Legal and Psychiatric Issues on the Hospitalization Of Children: The New Jersey Experience

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PART I: PSYCHIATRIC ASPECTS

Introduction and Background History

There has been a great amount of interest in court commitment proceedings of children following *Kremens v. Bartley.* The spur for the flurry of court actions has been recognition of the fact that parents do not always act solely in the best interest of their offspring. In particular, some have questioned the motives of parents involved in long-term placement; suspicion has been directed at the use of mental hospitals and institutions for the retarded and behaviorally deviant as "dumping grounds" for and by rejecting parents.

Despite anecdotal evidence, the extent of true abuse is unclear. Nonetheless, the tenor of the times is such that the law will scrutinize all situations which involve any impediment to freedom. Different states have attempted to handle the issues raised by this case in various ways. Corder, Haizlip and Spears[1] "explored many legal, therapeutic, and public policy questions that may be applicable to a wide range of similar treatment programs" regarding *Kremens v. Bartley,* basing their work on the experiences gleaned from the establishment of an adolescent unit in a regional state mental hospital in North Carolina. Following the initial *Bartley* case, the New Jersey Supreme Court by fiat implemented a new procedural system in 1975 for the handling of children. (See Part II of this paper, which deals more specifically with the ruling itself.)

The New Jersey experience, while in many ways encountering similar issues to those raised by our North Carolina colleagues, has been a unique one. The system was characterized by automatic judicial review, appointment of attorneys by the court to represent minors, and prompt hearings. Children 14 and above could waive a hearing, but such reviews were mandatory for those under 14.

These proceedings soon came under attack by psychiatrists, institutional

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administrators and others. The Adolescent Unit at Rutgers Medical School found itself hampered by the new systems.

Description of the Unit

The Adolescent Unit is part of the Department of Psychiatry, College of Medicine and Dentistry of New Jersey – Rutgers Medical School. It is designed to provide comprehensive care for emotionally disturbed adolescents and their families. Patients can move from an inpatient setting to a day-hospital program and then to outpatient status as they progress toward health. The inpatient and partial hospitalization programs are integrated and run by the same clinical staff; thus, the patient experiences a continuity of care as he or she progresses.

The faculty and staff maintain active contact with the referring professionals throughout the treatment stay.

The Units are multidisciplinary and multimodal. The Director is a child psychiatrist; the faculty and staff are trained in several disciplines. Individual, group, behavioral, milieu, and family therapy interventions are provided. The specific treatment design is based on the clinical needs of each patient.

A fully accredited special education program is available and integrated into the clinical programs.

Medical and neurological consultations are available within the Medical School. Clinical laboratory and EEG services are available within the Department of Psychiatry. A 24-hour nursing staff, assisted by mental health specialists, students, and volunteers from the community, provides care for patients.

The Unit is an open one; doors are rarely locked. If a patient is suicidal or aggressively acting up, intensive therapeutic intervention in the form of life space interviews, medication, or time-outs is favored over changing the free ambience by closing the facility, even though at times this has become inevitable, as will be explained later. After years of struggle, we have finally been able to reach a point where patients stay fundamentally because they want to.

With the initial implementation of the Supreme Court ruling, the Chief of the Service had to spend considerable time in preparation and discussion of cases which seemingly had little to do with the civil rights concerns of those who had pushed for reforms.

However, the ruling grew out of concern that mental patients in long-term facilities may be deprived of their civil rights without sufficient cause. Because of this orientation, attorneys initially viewed themselves as patient advocates with a primary goal of effecting the release of the client-patient, if possible. The lawyers representing the patients did so without any great enthusiasm. They personally complained about not receiving enough compensation and about the time involved in the proceedings. Initially they felt a lack of interest. The lawyers would show up at the last minute and sometimes would not have acquainted themselves with the families of the patient represented, and therefore would have hostile parents on their hands to deal with. Several patients had their families try to use their own lawyers, claiming that they felt inadequately represented. When the lawyers did get

interested, they bombarded the psychiatrists with questions, even to the point of over-involvement. As the lawyers were not acquainted with the Unit's psychological orientation, there was often mutual misunderstanding, with some mistrust.

We experienced a number of other problems that might be viewed as part of the "birth pains" of this process. On occasion, especially before the change in the ruling, the court and its officers would make judgments at variance with psychiatric testimony. On one occasion, a paranoid schizophrenic adolescent with hemophilia, who described himself in court as a boy genius, persuaded the court to release him from hospitalization. Fortunately, we were able to persuade this youngster to remain in the hospital as a voluntary patient.

On a number of occasions, attorneys acting as patient advocates secured the release of patients who we felt needed intensive, inpatient psychiatric treatment. Happily, the majority of these adolescent patients decided to remain in the hospital as voluntary patients.

