Adolescent Psychiatric Hospitalization and Social Control

by

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To be published in Mental Health and Criminal Justice, ed. Linda Teplin. Grateful thanks to the people who commented on earlier drafts of this paper: Robert Dingwall of the Centre for Socio-Legal Studies, Wolfson College, Oxford; Barbara Laslett of the University of Minnesota, and Peter Manning of Michigan State University. This paper was supported by a grant from the National Institute of Juvenile Justice and Delinquency Prevention, Law Enforcement Assistance Administration, U.S. Department of Justice, Nos. 77-JN-99-0012 and 78-JN-AX-0034.

The intent of this chapter is to provide some empirical data on the psychiatric hospitalization of adolescents in contemporary society, and to suggest an interpretive framework for understanding the use of psychiatric hospitalization as a means of social control. The empirical data are quite limited, and derive from one research project in which these authors participated (Guttridge, 1981; Guttridge and Warren, 1981) and from existing data gathered by others. The interpretive framework emphasizes social control as a general phenomenon whose specific forms and targets vary historically with political and economic circumstances (for a variety of discussions of this framework see, for example, Rose, 1979; Scull, 1977, 1981; Warren, 1981).[1]

The circumstances seen as relevant, in this essay, to the growth of adolescent psychiatric hospitalization include the deinstitutionalization movement of the 1960s and 1970s, the privatization of care and control, and the medicalization of deviance. In addition, special factors which give shape to the phenomenon of adolescent--as opposed to adult--psychiatric hospitalization include the parens patriae role of the state, parental rights in decisionmaking concerning the placement of their offspring, and youth unemployment.

Adult psychiatric hospitalization--especially involuntary civil commitment--has received considerable attention from legal scholars and social scientists for approximately the last decade, giving rise to a proliferation of case law (Wexler, 1981), empirical studies (Hiday, 1977; Warren, 1977; Morris, 1978), and a continuing debate over the propriety of depriving persons of liberty in the absence of criminal offense (for a summary, see Morse and Zusman in Warren, 1982). During the period of interest in adult psychiatric hospitalization in the mid-1960s and 1970s,

the commitment of children and adolescents[2] to mental hospitals received little notice from lawyers and social scientists. In a typically partisan statement, Szasz (1977; 1005) comments that "perhaps because children have no rights, the issue of their rights to protection from psychiatrists posing as their would-be protectors has received scant attention."

One reason for the relative lack of concern with adolescent mental hospitalization in comparison with adult is that the commitment of minors is seen as the business of parents more than of the public welfare. Adults may be involuntarily committed to mental hospitals under various state laws providing for emergency detention, evaluation and treatment, or they may submit themselves voluntarily to treatment. Persons under 18, however, can be committed voluntarily, in general, only as a result of parental action and not of their <u>own</u> volition, although they can be committed involuntarily under the same procedures as adults.[3]

The special legal problem of minor as opposed to adult commitment to psychiatric hospitals rests upon doctrines concerned with the <u>parens patriae</u> power of the state, and the identity of interest between parent and child. Although a parent is entitled to direct his or her child's fate (including "voluntary" placement in a mental hospital), the state is also the legal parent of the child, superordinate to the natural parent if the child's interests are materially threatened by the natural parent. Therefore, the child is at more risk of liberty deprivation than the adult in psychiatric hospitalization cases, since either the parent or the state may initiate commitment. In many states the law permits parents to place their child in a mental hospital without procedural protections (Ellis, 1974; Note, 1976; Note, 1978).

A second reason for the neglect of adolescent psychiatric hospitalization is the lack of empirical data on its scope and characteristics. Statistics on all kinds of public mental health agency clients are published, sometimes using age as a breakdown factor. However, if mental hospitals are private and do not receive federal, county, state or local funds, then their inpatient censuses need not be reported to statistics-collecting public agencies. Thus, much of the information that might be relied on for an assessment of the extent of the confinement of minors is not available; one can only infer from bits and pieces of data.

In addition to the lack of empirical data (with a few exceptions, e.g. Miller and Kenney, 1966), there has been little research interest in adolescent as opposed to adult commitment. The recent constitutional-legal and research interest in adult involuntary commitment since the 1970s was sparked in part by the theoretical and empirical exposés of mental hospitals in the 1960s by social scientists and critics such as Szasz (1961), Scheff (1966) and Goffman (1961). The various critiques, the rapid legal developments, and the empirical studies both before and after the introduction of reform legislation in a number of states (contrast, for example, Scheff, 1964 and Warren, 1977, and see Hiday, 1977) gave the topic of involuntary adult commitment an air of significance and urgency. All this has been absent in the area of adolescent psychiatric hospitalization. There has been no Goffman of the adolescent ward (but see Kovar, 1979); there are few statistics, few empirical studies, and few interpretations of those statistics and studies which do exist (but see Schwartz, 1983; Schwartz and Krisberg, 1982).

