The Rights of Juveniles in "Voluntary" Psychiatric Commitments: Some Empirical Observations†

CHARLES W. LIDZ, Ph.D.,*
ELLEN GROSS, M.S.W.,**
ALAN MEISEL, J.D.,*** and
LOREN H. ROTH, M.D., M.P.H.****

Nowhere in medicine is the strict implementation of the doctrine of informed consent more likely to cause problems than in the psychiatric treatment of adolescents. There are three specific problems that are not present in other medical decisions. First, the very fact that the patient involved is a psychiatric patient raises problems concerning competency.[1] Some psychiatric patients are probably at least episodically incompetent to make reasoned decisions about their future.[2] Moreover, some psychiatric clinicians tend to look skeptically at their patients' ability to make such decisions and thus often ignore or undercut them, and this is particularly true when the patient is psychotic.[3]

Second, unlike the diagnosis of most somatic diseases, the diagnosis of mental illness is frequently met with some skepticism by the patient. Patients know what psychiatric clinicians may forget: that being mentally ill is often a stigmatized category in society.[4] If the patient accepts the label, "mentally" ill, he or she is accepting a degraded status. The patient will not necessarily agree that he or she is sick and needs treatment just because the clinician says so.

Finally, the problem of informed consent is most serious here because the patients are adolescents. As numerous clinical studies have shown, adolescents are notoriously uncooperative patients and resistant to authority.[5] Furthermore, their status halfway between children and adults raises a series of difficulties, both in the law and in practice, concerning who is responsible for making decisions for them.[6]

Over the last decade, the question of what rights the adolescent has in determining the type of psychiatric treatment he will receive has increasingly been forced on the attention of legislators and judges. The

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*Dr. Lidz is Associate Professor of Psychiatry and Sociology, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic.
**Ms. Gross is a Social Worker, Neo-Natal Intensive Care Unit, Magee Women's Hospital, Pittsburgh, PA.
***Mr. Meisel is Associate Professor of Law and Psychiatry, University of Pittsburgh School of Law and School of Medicine, Western Psychiatric Institute and Clinic.
****Dr. Roth is Associate Professor of Psychiatry and Director of the Law and Psychiatry Program, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine.

debate has focused on the twin questions of the respective rights of the parent and the adolescent and how to protect rights without trials. It has been pointed out that the "voluntarily committed" child — since he is volunteered by his parents — has neither the protections of a court hearing afforded the involuntary patient nor the right to choose afforded the adult voluntary patient.[7]

The confusion about how to deal with the problem of adolescent psychiatric hospitalization is reflected in the large variety of different rules for hospitalizing adolescents which prevail in different states. Some states now provide that adolescents, age 14 or more, have rights similar to adults to admit themselves voluntarily and to a full court hearing if they are involuntarily committed.[8] In other jurisdictions, the right to hospitalize the adolescent is entirely the prerogative of the parent or guardian. In a recent case, *Parham v. J.R.,* the U.S. Supreme Court upheld the rights of parents and those standing *in loco parentis* to admit their children to mental hospitals if a neutral physician[9] agrees that the admission is appropriate. However, shortly thereafter, making a tenuous distinction between voluntary commitments (to which *Parham* applies) and involuntary civil commitments, a federal court in Maryland held that juveniles were entitled to legal representation at the initial stage of the commitment process and to periodic review of the need for continuing commitment.[10]

One effort to deal with these problems has been a compromise solution which prevailed in Pennsylvania until 1976.[11] While it was in effect, the Pennsylvania compromise procedure gave the adolescent the right to "object" to hospitalization. If she or he did object, the adolescent either had to be released or a judicial commitment process had to be instituted. This procedure, promulgated by a Pennsylvania Department of Welfare regulation required that children, ages 13-17, be notified in writing and orally within 24 hours of their admission that they could be provided with an opportunity to challenge the necessity for their hospitalization. If the child formally objected to hospitalization, he was provided the legal counsel (at government expense). If hospitalization was continued, a preliminary court hearing was held within two business days of the child's objection. The court either issued an order discharging the child from the hospital or set a date for a full scale commitment hearing. Although this regulation is not now operative in Pennsylvania, a procedure similar to it for protesting and/or acquiescing hospitalized juveniles now takes place in some other jurisdictions, *e.g.,* in California and New Jersey.[12]

In a previous study, we found that about one-fifth of the juveniles who were notified of their right to object did formally object, and one-third of these retracted their objections prior to the final hearing.[13] Of the remaining cases, two-thirds were discharged before a hearing could be held, and thus only 4.6% of the cases required a formal hearing. Interviews with staff showed fairly general agreement that the procedure

was therapeutically useful. The current research was undertaken in order to determine whether the relatively low rate of objections and hearings was due to the juvenile patients' desire to receive treatment in the hospital or if there were other factors that prevented adolescents from objecting. We wanted to know to what extent the "opportunity to object" effectively prevented adolescents from being hospitalized against their will without a hearing.