Each judge handled his case in a different manner, ranging from "This is a difficult, unwanted chore" to an intricate, detailed, strict interpretation of the ruling. Before the ruling was changed, and while it lacked the elastic clause of "need for intensive psychotherapy," several judges went along with the notion of *not* applying the strict letter of the ruling, and in a number of cases patients were not committed because they were not a danger to themselves or others. If the patient at that point expressed a voluntary desire to be hospitalized, the judge would rule that such a patient should remain in the hospital and that the institution "should not let him down." Thus one could infer that the judge would essentially go out on a limb, counting upon the good will of the patient to adhere to the wish and desire of the judge not to elope or terminate the hospitalization. Other judges decided to commit everybody, finding justification for commitment and continuing hospitalization of the patients; the irony of this situation was that patients were in effect getting committed to a non-committable facility. The judges seemed interested in the proceedings and asked many questions of the psychiatrists of a psychological and informational nature; they seemed to be better informed than the lawyers, and more closely attuned to the nuances of psychological and emotional issues.

Psychiatrists were not pleased with having to go to court once a week and talk openly about a patient in front of a judge, lawyer, parents, court clerks and guards. Initially there was a lack of feeling about what this all might mean to the patient and his family, even though the ruling was intended to be in the best interests of the patient. Families with adolescent children clearly in need of hospitalization refused to go ahead with the procedure because of feelings about court involvements. Proceedings were extremely time-consuming and necessitated preparation as well as actual court appearance. Hours were wasted waiting for the cases to be presented. Since the proceeding was a non-adversary one, there were only rare moments during which severe cross-examination happened, but when this did occur, it was very uncomfortable. At times, under questioning, psychiatrists would embark upon conjecture and speculation about probability and the future in front of the patient and his family, resulting in therapeutic confusion and

distortion.

After a year, the crescendo of complaints resulted in a marked modification of the procedures for minors, modification which made the procedures much more appropriate and workable. This revision was achieved in spite of the opposition of the Public Advocate, who favored the standards of "dangerousness" for all. Thus, following the original New Jersey Supreme Court *Ruling on Commitment of Children*[2] and *Revisions to Commitment Rule*,[3] the courts found it permissible to expand the concept of commitment of minors. Beyond the "danger to self or the community" test, grounds for committing minors could include the possibility of the patient's being in need of intensive psychiatric therapy which could not practically or feasibly be rendered in the home or in the community or on any outpatient basis.

With this change, a fundamental shift took place. The procedure began to become judicially less formal and more psychologically oriented. Judges no longer would appear in judicial garb; the hearings, in fact, were moved from the courtroom to the hospital setting itself. The lawyers, judges and psychiatrists were involved in what became adversary-like proceedings. Much of this change came about because, with the modification, it was possible to proceed with a structure that all would agree was in the best psychological interests of everyone concerned, including the patient and his parents.

At this point, the Unit, being part of a community mental health center, had to agree that *only* voluntary patients would be admitted. However, since all children under the age of 14 still had to be committed, a formula needed to be worked out so as not to exclude that age group from the benefits of psychiatric hospitalization. Again this problem was resolved by the mutual cooperation of all parties involved.

Basically, now, the hearing is held so as to ultimately determine the voluntariness of an adolescent admission over the age of 14. Following the initial hearing, if a re-hearing is needed, the format has become, as stipulated in the Rule, a summary one, thus further decreasing the formality and reducing the strain on the adolescent patient.

Since this change, over one hundred adolescents have been processed as voluntary admissions. In a few situations, parents signed out their children against medical advice despite the wishes of the children to remain. A half-dozen children under 14 have been processed by the courts as involuntary admissions, resulting in "Certificates of Admission," not classic commitment papers.

The average length of stay is roughly 45 days, with few exceeding three months (there was one admission of four months). When the adolescent patients are referred to the day hospital, court rules do not apply.

Those 14 and over who do not wish to become voluntary admissions face the prospect of court commitment to a regular state hospital.

In two cases, children who did not wish to "volunteer" were discharged "against medical advice." One was a 16-year-old girl with severe behavior problems – antisocial acting out, severe family problems, a history of past suicidal attempts, drugs, promiscuity and alcohol misuse. The other was a 16-year-old girl with possible multiple personality whose father had committed suicide at the time of hospitalization. Both insisted on discharge,

and mandatory hospitalization was not thought appropriate by the staff.

No patient has actually ever been forcibly committed against his will to the state hospital as a result of the ruling, even though one might argue that that threat is always implicit. There have been several incidents where a child has been committed to the appropriate state hospital following some self-destructive or aggressive act which could not be handled in the type of open setting that the Unit provides, but these cases really had nothing to do with the initial court proceedings or the spirit of the ruling.