However, since the early 1980s there has been a developing legal interest in the plight of hospitalized adolescents, in the form both of law journal

articles (see Ellis, 1974; Note, 1976, 1978) and case law (see Wilson, 1978; Wexler, 1981, 247-281). It appears to be time for social scientists to take an interest in this issue, and provide the kinds of empirical data and research interpretations that could guide developing social and legal policy-making in this area. This paper is intended as a preliminary "state of the art" venture into documenting and understanding the psychiatric hospitalization of adolescents as a social control measure.

Some of the supportive data for our argument are derived from a larger research enterprise which was designed to study the impact of a piece of juvenile justice legislation--AB3121--in California. The larger study was funded by LEAA under the direction of Teilmann and Klein. The intent of the larger study was to examine the impact and implementation of several provisions of the law, impact referring generally to the system consequences of it, and implementation to the manner in which practitioners carried it out.

AB3121 had a number of disparate provisions; the data discussed here pertain to a provision related to status offenses, especially runaways. In California, the population of juveniles under the social control auspices of the state are divided into "600"s--delinquent offenders; "601"s--status offenders (runaways, truants and incorrigibles); and "300"s--neglected and dependent children. Prior to AB3121 all three types of juvenile could be "detained in secure facilities" such as juvenile hall; subsequent to AB3121, which went into effect on January 1, 1977, status offenders could no longer be detained in such facilities.

In the first phase of the legislative impact study, we were responsible for a sub-component to determine the impact of the law on the juvenile court system in

Los Angeles County. During interviews with juvenile court practitioners, we found that many of them talked about "getting around" the status offender provisions by having juveniles diagnosed as mentally ill and sent to mental hospitals, rather than detaining in juvenile halls as they had been prior to the legislation.

In the second phase of the legislative impact study we transferred the focus of our sub-component to the mental health system as a possible alternative source of social control for troublesome adolescents who were no longer candidates for the traditional secure facility placement. Our interviews with police, probation officers, district attorneys (although not generally public defenders) judges and parents had convinced us that the status offender provision was seen by many of these persons as taking away a needed placement resource rather than as remedying an existing wrong. They were interested, therefore, in obeying the letter of the law--in not detaining status offenders in juvenile halls--but they were also interested in continuing to utilize secure detention as a control mechanism for troublesome youth.

We investigated both the feasibility and to a lesser degree the actuality of confining status offenders to mental hospitals as a means of social control. A context of feasibility is provided by two factors; the fiscal changes in the handling of deviants which have taken place over the last decade or so, including the deinstitutionalization movement, and the medicalization of deviance. This context of feasibility became the theoretical model within which we interpreted our empirical findings.

Our investigative research strategy to determine actual hospitalization rates was threefold. We searched and utilized existing data sets for

materials on age distributions in various types of mental hospitals over time. We attempted to survey both the numbers and populations of psychiatric facilities in the Los Angeles county area, a strategy which proved to be unproductive.[4] Patricia Guttridge undertook as her dissertation a comparison of four psychiatric facilities for adolescents, in part to determine whether or not there had been changes in the type of population in 1977 and 1978 as compared with 1976; specifically, whether or not there had been an increase in admissions related to status offense behaviors with the advent of the law.

The four psychiatric facilities were roughly stratified by the SES level of the population served.[5] The range was from a public, county facility serving a low SES population to a private hospital taking almost no public funds and serving a relatively middle class SES populations. There were two intermediate hospitals, one of which was private and one of which received public funds through a county contract (See Table 1).

Social Control and the Political Economy

The social control perspective on deviance emphasizes the importance of considering control as a total system rather than discussing one form of social control while excluding others from consideration. Malcolm Spector (1981) has provided an overview of the various elements which constitute this system. In addition to the civil and criminal law, the contemporary state has several other modes of "handling troublesome rascals." Those of most relevance to this discussion are the private social control sector, the medical establishment, and the growth of entitlements to "benefits;" all of which, says Spector (1981), are supplanting legal and correctional approaches to the handling of deviance.[6]

These newer methods of social control (some of which, however, have historical precedents) are often presented as "more humane, less intrusive,

and more progressive than the older ones" while at the same time they have "expanded the power of the forces of disapproval over the forces of trouble." (Spector, 1981; 138). A clear example of this social control dialectic is the deinstitutionalization movement of the 1960s and 1970s, which had as its goal the removal of deviants from 24-hour institutional care. This policy movement, directed mainly at mentally disordered persons and at juvenile delinquents, had as its guiding philosophy entitlement to the "least restrictive alternative treatment" principle, often also phrased as "community treatment." (Lerman, 1982).

