1990 American Psychiatric Association report.

According to the National Institute of Mental Health, there were 450 free-standing psychiatric facilities in 1988; less than half that number existed in 1980. Some doctors attribute the explosion in for-profit juvenile psychiatric services to greater public acceptance of psychiatric treatment or to improved detection of mental disorders.

But Lee Combrinck-Graham, former director of Chicago's Institute for Juvenile Research, sees excessive psychiatric investment in hospitalization. "I think the reason we're doing it," she explained to *American Medical News*, "is not because the kids need this care but because it's productive and lucrative." Her colleagues, she said, know "that's where they can make a bundle."

Investors in inpatient psychiatric treatment realize the potential for profits is great because overhead is low, especially compared to surgical procedures, which require expensive equipment and facilities. Although hospital psychiatric treatment for juveniles is reportedly labor-intensive, most of the patients' daily care is provided by low-paid technicians and nurses. Yet, in some regions, the average cost per stay for adolescent inpatient psychiatric treatment can be as much as $40,000.

Such chains as Hospital Corporation of America, Charter Medical Corporation, and National Medical Enterprises have targeted Sun Belt states with permissive patterns of third-party reimbursement. These states lack regulatory agencies empowered to set ceilings on private hospitals' annual revenue. The rush to build has been so great in some states that certain "markets"—including Dallas, Houston, Atlanta, Albuquerque, and Salt Lake City—are saturated, according to the health-care consulting firm Lammers & Gershon Associates.

Charter Medical—which now operates eighty-five psychiatric hospitals nationwide—announced plans to build several California psychiatric hospitals after the state repealed certificate-of-need laws. Such laws typically require hospitals seeking state certification to prove proposed projects will meet community needs.

"A lot of people think the health industry is this benevolent organization, looking out for their health, and what it is, in the private sector, is a business, trying to make a profit," says Barbara Lurie, who adds that these corporate chains are listed on the country's major stock exchanges. Fewer than two dozen investor-owned systems operate 80 per cent of all psychiatric beds, according to *Modern Healthcare*'s 1990 industry-wide survey.

But child advocates worry most about the financial conflict of interests of psychiatrists who refer patients to facilities where they are investors.

California mental-health ombudsmen have learned that a downstate private hospital pays a psychiatrist a large monthly sum to bring patients in, but, lacking incontrovertible proof, the advocates dare not name this notoriously litigious facility. And though the American Academy of Child and Adolescent Psychiatry has recently included such conduct in the list of behaviors it considers "inappropriate and/or unethical," the policy statement has no enforcement provisions.

Misleading, guilt-provoking, or unduly alarming advertising to promote self-referrals and admissions" are also on the Academy's list. Critics say the most offensive scare-tactic ads—one showing a kid in handcuffs, under the headline BUSTED, for example—have been pulled following press exposure. But current hospital ads continue to deceive harried parents who are hoping for a convenient resolution of parent-teen conflict.

Attorney Sidney Hollar recalls finding questionable advertisements in *Sunset* magazine, a popular California publication. One ad asks: "Is your teenager irresponsible, rebellious, or out of control? Running with the wrong crowd? Headed down the path of no future? Help your son or daughter before it's too late. . . ." Else-

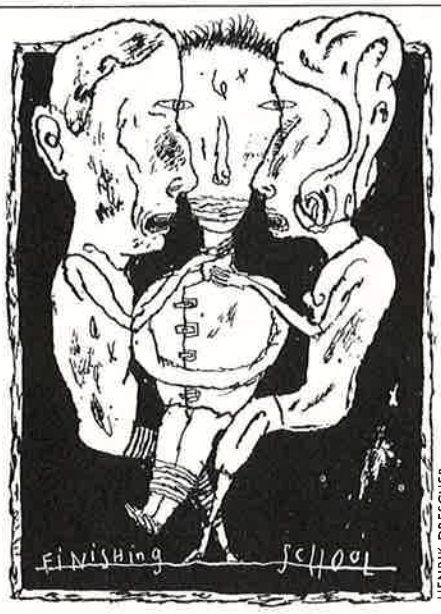
Life on the Psych Ward

Private psychiatric facilities of the 1980s and 1990s hardly fit the old stereotypes of filthy wards and neglected patients. Clean, modern, with higher staff-to-patient ratios than most adult wards, units treating children and adolescents exude professionalism, competence, and safety, say parents like Barbara DeFoe, who admitted her fourteen-year-old daughter Marissa to a Minnesota hospital after she began experiencing stress-related sleeplessness.