Formerly, the court order was for three or six months. Now all court orders are for an initial period of three months – a period which suffices for the usual handling and disposition.

Strong efforts have been made to explain to the minors that the court procedure is for their protection. This has resulted in greater clarity, although myths still persist.

Letters to parents about "involuntary commitment" causes multifold unfavorable reactions. The wording has now been changed to a hearing on the child's "voluntary admission" in those cases where the child has volunteered. Parental anger and confusion continue, but not to the previous degree.

A group of six to eight lawyers have been handling the court-appointed chores as representatives of the children.

Evolved Philosophy of the Unit in Response to the New Jersey Supreme Court Ruling

The adolescent hospital at Rutgers Mental Health Center is an unusual facility. Its inpatient service grew out of a partial hospitalization program, and its treatment philosophy is strongly influenced by the partial hospitalization experience. One important aspect of this influence has been the conviction of the program administrators that (1) the amenability of adolescent patients to treatment is enhanced as coercive measures are diminished, and (2) that hospitalization is a *positive* experience in the life of the patient.

Initially less than one per cent of patients admitted to the Adolescent Hospital were self-referred; of the remaining 99% referred by others, less than 10% were willing to be hospitalized. Thus almost all newly admitted adolescent patients felt, rightly or wrongly, that they were in the hospital because they had been coerced. The first treatment task of the hospital program was to deal with the anger and resentment toward adult authority experienced as a consequence of hospitalization. For many patients, this anger and resentment is a "life style" developed well before hospitalization.

Adolescent resentment finds expression in a variety of ways: social withdrawal and isolation, refusal to participate in therapeutic activities, verbal aggression, destruction of property, physical aggression directed at other patients or staff, and, with more sophisticated patients, organized resistance to the hospital program, *i.e.*, the formation of "counter-culture" groups. All of these adolescent behaviors can easily elicit a repressive response from adult authority and thus perpetuate a cycle of struggle between adolescents and hospital staff that consumes the attention of all involved and sidetracks important therapeutic work.

This cycle of struggle occurs within the hospital from time to time despite the concerted effort of the staff to prevent it. "Fighting the staff" appears to be an innately reinforcing activity for adolescents and is one of the most effective ways of avoiding engagement with the problems that led to hospitalization in the first place.

Combatting this drive for struggle is an ongoing treatment process, the main thrust of which is the formation of a "therapeutic community" composed of patients and staff and having as its goal the mutual sharing of problems and community cooperation towards their solution. An attempt is made to indoctrinate a "core" of patients within the community in the "therapeutic culture." As this "core group" expands, it exerts positive peer pressure on other adolescent patients; that is, patients receive therapeutic input from fellow patients, thus circumventing the adolescent-adult struggle cycle. Also, patients can observe the social rewards received by the "core group" for engaging in problem-solving behavior and thus gain incentive themselves to deal with their problems therapeutically.

In light of the process outlined above, one major function of inpatient hospitalization (apart from such standard functions as removal from disruptive environment, supervising patients potentially harmful to self or others, and controlling florid psychotic symptoms through the use of medication) is to expose the newly admitted patient to an intense affiliation experience with his peers through which his indoctrination as a member of the therapeutic community is begun.

The hospitalization process can be viewed as a short-term inpatient experience during which patients are supervised, stabilized and exposed to an intense living arrangement with peers who have similar concerns and interests and who, to some extent, treat and train each other. This inpatient experience averages about forty-five days and is an entry to the partial hospitalization program that relies for its effectiveness on the premise that patients in the "day hospital" attend because the therapeutic community provides important reinforcements for them.

From its inception, and before any court rulings, the adolescent inpatient program did not want, nor was it physically constructed to accept, committed patients. On several occasions patients were admitted who would otherwise have been sent to a correctional facility. Patients admitted under these coercive circumstances resisted therapeutic acculturation to a greater degree than other patients. Acting up would take place, leading to destruction of property, and limit-setting was difficult. These experiences reinforced the validity of Mental Health Center guidelines prohibiting commitment of patients to the Adolescent Hospital.

When judicial review procedures were instituted by the courts, our initial response was one of concern that our treatment program would be adversely affected. Our primary concern was that inpatient status would become more coercive in nature. Several of the first adolescent patients to experience the judicial proceeding left the hearing room with the idea, as previously stated, that the period until the next judicial review constituted a kind of "sentence" to the hospital. They would ask those who had attended court hearings, "How many months did you get?" The children viewed themselves as having been identified as criminals. We were extremely apprehensive that

the commitment proceedings would lead to more frequent cycles of struggle.

We decided that our most effective initial approach to the problems presented by commitment hearings was to persuade newly admitted patients to choose voluntary hospitalization status. Since commitment hearings generally took place three to four weeks after admission, there would be enough time to effect a sufficient engagement in the therapeutic community so that a large percentage of new patients would remain hospitalized voluntarily.