The deinstitutionalization movement has had several outcomes which indicate an apparent relaxation of the institutional mode of handling deviants to a more treatment-oriented mode. In the area of mental health the populations of state mental hospitals has decreased in most areas of the country in the 1960s and 1970s to such an extent that scholars speak of an "emptying" of these institutions (Lerman, 1982). In the area of juvenile justice, Massachusetts closed down all its juvenile public correctional facilities, while in many states there was a rush to establish the new, federally funded "diversion" programs for deinstitutionalized youth (Lerman, 1982).

If the impact of the deinstitutionalization movement on actual rate of institutionalization is measured only for one part of the system, then a rather distorted picture of implementation may be obtained. For example, if the only measure of deinstitutionalization of the elderly mentally disordered is public mental hospitalization rates, then the elderly have been deinstitutionalized: the rate of mental hospitalization for this population dropped from 400 per 100,000 in the 1950s to 200 per 100,000 in the 1970s. However, if the rate of institutionalization in homes for the aged and dependent is measured for the same time period, then these figures are reversed: there was a gain from

200 to 400 per 100,000 (Tekmekron, 1978: 20-21). Similarly, if the only measure of states' compliance with deinstitutionalization policy is rates of juveniles incarcerated in public correctional facilities, then deinstitutionalization clearly occurred. However, if total rates of juvenile incarceration are considered, then the rate per 100,000 actually rose during the decarceration movement (Lerman, 1982).

The phenomenon of shifting populations from one segment of the social control system to another has been referred to as transinstitutionalism (Warren, 1981). The causes of transinstitutionalism have been traced to the coexistence of an ideology favoring decarceration with high unemployment and with state fiscal crisis. From the political economy perspective on social control, as Rose (1979; 445) comments, "deinstitutionalization is best understood as a political and economic measure designed to sustain near-bankrupt state governments and to establish the basis for transferring funds from public services to the private sector."

As Foucault (1965) notes in his historical analysis, the asylum, since the birth of capitalism, has been one storing-place for those unwilling or unable to work within the system. In today's high unemployment society, the category "adolescent" is added to that of the elderly, the mentally disordered, the mentally retarded and the physically ill on the roster of types of individual unable to participate fully in the working economy of capitalist society. Furthermore, there appears to be a demand from parents to incarcerate their offspring; a direct demand which is absent in the case of adult types of deviant. Given this double jeopardy, we would expect the rate of youthful incarceration in various types of asylum to have increased with greater rapidity than that of adults under 65 during the past few years.

But even if asylums can warehouse the unproductive, they still cost the society money. From the 1900s to the 1970s, the cost of incarceration was borne by the public sectors, moving from county to state, then to federal, and finally to a system known as "revenue sharing," in which revenues from a variety of sources are combined to provide care. The 1970s and 1980s saw the development of a different kind of institution: a type of institution which promises to warehouse people more cheaply than the state institution. The board and care home and nursing home for the indigent elderly or mentally disordered exemplifies this new type of private social control institution (Estes and Harrington, 1981; Emerson, 1981); the cost of control is shifted from the states and counties to a combined federal welfare/entrepreneurial system (Warren, 1981). As a result, the cost of care to the public sector drops. One estimate of the cost reduction involved, in 1978, was from $31 per day for a state hospital inmate to $14.50 per day for a board and care home inmate (Rubin, 1978; 102).

The Psychiatric Hospitalization of Adolescents

Lerman (1980, 1982) has drawn attention to the indirect effects of juvenile delinquency law on public psychiatric hospitalization of adolescents at the national level, and has provided an explanation based in part on the political economy. The Federal Juvenile Justice and Delinquency Prevention Act of 1974, which was the legislative arm of federal deinstitutionalization policy, provided fiscal incentives to states to remove status offenders from public, correctional facilities. The states were enabled to collect money for deinstitutionalization but could still transinstitutionalize--place status offenders in private or public noncorrectional facilities, as well as private correctional facilities (Lerman, 1982). Of all the transinstitutional routes, for juveniles, "the mental health system represents the

fastest growing category of institutional care--on both a short-term and a long-term basis" (Lerman 1980; 292). Lerman's national findings echoed our AB3121 research experiences at the state level.