Research Methods and Setting

The research for this paper involved a series of intensive interviews with a group of 15 adolescents (aged 13-17) who were "voluntarily committed" to Western Psychiatric Institute and Clinic (WPIC) in Pittsburgh, Pennsylvania, in 1976. WPIC is the inpatient clinical, research, and teaching hospital of the University of Pittsburgh, with approximately 100 beds. All admissions were done through the admission unit and informing the juvenile of his or her rights was part of that procedure.

With their consent, patients were interviewed in detail using a structured interview. They were asked why they came to the hospital, what they expected the hospital would do for them, who had tried to persuade them to come, and how. They were also asked about how long they expected to stay, what staff had told them about the hospital and treatment plans, what they had understood about their rights to a hearing, and why they did or did not object to being admitted. In all but two cases these interviews were conducted before the patient had left the admission unit. The other two were interviewed within 12 hours of admission.

The patients were interviewed again on the second day of their stay and then usually every third day thereafter until discharge. These interviews were more loosely structured but continually sought to determine whether the patient desired to be in the hospital, why and what the patient felt could be done to get out. We tried to determine this without suggesting that the patient should want to leave or that there was anything in the experience to which he or she should object.

At all stages of the study, hospital records were reviewed and interviews with the staff were conducted to obtain additional relevant information. This method of study gave us access to many of our subjects' feelings and beliefs about which, for a variety of reasons, the hospital staff never knew.

Results

The interviews showed quite striking patterns of behavior and attitudes among the adolescent patients. Although attitudes about their hospitalization varied considerably among our subjects, not a single patient at any point during the interviews ever expressed the classical view of his or her situation that the hospitalized patient is supposed to

have, *i.e.,* "I know that I am sick. I am here to get better and for my own good."[14]

Several patients did express fairly positive attitudes about aspects of their hospitalization, and although they were brought to the hospital by others, they made no effort to resist. These included several adolescents whose parents had committed them and who felt that their parents must mean well. However when asked whether they personally thought that hospitalization was appropriate, none did. Generally, however, the patients saw their hospitalization as a setback in their lives and a matter of great concern to them.

In order to understand the patterns of attitudes among the patients, it is important to realize that they did not all come in under the same circumstances. Three groups can be distinguished. First, one-third of the patients were living with their parents and had no relationships with juvenile court when committed. As a group they were deeply involved with their families and the decision to commit was made by one or both parents. A second group composed of just under half the patients were deeply involved with an agency under the control of the juvenile court, such as a residential treatment center or child welfare. In these cases the initiative for the commitment usually came from the agency. A final group involved only three adolescents who had spent substantial periods living away from home either with friends or alone. Although none would be probably classified as legally emancipated, subjectively they believed themselves to be independent of their families and resented the efforts of either the juvenile court or their parents to commit them. Each of these three groups had different problems with, and responses to, their hospitalization.

One common aspect which we found, however, was that all of the patients seemed to have two fears about being hospitalized. The first worry was that since someone was trying to put them in a psychiatric hospital, they must be "crazy." A parallel concern was that they would be believed to be crazy. After they were admitted, a second fear became primary, that they would be held in the hospital for a long time. Discussions of whether or not to consent to admission and whether or not a lawyer would help invariably centered around these two concerns.

All of the adolescents committed by their families formally consented to admission to the hospital in spite of the fact that none of them thought that they were mentally ill or needed hospitalization. Most of these patients explained their agreement in terms of their relationship to their family. They explained that their parents must know what is best, even though it seemed like a mistake, or that they did not want to cause their parents any unnecessary trouble. All of them assured us (sometimes seeming to search for confirmation) that one family member or another could be counted on to make sure that they would be let out if it became necessary. In brief, in spite of some strong fears about hospitalization, these children seemed too tied to their families to

be willing to employ the right to a court hearing. The marginal exception in this group was a 17-year-old boy, a self-proclaimed gay, whose parents were divorced. His father had committed him, and he did not seem to feel that he had strong ties to his father. He explained that he didn't object because he had "no real rights because I am not an adult." He also believed that his mother would see that he was released when he felt he needed to get out.