As our experience with the process of hearings increased, we found that we were able to talk more openly with the judges and attorneys. In a sense, colleagual relationships began to develop, and a mutual sharing of problems and concerns surrounding commitment hearings was possible. In an effort to "demystify" the hearings, the court agreed to conduct hearings in the hospital setting, to dispense with judicial robes, and to pare down the number of court officers attending sessions.

Through the process of mutual problem-solving, it was possible to educate attorneys about the primacy of their "guardian" role in these matters, as opposed to the more familiar advocacy role. This process has been an informal one, relying on the accidental circumstance that certain attorneys have been repeatedly involved in these hearings. In essence, our task has been to educate these attorneys about a number of basic principles of behavior pathology and its consequences. In general, this task has been performed by the clinician with primary responsibility for treatment of an individual patient. This process consists of a presentation to the attorney of a detailed rationale for the patient's need for intensive inpatient therapy, including reasons why the patient's needs could not be met on an outpatient basis. This discussion would also include some speculations about possible behavioral consequences for the patient if inpatient treatment were not provided.

Fortunately, it has been our experience that these busy attorneys eventually became quite willing to involve themselves in this learning process. We would like to stress again, however, that this change took place following the introduction of the "need for intensive psychotherapy" formula.

The judge responsible for conducting these hearings has an extremely potent influence on the hearing process. Because the judge has been interested in understanding our orientation to this process in terms of its impact on adolescent patients and their course of treatment, he has been able to set a tone of cooperation between psychiatry and the law to protect the rights of patients without unduly disturbing the course of treatment. One clear evidence of this is the fact that these hearings have been characterized by an absence of adversary interactions between clinicians and attorneys.

Our attitude toward commitment has been clarified in this process. Our task is to expect a sufficient therapeutic engagement, within three weeks, that the patient will agree to voluntary admission to the hospital. Under these circumstances the commitment hearing has had an interesting reverse effect on adolescent patients. In the course of the hearing the patient receives clear information from the therapist, from his attorney and from the

judge that continued stay at the Adolescent Hospital is the patient's choice. It has been clear to almost all patients that they themselves can sign out of the hospital, "against medical advice," on 72 hours' notice. We have observed since this change in procedure a three-fold increase in the number of "72-hour release requests" filed by adolescent patients. Despite this marked increase in requests, there has been no significant change in the number of actual AMA releases. We have evaluated this occurrence and have concluded that a number of patients, subsequent to the hearing, appear to initiate a "decision crisis." This crisis tends to be characterized by a heightened resistance to involvement in the community, an intensification of provocative behavior calculated to elicit a repressive response, and in a few cases a brief elopement from the hospital (generally of a few hours' duration). During this period of time, talks about leaving and therapeutic engagements occur about such issues as: Can you go home or will you be sent elsewhere? Have the problems that led to your admission changed in any way? More than 90% of these crises are resolved within 72 hours by a decision to remain in the hospital. The majority of those who decide to stay seem also, in spite of themselves, to have made a significant personal commitment to engaging in therapy, and thus facilitate their course of treatment.

Since it is policy not to accept committed adolescents over the age of 14, there are from time to time a number of patients on voluntary admission who are potentially dangerous to self or others. In these instances, the court hearing provides a useful format for making explicit the implied coercion to remain in hospital; *i.e.,* failure to participate may lead to transfer to another facility where the patient will be actually involuntarily committed.

For those youngsters below age 14 who must be committed, our policy has been to treat them as if they were allowed to be voluntary patients in terms of the process of engagement. We have, as noted, changed the wording on the commitment papers to read "involuntary admission" and "certificates of admission," thus hoping to remove some of the negative connotations associated with commitment and diminishing the "stigma" attached to these types of procedures. This change has been very useful, and parents in particular feel more comfortable with this innovation in the process. Although we would prefer that such patients could have voluntary status, our sense is that only a small number of patients fall into this category, and the impact of these involuntary admissions on the treatment program is relatively insignificant.

PART II: JUDICIAL ASPECTS

The procedural and substantive aspects of civil commitment and voluntary admission of children to mental institutions are largely found in the *Rules Governing the Courts of the State of New Jersey.* The responsibility for making rules governing the practice and procedure in and the administration of all of the courts in this State is charged to the Supreme Court of New Jersey.[1] There are, of course, various statutory provisions which deal with the same topic.[2] However, this paper will deal with the impact of the 1975 and 1976 Rule revisions on the commitment and voluntary admission process. Before beginning that discussion, it would be helpful to outline the

Rule provisions, starting first with the involuntary commitment of children, usually referred to as a "regular" commitment.[3]

Regular commitment proceedings are initiated by the filing of a written application signed by a person qualified by statute to seek such admission.[4] Attached to the application form must be the certification of two physicians setting forth with particularity the facts upon which the physician relies in concluding that the child should be committed. The mere conclusion of the physician is not sufficient. The standard for the commitment of a minor[5] is either a determination that the child constitutes a probable danger to himself or to the community, or alternatively, that the child is "in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any outpatient basis."