One result of the transinstitutionalization of juveniles from juvenile correctional facilities is that while the population of adults in public mental hospitals--particularly elderly--has been declining, the population of those under 18 has been increasing. The per-100,000 rate of admission to state/county mental hospitals of persons with no prior inpatient care decreased from 70.6 in 1962 to 57.1 in 1975, with the most marked decrease in the 65+ age group--from 163.7 to 36.7. However, the under-15 rate increased from 6.0 to 15.5, while the 15-24 age group increased from 76.9 to 91.8.

The private psychiatric hospital as well as the public may be used to incarcerate troublesome youth, as our California research indicates (see Table 1, and Guttridge, 1981). In Minnesota, according to Schwartz (1983) private insurance carriers are experiencing economic difficulties as a result of the increased utilization of private psychiatric hospitalization for youth. In 1976, there were 1,123 juvenile admissions to private psychiatric hospitals or wings in the Minneapolis area, accounting for 46,718 patient days, while for the first six months of 1983 these figures were 1,124 and 43,855, respectively. The rate of psychiatric hospitalization per 100,000 population of juveniles was 187 in 1976 and 412 in 1983.

In addition, Schwartz (1983) has drawn attention to the increasing use of chemical dependency inpatient facilities for youth. He and Barry Krisberg (1982) found that:

> In 1980, there were an estimated 3000 to 4000 juveniles admitted to in-patient chemical dependency treatment programs. Although it is unknown how many juveniles were admitted to such programs in the early 1970s, it is generally assumed that the numbers were substantially less because there were few residential treatment facilities at that time.

In addition to private psychiatric hospitals, chemical dependency units appear to have joined group homes residences for the emotionally disturbed, and other child welfare institutions (Lerman, 1982), as part of the "hidden system" of juvenile social control. (Schwartz, 1983).

The growth of private psychiatric hospitals and chemical dependency units is parallelled by the shift to private, private-profit and corporate medical care in general, and also to private juvenile corrections. (Lerman, 1982). The shift to the private sector for the provision of care and control is generally understood as one outcome of the states' and later the Federal government's attempts to withdraw from increasingly costly welfare provisions (Scull, 1977). Parents have been enabled to utilize private psychiatric hospitalization of their offspring by the inclusion of psychiatric coverage in private insurance plans.

Since the 1960s there has been a rapid extension of insurance coverage by carriers such as Blue Cross and Blue Shield, into the inpatient (not the outpatient) mental health area. In the four adolescent psychiatric hospitals we studied, most of the admissions not paid for by public funds were paid for by private insurance and almost none by parental payment (see Table 1). Using private insurance, admission must be justified by an admitting diagnosis taken from the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (henceforth DSM).

Since the fees in the hospitals studied ranged from $180 to $300 per day in 1977 (one hospital we were not allowed to study, which took no public funds, cost $900 per day), clearly these hospitals would exist only with difficulty without bill-payment by the insurance companies.

This expansion of the medical handling of deviants through the expansion of rights in insurance coverage is a good example of the role of entitlements to benefits in shaping the social control system (Spector, 1981). In theory, the expansion of entitlements is

an example of counter-movement in the general proliferation of modes of social control beyond the legal system. However, in the specific case of adolescent psychiatric hospitalization, this new entitlement intersects with the trend towards medicalization to produce a substantial deprivation of liberty for some unknown proportion of youth. As Spector (1981; 153) indicates, the search for new entitlements can have unintended consequences, mainly because entitlements are granted not "in vacuo" but in a socioeconomic context.

One unintended consequence of the entitlement to psychiatric services under medical policies may be the "voluntary" psychiatric hospitalization of young people. This effect is less likely for the adult holders of medical insurance, since adults are not likely to turn themselves into mental patients because other people see their behavior as troublesome. As indicated earlier there is an apparent direct demand for psychiatric placement of children on the part of parents which is absent for the majority of other populations "voluntarily" seeking mental hospitalization.

There appears to be a demand for the psychiatric hospitalization of adolescents at all class levels, but in particular from parents at the higher end of the spectrum (Hospital 4 in Table 1 with over 90% voluntary admissions)

and from the public sector at the lower end of the spectrum (Hospital 1 in Table 1 with nearly 85% involuntary admissions). Parents have been financially enabled to utilize the psychiatric hospital route by the expansion of insurance benefits. Their reasons for doing so appear to be quite wide: they may have tried outpatient therapy for the child and failed to help him or her, they may want to avoid routine parental duties (Note, 1976; Szasz, 1977), gain respite from a troublesome adolescent (Ellis, 1974; Board of Supervisors, 1980), or placate a new mate jealous and resentful of the child (Kovar, 1979).