Although the legal arguments about the propriety of adolescent commitments have focused primarily on the rights of parents to commit their children, the largest group of patients we saw were generally residents of an institution supervised by the juvenile court and were committed "voluntarily" by the juvenile court judge. In several cases where the parents still had legal custody of the child, the court persuaded or threatened the parents into taking action themselves.

If the children from families who committed them felt morally and emotionally bound not to object, the adolescents committed by the juvenile court assumed that objecting was a waste of time. For the most part they assumed (correctly) that the case might go before the same judge who had signed the "voluntary" papers or who had strongly urged their parents to commit them. Furthermore, based on their experiences with other courts, they took it for granted that the court would not take them seriously. As one put it, "They won't listen to me." Thus they did not object to hospitalization either. There was one exception in this group also, a mildly retarded 16-year-old girl who had lived in an institution much of her life. She had a deep trust in her caseworker and, although she didn't think that she needed to be in the hospital, agreed because "Miss Jones said I should and I like her very much." In brief, she related to her caseworker the same as many children relate to their parents.

While the adolescents living with their families depended on family members to assure their release, the juvenile court group had more serious problems. Whereas the adolescents committed by their families had some discomfort about whether or not their families could be "trusted," the court-supervised adolescents lacked anybody who could be counted on to place the child's self-perceived interests ahead of parental and societal interests. In an effort to find such allies, these adolesents tried ingratiating themselves with their probation officers and with hospital staff. However, such people, with their commitments to the universalistic norms of their jobs, were bound to be unreliable allies. Staff often seemed to feel that these attempts by the patients were "manipulative." Some patients quickly decided that the hospital was better than the institution where they had been confined prior to hospitalization,and began to try to use staff as a means of negotiating their way out of that institution.

The final group involves only three adolescents, all of whom had lived away from their families in the larger society. They expected to be

treated as independent individuals. Two of these three patients formally objected to being hospitalized. Indeed these were the only two patients of the entire fifteen adolescents who formally objected. One patient withdrew the objection when she decided the ward was a nice place. The other did have a hearing at which she was sent to a state hospital. The last of this group simply refused to cooperate with treatment and was released on the third day. Both patients who formally objected were quite psychotic at the time they objected. They lacked the "realistic" perspective necessary to see that it was a waste of time.

Conclusion

Empirical findings cannot tell us what the law should be. Neither, however, should they be totally ignored. The beliefs, feelings, and experiences of adolescent patients are appropriate for lawmakers to consider. Our findings do tend to support the view of the dissenters in *Parham,* voiced by Justice Brennan, that children who are wards of the state need protections against state power which may not be needed by children who are in the custody of their parents. Although neither group of children in our study made use of their right to obtain a court hearing on the propriety of their hospitalization, the children admitted by their parents failed to exercise this right because they believed their parents were acting in their best interests, even though they themselves were not convinced that they belonged in the hospital. By contrast, the children who were wards of the state and who were admitted to the hospital by order of the juvenile court judge did not share the belief that they had been dealt with in good faith by people who had their best interests in mind. These children failed to exercise their right to a hearing because they did not believe, in light of their current and previous experiences with the juvenile court, that it would be helpful. It is possible that perhaps they were right. Even if they were wrong, the cynicism they had learned from their experiences with the courts would prevent them from feeling powerful enough to control their own destinies. But perhaps they were merely victims of a self-fulfilling prophecy, and if this is the case, the majority, by taking the position that it did in *Parham,* missed an opportunity to lay this prophecy to rest.

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8. See, *e.g.*, Pennsylvania Mental Health Procedures, 50 P.S. § 7201, § 7301, *et seq.* (1976)
9. *Parham v. J.R.*, 99 S. Ct. 2493 (1979)
10. *Johnson v. Solomon*, 3 M.D.L.R. 376 (D. Md., 1979)
11. In 1975 a federal district court ruled this solution insufficient to meet constitutional guarantees. See *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa., 1975). Subsequently, in 1976, the Pennsylvania legislature rewrote the Pennsylvania commitment law.
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