If the court is satisfied with the application and certification, a temporary order of commitment is entered. The order must establish a hearing date within 20 days of the date of admission and assign counsel to represent the child as guardian *ad litem.* The guardian *ad litem* so appointed is obligated to represent the minor until the child is released or reaches his majority.

Between the date of the temporary order and the hearing date, the guardian has the right to inspect and copy all records relating to the child's mental condition. If his review and investigation raise substantial questions of treatment, the guardian may apply to the court for the appointment of an independent psychiatrist to examine the child and testify at the hearing. Normally a judge will not decide issues of diagnosis and treatment unless the guardian has given all interested parties adequate advance notice and is prepared to offer evidence beyond the cross-examination of the treating psychiatrist.[7]

At the initial hearing the applicant for admission must be supported by the testimony of at least one licensed psychiatrist. If the psychiatrist feels that the child's mental condition would be adversely affected by hearing the testimony, he should bring this opinion to the attention of the court before his testimony begins and state his reasons for exclusion, whereupon the court will excuse the child from the hearing room. Otherwise, the child has a right to be present, and may also testify if he wishes to do so.

If the court is satisfied with the proofs submitted at the hearing, a final order of commitment will be entered. However, the court must review all final orders for commitment of minors every three months until the minor is discharged or reaches his majority.

If at the initial hearing or a review hearing the proofs lead the court to believe that the child should be discharged but that he still suffers from a mental illness which requires psychiatric care, an order of release containing appropriate conditions may be entered. Conditions for release may include, but are not limited to, attendance at non-residential mental health facilities.

A minor 14 years of age or older may request his voluntary admission to a psychiatric institution. Voluntary admissions are not conditioned upon either a determination of dangerousness or a need for intensive psychiatric therapy. In order to insure the best interests of the child, the court is notified of all requests for voluntary admissions by minors and must review them at a plenary hearing within 20 days of admission. A minor who voluntarily admits himself may also give notice of discharge in the same

manner as an adult and without parental consent.[8] The order approving a voluntary admission is reviewable every three months until the patient reaches majority, is discharged or signs himself out on 72 hours' notice. The periodic review provided for voluntary admissions, however, does not require a plenary hearing. The rule provides that the court may conduct a summary review, which I have interpreted to mean a statement by the guardian on the record of the court that he has discussed the matter again with the juvenile and that the juvenile's status is the same as it was at the initial hearing.

A parent may, without the consent of the child, obtain the admission of the child to a psychiatric institution solely for the purpose of evaluation or diagnosis of a mental condition. The period of confinement, however, may not exceed seven days. If during that seven-day hospitalization it is determined that further inpatient care is required, the voluntary application of the child must be obtained if he is 14 years of age or older. If this is not obtained, involuntary commitment proceedings must be commenced.

The New Jersey Supreme Court Rules dealing with the inpatient psychiatric treatment of children reflect the extension of Fourteenth Amendment due process guarantees to a class of people who were previously thought to be either disenfranchised of the basic Constitutional rights or incapable of effectively exercising their rights. Since the English common law, the state has assumed a paternalistic attitude toward the infant and incompetent, attempting to act as the guardian and protector of those unable to care for themselves. With respect to children, this theory of *parens patriae* either replaced or infringed upon parental authority. In cases where the parents had neglected or abused the child, or where the child's life was in jeopardy, the state acted swiftly in the child's best interests.[9] However, in the grey areas involving parental discretion, such as education and medical treatment, the state has been reluctant to interfere. The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This theme is echoed throughout the case law of this country in a variety of factual situations.[10]

The decision of a parent to seek psychiatric care on behalf of a child, like a parent's decision to seek orthodontic treatment for a child, falls clearly within the realm of parental discretion. Why then does the judicial process concern itself with the former decision but not the latter one? It is submitted that judicial involvement occurs not because of the nature of medical discipline involved but rather because of the consequences of the treatment and the complicated motivations involved in obtaining it.