> In family crisis situations, it is often the middle class parent who is unable to manage what might appear as normal adolescent behavior of the acting out kind...In these cases, there is no real severe pathology, but the family is unable to cope...What has occurred most often with the private hospitals is that the parent will take the child into the facility on an emergency basis. The hospital then assigns a child psychiatrist to the patient. This practitioner may never have seen this child before, but will keep the child in a facility when he does the evaluation, treatment and planning for the child. In many cases it is the family (the parent) who is in crisis and not the child (Orange County Board of Supervisors Report, 1980; 8).

At the lower social class levels, the drying up of funding for delinquents and other wards of the court in some states (including

California) have left probation officers and the courts with fewer and fewer "placement alternatives" for troublesome children--fewer foster homes, fewer group homes, and less accommodating juvenile halls.[7] The psychiatric hospital, with its growing number of beds and its support from public and private insurance, is an attractive alternative, despite the "technicality" of an absence of significant mental disorders on the part of admittees.

Within the context of social control as a multi-faceted system with historical, political and economic determinants, several phenomena appear to promote the psychiatric hospitalization of youth in trouble. The ideology of juvenile status and delinquent offender deinstitutionalization,coupled with the a continuing demand for incarceration of youth from both parents and the public sector has facilitated juvenile transinstitutionalism. The shift from public to private social control, a consequence of economic depression, has given part of its shape to transinstitutionalism. The medicalization of deviance, promoting a shift from the juvenile correctional to the juvenile mental health system has given it further shape. Since the nineteenth century, entire sets of people have been transformed by the medical model: from drunks to alcoholics, from criminals to psychopaths, from delinquents to emotionally disturbed children, and from bums and bag ladies to chronic schizophrenics (Spector, 1981; 152). The medicalization of deviance intersects with transinstitutionalism to facilitate the utilization of private psychiatric hospitals for youth.

The medicalization of troubled youth has a historical precedent in the parens patriae approach to juvenile delinquents. Since the beginnings of the juvenile court, the predominant policy perspective on juvenile deviance has been paternalistic rather than moralistic, although in recent years the tide

has turned somewhat with the expansion of the due process rights of minors. Misbehaving juveniles have for decades been handled as troubled and needy rather than wicked and wayward, a general orientation which has, as indicated, become more and more specifically medicalized in tone and practice.

The medicalization of deviance is seen by some--often psychiatrists--as a beneficial humanitarian reform while it is viewed by others--often lawyers--as harmful expansion of social control (Conrad and Schneider, 1980). The involuntary placement of adults in psychiatric hospitals is a substantial deprivation of liberty; for adolescents, voluntary placement is also generally against their will (Morse, 1978). Thus, the debate over the benign, or, alternatively the harmful dimensions of involuntary psychiatry is extended to the involuntary and "voluntary" hospitalization of the young.

The view of involuntary psychiatry as harmful to the child is expressed by Thomas Szasz, a psychiatrist. Szasz asserts that since children do not and cannot consent to psychiatric treatment, they are by definition (like involuntary adult patients but unlike voluntary adult patients) slaves to the authority of psychiatry. He asserts that "a child assigned to the role of mental patient is doubly incriminated and incapacitated: as a minor, and as mad" (Szasz, 1977; 1005). Furthermore, he insists that psychiatric intervention into the life of a child is by definition harmful, both because the child sees the psychiatrist as a powerful and dangerous figure out to control him or her (1977; 1016) and because psychiatry threatens the child's needs for dignity, privacy, and self-esteem (1977; 1009). From the opposite perspective, a child psychologist, Kovar (1979; 193) notes that "The hospital can be a sanctuary for the abandoned child from a destructive life at home,

enabling him to develop competences and experience loving relationships," and cites a number of cases such as one seventeen year old boy for whom "life in the hospital, however limited, compares favorably to living with his father."[8]

We would argue, with Morse (1978), that--beyond the debate over harm vs. benefit--the involuntary (or parentally voluntary) psychiatric hospitalization of a minor involves a deprivation of liberty which is anathema to constitutional notions of liberty unless there is solid justification for it. In a medicalized polity, such a justification would seem to be the presence of a mental disorder listed in DSM. However, we would argue--as have recent court cases--that since the deprivation of liberty is so massive, and the stigmatization of psychiatric hospitalization so potentially severe, that only the more serious psychiatric diagnoses merit the bypassing of the "least restrictive alternative" principle into the mental hospital (see also Morse, 1978).

