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ON THE VOLUNTARY ADMISSION OF MINORS

The past several years have been witness to dramatic changes in both the theory and practice of civil commitment. In the law, this development has taken the form of increased concern for the protection of the personal liberties of the mentally ill, while among members of the medical profession it has been experienced as a part of the process of opening up the back wards. Legislatures in many states have responded by revising their mental health statutes to establish more rigorous standards for commitment, periodic review of the status of committed patients, and better procedural safeguards throughout the commitment process. Courts have found portions of commitment statutes unconstitutional in several states.

While this concern over the rights of individuals confronted with the prospect of involuntary civil commitment promises to

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1. Civil commitment is defined herein to include any compulsory hospitalization or other confinement on an inpatient basis that is for the purpose of diagnosis or treatment of mental illness.

2. See, e.g., R. Ennis & L. Siegel, The Rights of Mental Patients (1973); A. Kittrie, The Right to Be Different (1971). For one of the most current, and certainly among the most comprehensive reviews of the state of the law of civil commitment as it relates to adults, see Development in the law—Civil Commitment of the Mentally Ill. 87 Harv. L. Rev. 1190 (1974).


4. Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wisc. 1972), remanded for more specific order. ___U.S.____94 S.Ct. 713 (1974), decision on remand No. 71 C 602 (E.D. Wisc. Aug. 15, 1974) (Wisconsin); Bell v. Wayne County General Hospital, ___F. Supp.____, consolidation of E.D. Mich. and W.D. Mich. No. 36384 (3 judge court, June 1, 1974) (Michigan); Garwood v. Maguire, No. 74-290 (E.D. Pa., March 21, 1974) (Pennsylvania); Schneider v. Radach, (S.D. Cir. Ct., Yankton County, May 9, 1974) (South Dakota). In addition, cases challenging the constitutionality of commitment laws have been filed in Ohio and Kentucky. See Ewing v. Gaver, No. C. 74-147 (N.D. Ohio. filed April 10, 1974); Kendall v. True, No. 74-64 L (a) (W.D. Ky. filed March 1974). Lessard v. Schmidt supra, is perhaps the most far reaching of these cases to date. In 1972, a three-judge court held the Wisconsin civil commitment statute invalid on its face and enjoined its operation. The Supreme Court remanded, finding that the lower court had failed to comply with the requirements of Fed. R. Civ. P. 65(d) that an injunction must be specific. On remand, the...
produce wide-ranging reform in mental health legislation.\textsuperscript{5} Little specific concern has been shown for the rights of minors in these circumstances. To be sure, the unique situation of minors is not entirely obvious; this is because the term "voluntarily" is a misnomer as applied in this context. An adult who enters an institution either does so of his own volition—that is, as a voluntary admission, or is compelled to do so by some form of state intervention—that is, by some commitment process.\textsuperscript{6} If he chooses to withhold his consent, he may not be admitted as a voluntary patient, but he must be committed. In such a case his illness must theoretically be shown to be of sufficient severity to satisfy an objective standard\textsuperscript{7} at a hearing before a disinterested tribunal at which he is given the opportunity to represent his interests.\textsuperscript{8} Since
\begin{itemize}
\item\textsuperscript{5} Michigan has recently rewritten its mental health code. See notes 81-100 and accompanying text infra. Illinois is now considering a revision of its mental health code as well.
\item\textsuperscript{6} Such commitment processes include emergency commitment, diagnostic orders, and judicial commitment. A three-judge court has recently held that commitment by means of the ninety day diagnostic order as utilized in Michigan is unconstitutional. Bell v. Wayne County General Hospital, ___F.Supp____, consolidation of E.D. & W.D. Mich. No. 36384 (June 1, 1974).
\item\textsuperscript{7} Standards vary widely from state to state and according to whether the commitment is "emergency" or "non-emergency." For emergency commitment the increasingly preferred standard is that the individual be dangerous to himself or others, and that this be manifested by imminent threat of such danger. See, e.g., COLO. REV. STAT. ANN. (1963) CHAP. 51 §§ 1-3 ("apt to injure himself or others"); LA. REV. STAT. § 28:52 (West Supp. 1973) ("dangerous to himself or others and/or makes him incapable of caring for himself or his personal safety"); TEX. REV. CIV. STAT. ANN. art. 5547-28 (Supp. 1973) ("mentally ill and because of his mental illness is likely to cause injury to himself or others if not immediately restricted"). But contra NEW JERSEY STAT. ANN. § 30:463 ("that the condition of the patient is such as to require care and treatment in a mental hospital.") Statutes as tautologous as that of New Jersey are, fortunately, giving way to more specific criteria.
\item\textsuperscript{8} There are, of course, wide-spread abuses of the commitment process as it applies to adults. These include such practices as pro-forma commitment hearings in which the prospective patient is unrepresented by counsel (some as brief as two minutes), deliberately vague and vacuous standards, and the use and "piggy-backing" of diagnostic orders. See, e.g., Comment, Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 ARIZ. L. REV. 1 (1971). In the Detroit area, a story is told of the judge who,
few state mental health statutes explicitly differentiate between adults and minors, it is reasonable to infer that minors would be similarly treated. However, this is not so. While an adult has the option of withholding consent to admission to a mental hospital, a minor does not. Voluntary admission, as it applies to minors, is a process in which the decision regarding admission is entirely in the hands of the parents or guardian and the institution to which admission is sought. No objective standard need be applied, apart from the hospital's own admission criteria, and there is no judicial appeal. Consent is given or withheld by the child's parents and he can be "voluntarily" admitted despite his most strenuous objections.