But what is life like in these units, where most patients spend from sixty days to two years? In their 1985 testimony before a Congressional committee, Barbara and Marissa DeFoe reported use of forced medication, restraints, seclusion, and other rigid forms of behavior modification. Patients' advocates say such procedures are still used on adolescent psychiatric wards around the country.

"They had a code in which you earned certain privileges if you did what they said, like taking your medicine," Marissa said, "and you could call people on the telephone if you did what they told you. The first thing they wanted to do was to strip-search me. And I refused. And that made them very angry."

When Marissa, an honor student and active member of her church, refused to take medication, she recalled, "Five or six people came into my room, and held me down on my bed, and took all my clothes off, and put me in a hospital gown." She was transferred to solitary confinement, where, she testified, hospital workers "pinned me to the floor and gave me an injection" of Haldol, a powerful tranquilizer commonly administered to psychotic patients.



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After ten days and with advocate Bill Johnson's help, Barbara DeFoe gained her daughter's release. By then, Marissa was unable to walk or to control her bladder—side-effects of receiving massive doses of Haldol.

Minnesota has a patients' bill of rights which should have given Marissa the right to participate in her treatment plan, but Kathy Kosnoff, an attorney with the Mental Health Law Project, notes that "it's very rare that a teenager—or even an adult—actually participates" in that process.

Laws in several states outline patient care, and often include limitations on the use of restraints or seclusion, but advocates charge that psychiatric facilities find ways to circumvent restrictions. Los Angeles County patients'-rights advocate Barbara Lurie explains: "With restraints, instead of applying belts or cloth," as the law defines such physical restriction, "they just sit the kid down in a chair and say, 'You can't get up from this chair.' And the kid will know, all he has to do is get up once and he has another three hours added to his time."

"Theoretically," says Kosnoff, "the kids are in there for treatment, so everything that's done to them comes under the rubric of therapy. The law says isolation and restraint 'shall not be used for disciplinary purposes.' Well, it's really arguable what is therapeutic and what is disciplinary."

Even when states enact stringent laws to protect committed adolescents, the protections afforded teens by residency may be lost when they're shipped out of state. "We have a lot of kids who come in here from all over the country," Kosnoff says. "Adolescent psychiatric hospitalization is an industry in Minnesota." Some hospitals, she notes, have had—and may still have—finder's-fee arrangements with probation officers and other professionals in a position to refer teens.

As one advocate put it, a kind of interstate commerce in children has developed, but without the overseers deemed necessary for other kinds of commerce. No state or national reporting system is required for admissions to private psychiatric hospitals. Paraphrasing a statement made in a National Institute of Mental Health brochure, Lurie says, "The Department of Agriculture keeps tabs on every single chicken sent out of state, but nobody seems to know how many kids are sent to psychiatric facilities out of state."

—H.M.

where in the state, another advocate saw an ad featuring a cartoon of a housewife pulling her hair out. Above her read the headline: SOMETIMES I COULD JUST. . . ! The copy below assured parents that kids *can* be frustrating, so call our hospital.

But Hollar notes that these ads never mention that kids will be placed on locked wards with psychotic patients, or indicate the kind of treatment that awaits them after admission.

M. Lee Dixon, deputy director of the Intergovernmental Health Policy Project at George Washington University, notes that variations on SEND US YOUR CHILD AND WE'LL MAKE JOHNNY, SALLY, AND SUE PERFECT FOR YOU appear in many states. Concerned New York legislators have even been moved to propose legislation regulating such ads. If passed, the new law will amend the state mental-hygiene statute to permit "reasonable restrictions" on marketing and advertising by juvenile psychiatric hospitals.

But competition among providers ensures that aggressive marketing campaigns are here to stay: A 1991 report by the Health Insurance Association of America states that advertising and marketing by psychiatric facilities has "increased tenfold over the past few years." Charter alone annually spends $35 million marketing its hospitals.

And, increasingly, investor-owned hospitals have new services to sell; they advertise the treatment of specialized disorders, harvested from the DSM-III-R. Chemical-dependency units are frequently linked to psychiatric facilities these days (and providers annually increase charges for both treatments). *Modern Healthcare* magazine reports the development of programs for persons needing inpatient treatment for compulsive gambling and pyromania.

"Unfortunately, my sense is that this is a major industry," says Patty Gilbert. "It employs a lot of people. And it's amazing to me how it's branched out: There are even hospitals that have co-dependency programs where they identify co-dependents in the family and hospitalize them."

The corporate chains actively pursue referral sources, including churches, probation officers, and schools. And sometimes the drive to fill beds goes a little too far.

"At one hospital," recalls Barbara Lurie, "the market director was on the school board to determine what happened to errant kids." ■