Instead, it appears that the psychiatric hospital is being used for the control of adolescents who are not, in the main, severly impaired psychiatrically, but who are more or less emotionally disturbed, behaviorally deviant, or (in a minority of cases) simply lacking in alternative placements. In his analysis of current trends in the institutionalization of juvenile delinquents, Lerman (1980; 287) states that recently "the mental health profession has extended its services to persons not usually cared for in a hospital--alcoholics, drug users, and adolescents with a variety of 'transient' behavior problems". The implication of this statement is that the adolescents admitted to psychiatric institutions in recent years are not necessarily mentally ill, but are likely to be behaviorally deviant. At the same time, they must have psychiatric diagnoses in order to obtain admission and/or

insurance coverage; "behavior problem" will not suffice as an insurance category. What we would expect, therefore, if Lerman's assertion is to be demonstrated empirically, is for the adolescents' diagnoses to be mild rather than severe, and oriented to adolescent behaviors and characteristics rather than to severe psychiatric symptomatology. And this is what we found in our research.

As indicated in Table 1, of 1119 adolescent inpatients admitted to four psychiatric hospitals in the Los Angeles area between 1976 and 1978, we found that over 70% of the admissions were for anti-social, depressive, runaway, drug abuse, or personality disorder diagnoses using discharge data and DSM II diagnoses (see also Ginsberg, 1973, 16; Note 1978, p. 197, fn. 49).[9] Less than one-fifth of the admissions were for serious (psychotic or schizophrenic) mental illness. In contrast, adult admittees to mental hospitals have more serious diagnoses. Schizophrenic diagnoses constitute 50-60% of the state hospital population (Gallagher, 1980; 91); in United States psychiatric hospitals as a whole, "schizophrenia is the major diagnosis of admission... where the sufferers from this illness fill the largest proportion of beds" (Rosenberg and Raynes, 1976; 97).

The equation of troubled adolescence with mental illness cannot be confirmed, at this time, by available evidence; indeed, some psychiatrists and legal scholars claim that "severe" diagnoses are avoided because of their greater potial stigma for the child (Note, 1978). However, we found that hospital staff in the field of adolescent psychiatry--including psychiatrists--routinely divided their charges into "behavior problems" with "nothing wrong with them" and the "really mentall ill," with the former far outnumbering the latter.

Our evidence indicates for California--as Lerman's (1980; 1982) work does for the nation--that such hospitalization is being used for the social control of a wider variety of troubled adolescents than might be indicated under a strict application of the medical model. (see also Schwartz, 1983). Our general findings, thus, can be tentatively generalized; such is not the case for our more specific findings on the relationship between diagnosis, length of stay, type of payment, and SES, which are limited by our California location and by the non-random character of the selection of the four hospitals.

The length of the stays of the adolescents in the four hospitals we studied varied widely, from a mean of 13 days for the public, lower SES hospital to a mean of 106 days for the private profit middle SES hospital (see Table 1). In the literature on the relationship between social class and psychiatric facility utilization there is a strong direct relationship between mental hospitalization and lower socioeconomic status, whether one takes the labeling or the psychiatric perspective on mental illness (for a summary of these issues, see Gove, 1975, Ch. 3). In the case of adolescents in our study, with the measure length of stay rather than admission, we found that the higher the SES level of the clientele the longer the average stay. These findings need to be supplemented by an analysis of admission rates of adolescents to psychiatric hospitals by SES.

The relationship between SES, length of stay and source of funding may be an essentially economic one. The state can no longer afford, as it could in the 1950s, to control its deviants by lengthy incarceration in public institutions (Scull, 1977). And the proportion of hospital funding derived from private sources is clearly related to longer patient hospitalization, indicating the possibility of the operation of a profit motive. The percentage of hospital funding deriving from the public vs. the private sector is also related to the

proportion of voluntary to involuntary admissions. The increase in voluntary admissions the more private the hospitals provides a rough indication of the demand from middle class parents for the medicalized social control of adolescence, especially when considered in relationship to length of stay. As Dillon et al (1982;421) note, under current case law "the child whose parents can afford to pay for his institutionalization has less protection than his poorer counterpart" and thus may be liable to longer institutionalization.