Because of its informality and ease of implementation, hospital administrators prefer the voluntary admission procedures for minors. While accurate statistical data on the percentage of minors "voluntarily" admitted to mental hospitals as compared to the total number of minors in such institutions is difficult to obtain, it seems fair to say that most of the minors currently in mental hospitals were initially admitted on a voluntary basis. In sharp contrast, a survey of state mental hospitals in Oakland County,

_ Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York, Mental Illness and Due Process 56-57 (1962). _

As an example, there are roughly 750 beds for minors in the Michigan State mental health system. In early 1974, Hawthorn Children's Center had an in-patient population of 152, of which only 15 were committed involuntarily. (Dr. Wright.) At York Woods Center, in Ypsilanti, Michigan, "about 40%" voluntary. (Rosalyn Rodgers, R. N.) Children's Psychiatric Hospital accepts only voluntary admissions. (Dr. Peter Blos.) See note 101 infra. Although accurate information on the percentage of voluntarily admitted minors in the remaining state-connected hospitals was not obtainable, it appears, on the basis of information available that certainly the sizeable majority of minors in Michigan state institutions had been placed there by informal, voluntary admissions. There is no reason to believe that Michigan is atypical in this respect.
Michigan, in 1967 and 1969\textsuperscript{14} revealed that only 16.4 percent of the total patient population had initially entered voluntarily.\textsuperscript{15} The contrast is even more striking when one notes that fully 13.4 percent of the total patient population were minors, most of whom must be assumed to have entered "voluntarily."\textsuperscript{16} One is led to conclude that the process whereby most minors are placed in mental hospitals is one which gives them neither the right to withhold consent, nor any other legal safeguard,\textsuperscript{17} and one which consequently offers no external protection against the possibility of abuse. Such a process, if applied to adults, would be a flagrant denial of the most rudimentary principles of due process. This article will examine the reasons underlying this distinction between the status of adults and minors, to evaluate the procedures and criteria currently employed in the "voluntary" admission of minors to mental hospitals, and suggest one or two possible ways to better protect the interests of minors.\textsuperscript{18}

I. THE DEVELOPMENT OF ADMISSION STANDARDS

At common law, minors were regarded as the property of their parents. In England, a father had the right to sell his son into indentured servitude, and exercised virtually unrestrained dominion over the affairs of his female children. It is said, perhaps apocryphally, that the first case of child abuse prosecution in the United States did not occur until 1874, when a church social worker learned of a child who was kept in chains, frequently

\textsuperscript{14} Note, Civil Commitment in a Suburban County: an Investigation by Law Students, \textit{SANTA CLARA LAWYER} 518 (1973).
\textsuperscript{15} Id. at 526.
\textsuperscript{16} Id. at 524. \textit{See also} note 13 \textit{supra}.
\textsuperscript{17} The large majority of adolescents are brought for treatment by their families, and while the adolescent does not usually object to the extent of non-cooperation, he often fails to participate actively in treatment. . . . Characteristically, once their initial protest has been made, they will accept the hospital. . . . Other adolescents are either seriously disturbed themselves or come from families that have no understanding of the realities of the situation, or both. With these more difficult cases the significant family members just cannot voluntarily bring themselves to allow the hospital to take responsibility for even temporary management of the patient. Since the firm backing of the parent or legal guardian is necessary if an adolescent is to be kept in a hospital, other than a legally committed basis, a useful device is for the patient to be made a ward of the county juvenile court or equivalent agency. This is not as difficult as it sounds, since often in practice this type of family has such poor control over the adolescent that antisocial acting out has already been brought to the attention of the court.
\textsuperscript{18} No attempt will be made to approach these matters as they may apply to the mentally retarded child.

beaten, and fed only bread and water. After unsuccessfully attempting to interest various state and municipal agencies in the child’s plight, she finally prevailed upon the American Society for the Prevention of Cruelty to Animals to bring suit against the little girl’s parents. The Society won, the court holding that children, being part of the animal kingdom, were entitled to the same protection as was afforded other animals. It was the public furor that followed this decision that produced the first child abuse statute in the United States.\textsuperscript{19}

As late as 1904, in a dispute between a mother and her daughter over the daughter’s placement in a reform school, a court could hold that

\begin{quote}
The child . . . having no right to control her own action or to select her own course of life, had no legal right to be heard in these proceedings.\textsuperscript{20}
\end{quote}

In the early part of this century, there began a slow erosion of the absolute power enjoyed by parents over their minor children. The notion that the state had an independent interest in protecting the child against abuses found its expression not in a broadening of the child’s rights, but in a narrowing of those of the parent.\textsuperscript{21} In Michigan, the earliest cases had not to do with minors, but with the protection of another unemancipated class—married women. \textit{In re Phillips}\textsuperscript{22} was an attempt by Mrs. Phillips’ adult son to have her declared incompetent and to have himself appointed guardian of her not inconsiderable estate. He based his application on the fact that she had previously been committed to a “hospital for the insane” for a period of six months by a petition of her husband. The court denied the application on the grounds that the original commitment order had been in violation of the law,\textsuperscript{23} and thus there was no evidence of insanity. The court said,

\begin{quote}
Proceedings taken for an adjudication of insanity against an individual should require the strictest compliance with all the statutory requirements provided. The determination affects the rights of the individual to life, liberty, and property. Courts will ever protect the rights of the individual who is so unfortunate as to be called upon to make a showing to main-
\end{quote}

\textsuperscript{19} A. \textsc{De Francis}, \textit{The Fundamentals of Child Protection} 3-5 (1955).