It is the institutionalization or confinement of a child which activates judicial concern. In the landmark case of *In re Gault,* the United States Supreme Court first enunciated the principle that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone," and that substantive and procedural "due process" must be observed where a juvenile's freedom from incarceration is at stake.[11] In that case, the court held that even the judiciary in exercising its paternalistic power of *parens patriae* over juvenile delinquents could not satisfy the requirements of due process, but rather that the child should be afforded the right to independent counsel as well as a full and fair hearing before incarceration could take place.[12]

The institutionalization of a child in a psychiatric facility with the

attendant social stigma is undeniably a deprivation of freedom on par with incarceration in a reformatory school. The results, then, in the cases of *Kremens v. Bartley*[13] and *J. L. v. Parham*[14] were hardly unpredictable. The courts in both cases applied the *Gault* theory to the institutionalization of minors. In both cases the state argued that due process was afforded the child under the commitment statutes through the participation of the parents and the required certification by two physicians. The court answered this argument by stating that while ideally parents always have the child's best interests in mind when making decisions affecting the future of the child, reality belies this ideal. Many instances of inappropriate reasons for commitment were cited by the court, such as difficulty in relating to one parent, delinquent behavior, and inability of the family to cope with the child's needs.[15] It was clearly pointed out that parental authority and discretion are open to major abuse in this area, and thereby require some procedural check.

In New Jersey, the procedural check afforded is the appointment of a guardian *ad litem*, who is also an attorney, to represent the child. There are those who contend that the appointment of an attorney is unnecessary and that the court and psychiatrist would afford a sufficient "due process" buffer between the parents and the disturbed child. We already know from the *Gault* decision that the judge is not enough protection for the juvenile threatened with incarceration, that someone who can give individualized attention and specialized treatment to the problem is needed: an attorney. Why, then, not the psychiatrist? Several reasons are traditionally offered. The first one, although somewhat parochial, recognizes the distinction between the relative disciplines. Admittedly, the diagnosis and treatment of a mental illness is essentially the responsibility of the medical expert; however, the issue of compulsory confinement carries with it elements that are clearly jural.[16] Secondly, and perhaps more practically, the physician should be free from the responsibility of being an advocate either for the parents or the child. In that way his objectivity is not affected. Indeed, it may be beneficial to the doctor in terms of the selection of a treatment modality to be flexible and neutral on the issue of confinement. For example, it is much easier for a physician to persuade a parent to pursue family counseling as a means to resolving the child's problems when the parent realizes that the physician has not assumed an advocate's role relative to confinement or release.

The role of the attorney in the commitment process has been the subject of much analysis and debate.[17] There is no question in the present writers' minds that the traditional concept of advocacy in this setting is counterproductive. The New Jersey Supreme Court, we believe, recognized this problem when it required that the court having jurisdiction over the matter appoint a "guardian *ad litem* . . . who shall also be an attorney."[18] The function then of the attorney is primarily that of a guardian *ad litem* – a person appointed by the court to both protect and advance the best interests of the child. In this context, his job is not simply to "spring" the child from the institution but first to interview the patient's family in order to develop some understanding of the child's social and educational background. Having done this, the attorney should then review the child's

medical chart and interview the psychiatrist and staff involved in his case. Only in this way can he make an educated judgment as to whether the child's best interests are served in an inpatient setting. It is further the attorney-guardian's duty to advise the child of the nature of his representation so that the patient, too, understands that his representative will not be blindly arguing for discharge at the court hearing.

Once he is armed with all this information, what avenues are open to the attorney-guardian short of seeking discharge on behalf of the child? Let us assume first that the attorney learns the family situation is such that the child cannot be returned home even if out-patient care is feasible. In such situations he can request the involvement of the Division of Youth and Family Services, who can explore the availability of either foster care placement or residential care and education facilities. This action sometimes spurs the indifferent or unmotivated parent into positive action, such as family counseling. If not, then a viable alternative to an indefinite stay within the institution is being developed while the hospital staff is continuing therapy toward eventual discharge.

In the voluntary admission setting, relatively few issues concerning medical treatment and diagnosis are presented to the court, since the criteria for involuntary commitment, *i.e.,* dangerousness and/or need for intensive psychiatric care, are not relevant in the voluntary setting.[19] The only remaining question to be answered once the family situation has been satisfactorily addressed is whether the child's mental illness is manifested in such a way that the child can understand the nature of his voluntary undertaking. Obviously a child who is so mentally ill that he cannot understand rational conversation and form a considered judgment should not be allowed to make a voluntary application for hospitalization. There is a clear analogy between this principle and the doctrine of informed consent in related fields of medicine. The attorney-guardian confronted with this situation should advise the family and hospital staff that he will oppose approval of voluntary hospitalization on this basis so that all interested parties will be prepared to offer proof on the issue at the initial hearing. If the court decides from the evidence that the child is incapable of making a voluntary consent, the rules of court and statutory laws of New Jersey require discharge within 72 hours after the hearing.[20] During this period of time the family and/or the physician can decide whether to seek involuntary commitment.