Finally, there is a clear, although less strong or linear relationship between diagnosis and the set of variables already considered. The proportion of patients with the more serious diagnoses--schizophrenia and psychosis--is highest in the public hospital, where the mean length of stay is the lowest. The proportion of patients with the type of diagnosis that we found was related to troublesomeness in adolescents--anti-social, runaway reaction and personality disorder--was highest in the two SES-intermediate hospitals (just as the proportion of severest diagnoses was lowest in these two hospitals), accounting for over half in the highest SES hospital but under a third in the public hospital. Whether one takes the psychiatric or the labeling perspective on mental illness, at least in this study, it seems clear that severity of diagnosis is not the factor most predictive of length of stay in adolescent psychiatric hospitalization.

Summarizing the findings in Table 1, we found, very roughly, that the larger the proportion of fees paid to the hospital by private insurance and the higher the SES level of the hospital site, and--less clearly--the less severe the diagnosis, the longer the stay of the adolescent in the facility. Our work (Guttridge, 1981; Guttridge and Warren, 1981), indicates that there is something of a symbiotic relationship between private hospitals and the families of adolescents; the private hospitals make money from extensive stays in the hospitals (by adolescents who do not, in the main, have the

severer diagnoses), while the adolescents' parents gain some respite from their troublesome offspring. While labeling theory predicts that a lack of power and resources would precipitate hospitalization and longer in-hospital stays for the lower-class adult patient, a social control perspective predicts, for adolescents, the separation of class origins from power and resources. Thus, if middle class parents are bothered by their adolescents' behavior, they have both the resources (financial, through insurance policies and/or fees) and the power (of legal and medical decisionmaking, over the adolescent) to hospitalize the minor. The middle-class adolescent is more liable to "voluntary" incarceration than the lower-class adolescent.

Summary and Discussion

We have examined some limited data on the psychiatric hospitalization of adolescents, in the context of a social control model of deviance and its relation to the political economy. The trends fostering the use of psychiatric hospitalization of adolescents include a demand from parents for institutional placement (an interesting topic of inquiry in its own right), the lack of alternative placement resources for both parents and the public sector, the deinstitutionalization movement and the transinstitutional response, the entrepreneurial expansion of private social control facilities and the medicalization of juvenile (and other) deviance. We have been able to document the development of a mental hospital system which mixes a variety of youth in trouble, (ranging from the seriously symptomatic to the homeless) in a relatively class-segregated manner, with the more middle class youth relatively more deprived of procedural protections, and relatively more liable to lengthy incarcerations.

So long as the demand for adolescent social control continues, and these trends are not interrupted, then the continuation and expansion of adolescent hospitalization can be expected. However, there are some counter-trends.

As indicated in the introduction, legal scholars are becoming more interested in the topic of adolescent psychiatric commitment; some of them are writing on the topic in ways which suggest a new advocacy (Dillon et al., 1982). Both this specific legal interest and the general movement for children's rights--due process and otherwise--could have a countering impact.

Although there are legal challenges to it, it does not appear that the medical model of deviance is in imminent danger of collapse. However, there is evidence that the insurance companies who are being asked to subsidize this form of social control are becoming aware of the potential for financial loss (Orange County Board of Supervisors Report, 1980), and are beginning to limit inpatient hospitalization benefits to minors (Schwartz, 1983).

The shifting of fiscal responsibility back and forth between the public and private sectors, and between levels of government, may pose no long-term solutions to the economic problems of social control. Rather than saving money overall, as some economists claim, revenue sharing and privatization may simply shift the money around and provide a temporary respite (Rose, 1979). Thus the pressure to save money may again build up, precipitating changes in the locus of social control. It would be useful for us, as social scientists, to prepare to observe the next asylums into which those released from the mental hospital could be put: foremost among the possibilities seems to be the chemical dependency unit (Schwartz and Krisberg, 1982). It would also behoove those of us who work in or for governmental agencies to institute a statistical watch on all types of asylum, by whoever's ownership they flourish, and whatever name they pass.

Table 1

Variables Associated with Length of Psychiatric Hospitalization* of 1119 Adolescents Hospitalized in 1976-1978.