\textsuperscript{21} See notes 31-37 and accompanying text \textit{infra}.

\textsuperscript{22}158 Mich. 88, 122 N.W. 554 (1909).

\textsuperscript{23} The hearing was held 24 hours before the time fixed in the order and Mrs. Phillips was not present. She was declared insane and committed within 24 hours after the husband’s petition was filed, \textit{Id.} at 159, 122 N.W. at 556.
tain his or her mental integrity. It is apparent that the original proceedings . . . did not comply with the statute . . . . To hold this to be an orderly judicial proceeding would be a travesty upon the administration of justice.\(^2^4\)

Citing Phillips, *In re Davis*\(^2^5\) held that in the absence of a showing of an independent inquest as required by law,\(^2^6\) affidavits by two physicians to the effect that Myrtle Davis was mentally diseased were insufficient to satisfy the statute and that the commitment proceedings were, therefore, a nullity. The principle set forth in *Davis* was that the statute pertaining to the commitment of "insane persons"\(^2^7\) required scrupulous compliance including independent inquest, the taking of proofs, and a full investigation of the facts. In effect, *Davis* invalidated commitment orders arising out of proceedings in which little or no testimony apart from written affidavits was presented to establish insanity.\(^2^9\)

Because the practice of voluntary admission was not permitted at that time,\(^3^0\) all commitment proceedings involved judicial hearings; the *Davis* principle was thus available for application to proceedings against minors as well as those against adults. In *In re Miller*,\(^3^1\) apparently the first case in which the principle was applied to a minor, there is no mention of the petitioner's youth. Rather, it is simply observed that because petitioner's commitment to a training school had been based solely on the certificates of the doctors who had examined him and because no other

\(^{2^4}\) Id.


\(^{2^6}\) Cited by the court as "2 Comp. Laws 1929 § 6888." The court quotes the statute as follows:

> the court shall also institute an inquest and take proofs, as to the alleged insanity, feeble-mindedness, epilepsy, or mental disease of such person, and fully investigate the facts before making such order. *Id.* at 91. 268 N.W. at 823.

\(^{2^7}\) 277 Mich. 88, 89, 269 N.W. 822, 823 (1936).

\(^{2^8}\) See, e.g., In re Clifford, 303 Mich. 84, 5 N.W.2d 575 (1942); In re Ryan, 291 Mich. 673, 298 N.W. 291 (1939).

\(^{2^9}\) See, e.g., In re Gordon, 301 Mich. 224, 3 N.W.2d 353 (1942).

\(^{3^0}\) The rule was:

> An admission of insanity can never fix the status of unsound mind in the person making the admission. The law prescribes the only way a determination of insanity may be made.


\(^{3^1}\) 303 Mich. 81, 5 N.W.2d 575 (1942). *See also In re Maffet*, 304 Mich. 173, 7 N.W.2d 260 (1943), in which the court found the commitment of a 14 year old boy invalid on precisely the same grounds as are cited in *Miller*. In the latter case the court notes that *Maffet* and *Miller* are "as nearly identical as two cases could be." *Id.* at 174. 7 N.W.2d at 261 (1943).
proof was offered, compliance with the statute was lacking; the commitment order was accordingly invalid.

The right of the subject of the proceedings to be present at the commitment hearing was extended to minors in *In re Roberts*, a case which held that without a showing that it would have been impossible for the minor to be present at the hearing, his absence alone was sufficient to render the commitment order a nullity. But it was not until *In re Aslanian* that judicial protection against improper commitment procedures began to be extended to minors. In that case, the girl's mother brought a writ of habeas corpus to secure her daughter's release from a training school to which she had been committed as "feeble-minded" six years earlier. The original commitment petition had been made by her father, who at the time had sole custody of her. At the initial hearing two physician's certificates had been presented, as well as the testimony of a social worker that the girl was "a very serious sex delinquent." It was found that

... the court did not conduct a proper inquest, take sufficient proofs, or make a full investigation of the facts, without which the order of commitment is a nullity.

Though the court acknowledged that

at the time she was committed, the girl was not only feeble-minded and a sex delinquent, as charged in the petition, but that she was a behavior problem as disclosed by the record,

it ordered her release. *Aslanian* thus supports the proposition that the dangers of abuse of commitment proceedings are so great that, even in a case in which proper procedures would have resulted in a legally justifiable commitment, resort to improper procedures would require that the commitment order be voided.