The preceding example presents the more obvious of the issues concerning the voluntariness of a child's request for admission. There are many instances in which the child's illness does not prevent considered judgment but in which other elements might affect the voluntariness of the patient's consent. For example, the child will occasionally indicate that his parents threatened to commit him to another state institution unless he volunteered to enter the Community Mental Health Center. Such a statement, while tainting the voluntariness of the child's decision, does not necessarily require the invalidation of the admission. What is necessary, however, is a fuller inquiry by the attorney-guardian. If the facts indicate that there is a probability that the child is committable, the attorney-guardian should advise the child. He should also advise the child what would be necessary in terms of substance

and procedure to commit him. If the child elects to remain at the hospital, he has then made an informed, albeit reluctant, consent to hospitalization. Similar situations are encountered in which the juvenile has been involved in delinquent behavior and finds himself in a mental health facility for fear that he would otherwise be sentenced to a correctional institution. In such cases the child's attorney should explain the powers and limitations of the Juvenile Court and the probabilities of the child's being sentenced to a correctional institution for his delinquent behavior. If, after consulting with his attorney, the child decides that hospitalization, although not desirable, is the best alternative, an informed decision has been made and the court should approve his request for admission.

The hearing itself has been found to be a source of problems in determining the voluntariness of the child's admission. There have been many instances where children have appeared in the hearing room and have exhibited both insight into their psychiatric problem and a desire to be treated for it, but have balked at answering the threshold questions concerning voluntariness. We have identified several reasons for this phenomenon. Firstly, the form of this most important question is usually inartfully presented by the attorney. The most often used question is: "Do you want to be here?" Clearly not even the most eager patient "wants" to be in a mental hospital. It is foolish to think that a patient is likely to answer that question in the affirmative. Moreover, the answer to that question really is not always relevant to the issue of voluntariness. A child may not want to be in the hospital but can still make a voluntary decision to remain there, just as he may not want to have a tooth extracted but, after considering the alternatives, consents to having it removed. In order to avoid this pitfall, the attorney must be able to elicit information from the patient in such a way that the courts can conclude that voluntariness exists or does not exist, based on the child's response to several areas of inquiry, including the child's situation at home and in school, his status with peers, the events that brought him to the hospital, the conversations relative to his signing the admission papers, his feelings at the time he requested admission, his present feelings about it, and his attitudes toward the doctors and staff.

Secondly, we found that some children, after expressing satisfaction with their hospitalization privately to their attorney and physician, responded differently at the hearing due to a mistaken belief that if they told a judge they were happy with their present status, the judge would "sentence" them to a minimum of three months. This misunderstanding of the role of the judge results, again, from improper preparation of the child for the hearing. It can be easily solved simply by educating the child prior to the hearing and by reassurance from the judge during the hearing. If a child is concerned about the three-month review period, we assure him that he can be discharged much sooner and that he retains the right to sign himself out on 72 hours' notice, but that, if he happens to be in the hospital three months from the hearing date, we will be there to see him again.

We are told by hospital personnel that some children will simply not accept as true the non-sentencing role of the judge no matter how clearly and sincerely it is explained. There are apparently some children who want to be "sentenced." In that way they do not have to admit to themselves that

they need help. We have been encouraged by the staff not to yield to the patient's charade but, rather, to re-enforce in his mind the fact that the decision as to whether he should stay or go is squarely in his hands. It is apparently widely held in medical circles that a person who can accept the decision to seek and maintain voluntary treatment is a more promising candidate and a more willing participant in therapy than an involuntary patient.[21]

Thirdly, we have found that the formality of the proceedings themselves has caused unpredictable responses to questions. The child was often awed and confused by the number of people involved in the proceedings and the general commotion around the hearing room, what with a court stenographer, court clerk, sergeant at arms, attorney for the county adjuster, and so forth. Then, too, we experienced attorneys asking very personal and embarrassing questions of the doctor and staff while the child was present. Honest answers to such questions often elicited angry retorts from the child, gestures of frustration and just plain expressions of humiliation. It did not take long to realize that the intent of the Supreme Court Rules could be carried out much more efficiently and in the best interests of the patient by informalizing the procedure as far as possible.

As results of this informalizing, the judge now sits at a table in a business suit rather than robes; the court officer appears in civilian dress rather than in uniform; the court stenographer sits discreetly off in a corner of the room; all witnesses are sworn at one time while the child is outside the room; counsel for the child asks delicate questions of the psychiatrist and staff without the child present; and informal conversation occurs between the judge, the patient and attorney, rather than formalized courtroom questions and answers.