	Hospitals				
Variables	1. County/ Public, Lower SES N = 302	2. Nonprofit Private, L/M SES N = 301	3. Private Profit, LM/M SES N = 298	4. Private Profit, M SES N = 218	Overall or Mean N = 1119
LENGTH OF HOSPITALIZATION IN DAYS					
Mean	13	25	43	106	42
Median	11	18	33	65	20
Range	1-88	1-254	1-276	1-465	1-465
TYPE OF PAYMENT					
Public Insurance	29.2	54.7	26,5	1,8	29,9
Private Insurance	10.6	28.7	62,8	95.0	45,8
Missing (includes direct public subsidies)	60.2	16.6	10,7	3,2	24,3
TYPE OF COMMITMENT					
Involuntary	84.3	50.5	13,1	9,6	41,6
Voluntary	15.3	49.5	86.9	90.4	58,2
Missing	.4	0	0	,4	.2
DIAGNOSIS (Discharge)					
Schizophrenia	24.5	15,6	12,4	15.6	17.2
Psychosis	5.0	1.0	0.0	3.7	2.3
Suicidal	1.7	0.0	0.0	0.0	.4
Anti-social	25,5	56,1	53.7	31.7	42.4
Personality Disorder	3.6	.7	3.0	21.1	6.1
Depression	13.9	10.6	24.8	18.8	16.9
Runaway reaction	,7	8.3	,7	4.6	3.5
Drug Abuse	9.3	4.3	1.3	.9	4.2
Organic Syndromes	2.0	.3	1.7	0.0	1.1
Other	2,0	2.0	1.7	2.3	2.0
Missing	11.9	1.0	.7	1.7	3.9

* Table adapted from Guttridge, 1981.

Footnotes

1. The term "social control" has been used to indicate all the means by which society is reflected in the behavior of individuals, from socialization and internalization to incarceration in total institutions. The usage in this paper is intended to reflect the latter rather than the former meaning.
2. The commitment of minors can be seen as one issue (Szasz, 1977), or as a developmental issue which divides children from adolescents (Note, 1978). However, this essay is concerned with adolescents (from about 13 to 18) rather than with children, since the data relied upon are within that age bracket. In addition, adolescents far outnumber children in psychiatric hospitals: approximately 80% of nonadults admitted to inpatient psychiatric treatment are 13-19 years old, while 16% are between 6-13 (note, 1978; 197, fn. 48).

   The mean age of our sample of cases (see Table 1) was 15.5 52% were males and 48% females, 77.6% of the sample were Caucasians, 12.8% Hispanic, 8.1% Black, and .7% Asian.
3. In California, as in most other states, involuntary commitment requires a psychiatric element (the person committed must be mentally disordered) and a behavioral element (the person committed must, by reason of the mental disorder, be dangerous to others, and/or dangerous to self, and/or gravely disabled.
4. The response to two survey mailings to mental hospitals in the area was close to 0.
5. The classification was ecological and reputational, based on residents' knowledge of the areas into which Los Angeles is divided. Although we had access to the adolescents' medical records, the parents' actual income or

occupation was very rerely available in the files. The roughness of our measure should be kept in mind when evaluating Table 1 and the discussion on pages 21-23.

6. Spector (1981) discusses other modes of social control which are not directly relevant to adolescent psychiatric commitment but are for other types of deviance handling. For example, the welfare mode he mentions is relevant to the new board and care system for ex-mental patients, which combines private entrepreneurship with Federal social security funding (Emerson, 1981).

7. Lerman (personal communication) denies that there is any "fiscal crisis of the state," and claims that social control practices continue to follow public as well as private money. He cites, for example, the recent expansion of the child welfare system in the handling of juvenile delinquents.

8. Szasz (1977) is against not only the inpatient psychiatric hospitalization of minors but also their outpatient treatment. He argues that psychiatry should only be provided on a truly voluntary basis; children who are under parental authority, have no effective choice. In contrast to Kovar's (1979) claims, Szasz says that "Not a single one of my patients who had been subjected to psychiatric treatment as a child felt that it had done him or her any good...they all felt that having to go to a shrink was humiliating and shamefull...The therapist was their parents' agent in whom they neither wanted to, nor could, confide" (Szasz, 1977; 1007).

The difference between Szasz's and Kovar's accounts may have to do with the socio-economic level of the minor patients. Szasz, as a psychiatrist accepting only voluntary patients, probably has well-to-do clients for whom the psychiatric hospital would have been an affront. For poor, unwanted, or abandoned children, however, the reverse can be true. In both cases the child may be intimidated by, and mistrust, the psychiatrist.

9. Discharge rather than admission diagnoses were used in our studies because records were kept by discharge data. DSM II had not yet been superseded by DSM III at the time we collected our data. The diagnostic categories used in Table 1 were collapsed from 90 specific diagnoses, after consultation with a psychiatrist and a psychologist.

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