The development of the voluntary admission procedure came substantially after *Aslanian*, and there is no question that it is a legitimate practice under current statutes. Yet it is informative to compare the grounds upon which the court ordered the girl in *Aslanian* released with the fact situation of a voluntary commitment. In *Aslanian* there was a hearing at which affidavits and

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33 310 Mich. 560, 17 N.W.2d 752 (1945).
34 318 Mich. 55, 27 N.W.2d 343 (1947).
35 Id. at 58, 27 N.W.2d at 344.
36 Id.
37 Id.
some testimony were presented; in a voluntary admission there is no hearing. In Aslanian the girl's father petitioned for her admission to a training school; in a voluntary admission the parent consents to the child's admission to a mental hospital. In a voluntary admission the child has no right to be present when the decision on admission is made; in Aslanian the girl's absence from her commitment hearing was specifically cited as an omission sufficient to compel her release. If anything, greater protection was given to the girl in hearings which were found defective for insufficiency than is afforded the minor child in the voluntary admission process as it currently functions.

It must be recognized, however, that in none of these instances did a minor bring the action on his or her behalf and that in none of them was the decision based upon a recognition of the minor child as an individual with legitimate rights and interests apart from those of his parents or of the state. Judicial intervention was at the behest of a petitioner who was viewed as having the right to speak for the minor. The minor was not permitted to act on his own initiative. It was not until In re Gault\(^{38}\) that such rights and interests were recognized. Gault had to do with a juvenile delinquency conviction based on an obscene telephone call. The Supreme Court, in an opinion by Justice Fortas, held that the boy therein committed had been denied due process because

> juvenile delinquency proceedings which may lead to commitment in a state institution must measure up to the essentials of due process and fair treatment, including
> 1) written notice of the specific charge or factual allegations, given to the child and his parents sufficiently in advance of the hearing to permit preparation;
> 2) notification to the child and his parents of the child's right to be represented by counsel retained by them, or if they are unable to afford counsel, that counsel will be appointed to represent the child;
> 3) application of the constitutional privilege against self-incrimination; and
> 4) absent a valid confession, a determination of delinquency and an order of commitment based only on sworn testimony subjected to the opportunity for cross-examination in accordance with constitutional requirements.\(^{39}\)

\(^{38}\) 387 U.S. 1 (1967). Gault has been the subject of such exhaustive examination by scholars and practitioners alike that one commentator has been moved to suggest that "If the authors of law review articles about Gault were laid end to end, it would be a good thing." Kenon, On Re-examining Gault—Again and Again, 4 FAMILY L.Q. 387 (1970).

\(^{39}\) 387 U.S. at 2 (1967).
Following Gault, the question was no longer whether minors had any personal rights, but what the limits of their rights were. A constitutional collage has emerged, with minors achieving the rights of adults in some cases but not in others. In re Winship\(^4\) established that, notwithstanding the “rehabilitative nature” of juvenile delinquency proceedings, a juvenile charged with having committed what would be, for an adult, a criminal offense, is entitled to the same presumption of innocence that an adult enjoys; that is, his or her guilt must be established “beyond a reasonable doubt.”\(^4\)\(^1\) However in McKeiver v. Pennsylvania,\(^4\)\(^2\) the Court, while recognizing that certain due process procedural safeguards apply to delinquency proceedings, held that the right to a jury trial is not among them. Although state juvenile delinquency codes are notoriously vague, persistent attempts to have them declared “void for vagueness” have been uniformly unsuccessful.\(^4\)\(^3\) Finally, despite a cautious trend extending the limited due process rights enjoyed by adult prisoners to those confined in juvenile correctional institutions, the discretion of juvenile correctional administrators remains largely unfettered.\(^4\)\(^4\)

\(^{41}\) Id. at 365-68.
\(^{43}\) A typical case is In re L.N., 109 N.J. Super. 278, 263 A.2d 150 (1970). A youth apprehended for allegedly sniffing “carbona” (a carbon tetrachloride base cleaning fluid) was prosecuted for delinquency under N.J. Stat. Ann. § 2A: 4-14, subsections (i) (“Growing up in idleness or delinquency”) and (m) (“deportment endangering the morals, health, or general welfare of said child”). In rejecting the defense assertion that the statute was “void for vagueness,” the court said:

He has cited no case, and we know of none, in which statutes of this type containing wording similar to that found in subsections (i) and (m) have been held to be unconstitutional as violating due process by reason of vagueness. Statutes setting up juvenile systems of correction have been uniformly upheld.

\(^{44}\) For a discussion of this topic, see Meyers, Legal Rights in a Juvenile Correctional Institution, 7 U. Mich. J.L. Reform 242 (1973).
As a general rule, parental authority is controlling in matters pertaining to the child’s welfare.