Other very different problems are presented by involuntary commitment hearings. In these hearings the battle lines are more sharply drawn and the differences between the disciplines involved in the process more noticeable. The standard for involuntarily committing a juvenile is proof that the child is "in need of intensive psychiatric therapy which cannot practically or feasibly be rendered in the home or in the community or on any outpatient basis."[22] This standard for committing a juvenile should be distinguished from the proof required to commit an adult: "a danger to himself or the community if he is not so confined and treated."[23] A child, of course, can be committed under the "danger" theory, but clearly the alternate standard for juvenile commitment is less burdensome.

We know that the justification for the denial of freedom to an adult or child who presents a danger to himself or others lies in the state's exercise of its police power: a compelling state interest to protect its citizens from harm or its moral responsibility to protect an individual from destroying himself.[24] We also know that the *Gault* decision held that Fourteenth Amendment guarantees apply to children as well as adults.[25] One of these guarantees is equal protection of all citizens under law. The question then raised by attorneys representing children involuntarily committed under the alternative standard of "a need for intensive psychiatric therapy" is whether there is a denial of equal protection to juveniles by application of this standard. More simply stated, the question raised is: Why should a juvenile

be more easily deprived of precious freedom and liberty than an adult?

The attitude of psychiatrists on this subject usually has been that both adults and children should be committed when a need is shown for intensive inpatient psychiatric therapy. In legal terms, the psychiatrists are saying that the state as *parens patriae* has a moral responsibility to its citizens to protect them from themselves and to guarantee their mental health. This latter argument is somewhat analogous to those cases wherein hospitals or physicians have sought court orders to compel patients to submit to life-saving, although unwanted, medical procedures. The purpose of this paper is not to resolve this basic issue (since it is not advisable to do so in this context) but simply to define it so as to better understand the underlying struggle.

To avoid this most serious conflict, the psychiatrist who seeks to involuntarily commit a juvenile should make every effort to define his reasons for commitment within the confines of the "danger" test. It is suggested that a patient need not be suicidal in order to be "dangerous to himself." For example, a drug-addicted juvenile with psychotic manifestations may require intensive psychiatric care on an inpatient basis in order to keep him away from drugs, in a structured environment, and actively engaged in group or individual psychiatric therapy; the same individual may also present a danger to himself unless so confined and treated, for if he were discharged, his environment would be unstructured, permitting continued exposure to the drug milieu, his drug dependency would continue and worsen, and his psychosis would also progress and worsen, ultimately leading to a destruction of mental and physical health.

As a matter of practicality, I have seen very few cases in which the involuntarily committed juvenile patient would not fit within the "danger" test. It is difficult to conceive at this moment of a situation where outpatient therapy could not be arranged for those juveniles who fall short of such a test. The rules of court permit the judge who discharges a patient from involuntary commitment to impose "in appropriate circumstances, conditions for the release such as attendance at non-residential mental health facility or other form of supervision."[26] This provision should assuage the fears of those psychiatrists who believe that to release the patient is to lose control over him.

Conclusions

A difficult and complex situation was created in which a voluntary adolescent inpatient unit of a community mental health center had to comply with a court ruling really designed for a more traditional involuntary hospital setting. This paper illustrates how psychiatry and the legal system worked together to try to organize a system so as to ensure good patient care while at the same time protecting the rights of those same patients.

Our experience with the judicial system has been quite positive despite our initial anxious resistance. A process we initially viewed as potentially harmful to the treatment of disturbed adolescents has, in fact, proved to be a very useful adjunct to the treatment program. The adolescent patients had to make a decision as to whether or not they really wanted to stay on the unit and in effect *commit themselves* to the notion of being involved in the

therapeutic milieu. Thus one of the major problems of dealing with adolescents on an inpatient unit was to a large degree resolved by the procedure. The process in effect *has* facilitated our treatment program. This change was made possible through an informal, mutually educative process involving mental health professionals, attorneys and judges. One is tempted to consider formalizing this process through psychiatric liaison with the court or through the development of a basic course in psychiatric principles for guardians *ad litem.*

Of great importance to us also is to point out how, with adolescents, inpatient hospitalization can be justified using seemingly broader and more flexible criteria than with adults. Allowing for that flexibility facilitates the persuasion and education of all those involved in the hospitalization process – agencies, schools, patients, lawyers, judges, clinicians and psychiatrists. Once the more flexible criteria became operative, as pointed out, the complex, multimodal world which revolves around every adolescent patient seemed to coalesce and become more functionally supportive and therapeutic. The adolescents were allowed to be patients. Control issues diminished in intensity; greater freedom of choice within the rules as applied worked for this particular unit. The psychiatrists and judges, through hard work, frequent discussions, arguments, enthusiasm, personal liaison and mutual therapeutic interest, have come to essentially similar philosophies regarding this difficult and complex age group.

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2. New Jersey Statutes Annotated. Title 30, Chapter 4, Article 3
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4. N.J.S.A. 30:4-27

5. In New Jersey, a minor is someone who is under the age of 18.
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