Parental power probably cannot be defined except as a residue of all power not lodged elsewhere by the law .... Much authority ... supports the general proposition that except where there is some authoritatively expressed public policy to the contrary, parental power extends to all areas of a child’s life.45

However, courts have been increasingly willing to consider the child the best judge of his or her interest, even when the child’s view conflicts with that of the parent. In re Smith,46 while affirming both a finding that a sixteen-year-old girl who had run away from home in order to avoid having an abortion was a “child in need of supervision” and an order placing her in her mother’s custody, also held that the mother did not have the right to compel her daughter to have an abortion. The court said,

[T]he minor, having the same capacity to consent as an adult, is emancipated from the control of the parents with respect to medical treatment within the contemplation of the statute. We think it follows that if a minor may consent to medical treatment as an adult ... the minor, and particularly a minor over 16 years of age, may not be forced, more than an adult, to accept treatment .... Consent cannot be the subject of compulsion; its existence depends upon the exercise of voluntary will of those from whom it is obtained; the one consenting has the right to forbid.47

Similarly, it has been held that although parents have the right to attempt to commit their child, they cannot compel the child to accept their attorney in commitment proceedings, nor have they the right to waive the child’s doctor-patient privilege.48

Although no instance has been found in which a minor was held to have the right to refuse his or her “voluntary” admission to a mental institution, in Application for the Certification of Anonymous,49 the parents were not permitted to place their ten-year-old child in a mental hospital when such hospitalization was not shown to be necessary. Responding to the allegation that the child was in the habit of setting fires, the court, after noting

47 Id. at 246.
several inconsistencies in the allegation, demonstrated unusual sensitivity to the factors underlying the juvenile’s behavior. It said,

[T]here is nothing abnormal about the behavior of this child that cannot be dissolved by the human catalyst of love and affection. One aspect of this proceeding that . . . shocks and perturbs this court is the attitude of the adoptive parents of this child. Their personal attitude and the atmosphere they supplied on behalf of this child was . . . completely devoid of any affection or feelings that were conducive to the inculcation of a feeling of belonging and of being loved . . . . The attitude of the adoptive parents caused the child to hallucinate in regressive stages, which compels the court to volunteer the opinion that the adoption be abrogated with dispatch.\(^5^0\)

The court went on to observe that it was this lack of care that was probably the causal factor behind the child’s delinquent behavior.

Among the few cases in which the “voluntary” admission of a minor has been directly challenged\(^5^1\) is *In re Slayton*,\(^5^2\) which involved a fifteen-year-old youth who had been confined, despite his objections, as a “voluntary” admission on his father’s application. A writ of habeas corpus was brought which alleged, first, that he had been denied due process in that he was being held in the institution without a hearing, that he had not consented to his admission to the institution, and that the statutory language\(^5^3\) did not permit the inference that he had done so; and second, that in so far as the Michigan Mental Health law provided for incarceration of minors without a hearing, it was unconstitutional on
its face. The court, avoiding the constitutional issues, read the statute narrowly. Since the statute, literally interpreted, required that a minor desire to be admitted to an institution and since there was no showing that John Slayton had expressed such a desire, his admission was void. The case attracted considerable attention, and the decision occasioned the rapid passage of an amendment to the mental health statute. In its amended form, the statute is still open to the constitutional challenge which Slayton presented, for it explicitly provides for the detention of minors in mental hospitals on the application of their parents, without any inclusion of the due process requirements ordinarily applicable to adults; as Justice Fortas wrote for the Court in Gault, "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."

Melville v. Sabbatino presented a similar fact situation. A seventeen-year-old youth who had been "voluntarily" admitted to a private psychiatric institute at the age of fifteen succeeded in

54 The writ advanced three causes of action: Minor John Slayton is being deprived of his liberty and held in a state facility for mentally ill or emotionally disturbed persons with due process of law. He has had no hearing in any court of law or before any proper administrative board warranting his detention in a state institution for the mentally ill or emotionally disturbed. Minor John Slayton has no desire to be confined in the Hawthornes' Children's Center. The statute... under which a minor can be confined would seem to require some showing that the minor is desirous of such commitment. (No document exists showing John Slayton's consent to his detention and confinement and to the extent that the statute can be read to assume the minor's consent to his commitment, it is unconstitutional as applied to a situation such as that presented to this court, in so far as it denies to minor the equal protection of the laws guaranteed to all citizens under the Fourteenth Amendment to the U.S. Constitution.)

M.S.A. Sec. 14.80999) is unconstitutional on its face, since it results in the deprivation of liberty of all minors in the state of Michigan who are committed without hearings upon the consent of their parents. Minors therefore may be substantially deprived of their liberty without hearing and without a proper waiver at a time when they may be said to be sufficiently mentally-ill so as to be unable to properly express their desire to enter a public institution for the mentally ill voluntarily.

55 In response to the decision in Slayton the statute was amended to read as follows: The superintendent of any institution named in this act under the department of mental health may receive and detain for treatment any adult who submits himself to treatment as a voluntary patient, and who makes written application therefore, and whose mental condition is such as to render him competent to make application. The superintendent of any institution named in this act or under the control and jurisdiction of the department of mental health may receive and detain for treatment any person under 18 years of age and not an emancipated child whose parent or guardian made a written application therefore.


56 In re Gault, 387 U.S. 1, 13 (1967).

obtaining his release. Although the relevant statute could reasonably have been found to have made no provision for voluntary commitment of a minor by his or her parents, the court declined to rest its decision on that ground. Instead, it read the statute in the context of the Connecticut “Patient’s Bill of Rights,” which authorizes a minor of the age of sixteen or older to apply for and be admitted to a mental hospital as a voluntary patient, and concluded,

It therefore logically follows that if one between the ages of sixteen and eighteen can admit himself into an institution as a voluntary patient, he has the same right to sign himself out under §17-187, whether or not his parents originally initiated the admission.

There is, then, at least one instance in which a minor child has been recognized to have the right to remove himself, in the face of parental opposition, from an institution to which he has been “voluntarily” admitted. It is but a short step from this position to its logical consequence: if a minor child’s desire to leave an institution to which he or she has been “voluntarily” admitted has been given legal recognition, his desire not to be “voluntarily” admitted to an institution at all should also be given legal recognition. Indeed, there is good reason to anticipate that this recognition will be forthcoming in the very near future. In *Bartley v. Haverford State Hospital*, a class action suit on behalf of all minors in Pennsylvania who have been “volunteered” for admission to mental hospitals by their parents or guardians, a three-judge court has recently denied a defense motion to dismiss. Instead, it has appointed plaintiff’s attorneys guardians ad litem for all such institutionalized minors and has ordered the appointment of counsel on behalf of the parents. A three-judge court in *Saville v. Treadway*, in a case dealing with the voluntary admission of retarded children, has found unconstitutional a Tennessee statute authorizing the superintendent of a mental hospital to

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58 Conn. Gen. Stat. § 17-187. As the court observed, it does not by its express terms authorize “the voluntary admission of a minor child to a mental hospital by his parents.”


61 No. 72-2272 (E.D. Pa., April 29, 1974, 3 judges), reported in 8 Clearinghouse Rev. 117 (June 1974). See also Waller v. Catholic Social Services (E.D. Pa., filed July 12, 1974). Plaintiff, a thirteen year old female in a state hospital charges defendant with violating her constitutional right to the least restrictive conditions necessary to achieve the purposes of her commitment by detaining her in the hospital after the hospital itself had indicated it was no longer necessary to do so.

62 No. 6969 (N.D. Tenn. April, 1974), reported at 8 Clearinghouse Rev. 119 (June 1974).
admit minors on the application of their parents or guardians. The court has ordered review of the cases of minors so institutionalized and has established the presumption that those minors under sixteen years of age would refuse institutionalization if given the opportunity and must therefore be treated as involuntary admissions. A similar case is pending in Maryland, where plaintiff seeks the right to pre-admission hearings.

II. THE CONTROVERSY OVER STANDARDS

There is a large body of opinion to the effect that the question of whether parents should have the right to place their children in therapeutic institutions should never be seriously raised. According to this position, the parental role in providing for the child’s mental health is analogous to the parental role in providing for his physical health. When a child needs treatment for a physical ailment, it is the parent’s unquestioned duty to see to it that such treatment is obtained. If the ailment is so serious as to require the hospitalization of the child, nobody questions the parent’s right to make the necessary arrangements for his admission, and no one suggests that the child should have the right to refuse to go. The question of personal liberty is simply not regarded as relevant in this context. The parent is viewed as having the responsibility to provide adequate medical care for his child and the placement of a child in a therapeutic institute is nothing more than an occasion in which the parent is called upon to fulfill that responsibility. Mr. Samuel Davis, Executive Director of the Association for Emotionally Disturbed Children, described this position:

Obviously, if a child had a severe stomach ailment and required hospitalization, his parents would have to admit him. We see no reason to change this procedure when psychiatric hospitalization is required. Given our social system, it seems quite sensible that families act on behalf of their dependents. It is a perfectly logical and responsible way to proceed.


64 Interview with Mr. Samuel Davis, note 66 infra. See also note 13 supra.

65 Indeed, in some states the failure to obtain necessary treatment for a child suffering from mental disability may be grounds for a neglect petition. See, e.g., MISS. CODE ANN. § 7185-02 (h) (1971).

66 Interview with Mr. Samuel Davis, Executive Director of the Association for Emotionally Disturbed Children, November 16, 1973.
It follows, it is argued, that any reform permitting a child to challenge his admission to a hospital, whether general or psychiatric, would be detrimental to the child’s interest, since it would delay his treatment and create unnecessary controversy and tension.

Although other rationales are often cited in support of the present system of “voluntary” admission (its informality, its flexibility, the avoidance of unnecessary stigma, the avoidance of an adversarial relationship between the psychiatrist and the child, and the preservation of psychiatric resources), the essence of the matter is that the supporters of the system perceive no adequate reason to change it. It is argued that the system works well, it is inexpensive, and it cannot be modified without harmful results.67 The suggestion that children who do not need hospitalization may be admitted has two common responses. The first is that there are strong informal factors that effectively preclude the possibility of such an error. The most important of these is the fact that hospitals and child treatment centers are overcrowded. As one hospital director put it, “we are not exactly looking for business.”68 For most parents, the placement of a child in a psychiatric treatment facility entails considerable expense and some humiliation.69 Thus, both parents and the hospital have a strong incentive to avoid hospitalizing the child. A second argument is that, unless one is willing to assume bad faith—that is, collusion between the hospital and the parents, it is hard to deny that the psychiatrist who examines the child is in a better position than anyone else to determine whether that child is in need of psychiatric assistance.70

67 Id.
68 Every institution visited by the author had a waiting list, some of which were several months long. Interview with Dr. William Kirk, Director, York Woods Center, Ypsilanti, Michigan, November 21, 1973.
69 Hartmann says:

For most parents, hospitalization was a traumatic experience, although almost all of them . . . expressed a feeling of relief at having the burden of the care and responsibility of the sick adolescent lifted from the shoulders of the family.

E. Hartmann, Adolescents in a Mental Hospital 84, (1968).
70 There is, however, a significant body of opinion to the effect that the ability of the psychiatric profession to diagnose mental illness and to differentiate among its various manifestations is not all that it might be and, in fact, is so limited that little deference should be given to it. The proponents of this view, observing correctly that psychiatry is not a precise science, buttress their position with various “empirical” studies. One such investigation is reported in Rosenhan, On Being Sane in Insane Places, 179 Science 250 (1973). There a number of professionals applied for admission to mental hospitals, representing that they were hearing voices. Once admitted, they purported to act in a normal fashion. The object of the investigation was to discover how long it would take for the hospital staff to determine that they were not in fact in need of in-patient care, i.e., that they were normal. The time required for such a determination ranged from seven days to
Again, the analogy to a physical ailment is striking. If a person suspected that he had a broken leg, he would probably prefer to have the decision as to whether or not it was broken made by an orthopedic surgeon rather than by a court.¹¹

Viewed in this perspective, the proper function of the legal system is not to put barriers between the needy child and necessary hospitalization, but to provide mechanisms through which a child in need of treatment can receive it when the "voluntary" system breaks down. An interesting discussion of how the legal system might fulfill this role has been proposed by Nir and Cutler.⁷² Observing that most court-ordered referrals of juvenile delinquents to psychiatric clinics fail therapeutically because of family reluctance to accept therapeutic intervention,⁷³ the authors propose several ways in which the coercive power of the court may aid the therapeutic rehabilitation of youths. With respect to those juveniles who are likely to be unable to control their tendency to "act out"⁷⁴ but who are not in need of hospitalization, they

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¹¹ This analogy has its weaknesses, chiefly the imprecise nature of psychiatry in contrast to orthopedic medicine.


⁷³ It became clear to the authors that:

our young patients were being used by their families to "act out the parent's poorly integrated and forbidden impulses". The parent's resistance to treatment was an attempt to maintain the psychodynamic equilibrium of which the delinquent behavior of the youngster was an integral part, and a recommendation for psychotherapy or institutional placement had little chance of being accepted unless one could find leverages powerful enough to interrupt the tendency toward acting out.

Id. at 1113.

⁷⁴ The term "act out" is used to describe behavior, frequently of an anti-social nature, in which is manifested an individual's pathology.
suggest the use of extended and closely supervised probationary periods. For those who refuse to take part in court ordered outpatient therapy, they further suggest a strict probation with attendance at psychotherapy as one of its conditions.\textsuperscript{75}

The difficulty with approaching the issue of the "voluntary" admission solely from the perspective of a treatment problem, however, is that the child's rights are not considered at all. The assumption that the issue of the child's rights is not relevant to the issue of "voluntary" admissions is equivalent to the position that the child simply has no rights in this area.\textsuperscript{76} If that assumption is made, the position is unassailable. But it is the reluctance to make that assumption, the contention that the minor does in fact have certain rights independent of those exercised on his behalf by his parents or by the state, that is at the foundation of any consideration of the issue.

The polar opposite of this view is the position that the rights of an individual should not be a function of his age. With respect to "voluntary" admission, this view would require that there be no distinction between the manner in which an adult is placed in a therapeutic institution and the manner in which a minor is placed in a therapeutic institution. Under this system, voluntary admission would require a true manifestation of informed consent on the part of the child. In the absence of such consent, the child could be placed in an institution only through formal commitment proceedings. These proceedings would, as with adults, entail the convening of a full hearing at which the minor would be represented by counsel and afforded full due process safeguards. The court would have to be satisfied beyond a reasonable doubt that the minor was dangerous to himself or others if left unhospitalized.

\textsuperscript{75} The authors illustrate with the following case history:

John, a 16 year old, was brought to the court on a PINS (person in need of supervision) petition by his mother because of his uncontrollable behavior and excessive truancy, stealing, and procuring, . . . Our assessment revealed that although the plan of choice for John would be placement in a residential center, his mother would not accept this because of her close attachment to all her children, especially John. She condoned his behavior as she identified with his acting out and his frequent sexually perverse behavior. . . . We used two leverages to implement our recommendation: 1) We requested the court to keep the case open in order to maintain the crisis momentum; 2) we worked with the attendance officer of the school in order to effect a truancy charge against John, which would make it almost mandatory for the judge to remand the child to a residential treatment center.

\textit{Id. at} 1114-15.

\textsuperscript{76} Mr. Davis said:

We are brought to deal with this very concrete problem on a very high level of abstraction, . . . I do believe in personal liberty. What has that got to do with the hospitalization of children? I don't see that the personal liberty of the child includes the right of self-destruction.
and that no less drastic measure would suffice. In brief, control over the minor's placement in a therapeutic institution would be taken away from his parents and placed in the hands of the minor and the state. As envisioned, the system would require the presence of hospital psychiatrists at court hearings whenever a child was to be admitted. One of two results would be probable: either an enormous strain would be placed on community psychiatric resources, with a concomitant reduction in the quality of service, or the hearings would revert to essentially pro forma rituals. Every psychiatrist interviewed strongly opposed this system, and several went so far as to flatly state that rather than spend so much time in court, they would simply refuse to take nonvoluntary patients. With the demand for psychiatric services as great as it is, the effect would probably be to defeat the purpose of the proposal altogether.

Another danger in such a system becomes evident if one considers the consequence of a successful defense on the part of the child. His parents have attempted to place him in an institution because they believe that they cannot deal with him. If he returns to the family as before, then nothing has changed. Whatever situation brought about the attempt at placement has been exacerbated by the attempt itself. Where, then, is the minor to go?

In any event, the legal system has thus far shown little inclination to do away with the legal distinctions between minors and adults. Justice Stewart, in his concurring opinion in *Ginsberg v. New York*, expressed the prevailing judicial philosophy:

I think that a State may permissibly determine that, at least in some precisely delineated areas, a child—like someone in a captive audience—is not possessed of that full capacity for individual choice which is the presupposition of First Amendment guarantees. It is only upon such a premise, I should suppose, that a State may deprive children of other rights—the right to marry, for example, or the right to vote—deprivations that would be constitutionally intolerable for adults.

A more extreme version of this system would delay action until the individual had actually committed an act punishable as a crime. At that point a trial as to guilt or innocence would be held. If the individual were found guilty, a second hearing as to his disposition would be held. It would be at this hearing that the decision whether to hospitalize would be made.

There is currently a class-action lawsuit in the Probate Court for Wayne County, Michigan challenging this very distinction.

*390 U.S. 629 (1968).*

*Id., at 649-50.*
III. THE MICHIGAN PROPOSAL

Michigan has recently undertaken a thorough revision of its mental health laws. In the process, it is proposed to give statutory recognition to the proposition that a minor faced with the prospect of "voluntary admission" ought to be permitted to do something about it. While the proposal does not give the minor any right before the fact, he is permitted an appeal after hospitalization.

As presently drafted, the law provides that "an individual less than 18 years of age may be hospitalized as a formal voluntary patient" if an application to that effect is made by his parent or guardian, and if the application is accepted by the hospital director. Upon hospitalization, the individual, if he is at least thirteen years old, is informed of his right to appeal his placement, and he receives a copy of an application to institute such an appeal. In addition, he may direct that a copy of the application be given to one other person. Objection to the hospitalization of a minor of any age may be made by a person "found suitable by the court," or by the individual himself if he is at least thirteen years old. The application must be made within thirty days of hospitalization and, once made, may not be repeated more than once every three months. If the hospital has formally agreed to admit the minor but has not yet done so, objection may be made prior to hospitalization. If a hospitalized minor desires to object, the hospital is required to assist him in submitting his objection to the court. Upon receipt of an objection the court is to schedule a hearing within seven days, and must so notify the objecting person, the patient, the person who made the application, and the director of the hospital.

At the hearing, the patient is given only such due process safeguards as the court, in its discretion, "deems necessary to ensure that all pertinent information is brought to its attention." Such fundamental matters as the appointment of counsel, the right

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82 Id., § 415(2).
83 Id., § 415(2).
84 Id., § 416.
85 Id.
86 Id., § 417(1).
87 Id., § 417(1).
88 Id.
89 Id., § 418.
90 Id., § 417 (2).
91 Id., § 417 (3).
92 Id., § 417 (4).
to an independent psychiatric evaluation, the right to be present at
the hearing, and the right to have the issue of his need for
treatment submitted to a jury—matters which are guaranteed in all
other hearings—are specifically excluded from this one.

Unless the court sustains the objection, the hospital may con-
tinue to hold the minor. In order to sustain the objection, the
court must find that the minor is not in need of treatment which is
available at the hospital or that a treatment program not involving
hospitalization is available and appropriate for the individual.

Although it is not expressly stated, it is implicit that the burden of
proof is upon the one making the objection. The unwillingness
or inability of the parent or guardian of the minor to provide for
him is not to be considered grounds for denial of the objection. In
that event, the court is to convene a proceeding in the juvenile
court for the purpose of ensuring that the minor will receive
proper care.

The proposal has serious deficiencies from several points of
view. Except in those situations in which there is a postponement
of his admission, the minor who wishes to object will find that he
may do so only after having been hospitalized, and this is so
whether or not he was hospitalized under emergency circum-
stances. Having been hospitalized, he is placed in the difficult
position of being compelled to show why he should not be. If the
minor is under thirteen, he is deprived both of the power to
proceed on his own behalf and of effectively seeking the assis-
tance of anyone else. He is not given a lawyer as of right, and
even if a lawyer is provided, this is not done until the hearing.
If he is to be released, he must be able to demonstrate, without the
benefit of independent psychiatric evaluation, that he is not in
need of treatment which is available at the institution. The alter-
nate ground for release, that there is another approach to treat-
ment which would be adequate and which does not involve his
hospitalization, would be difficult for a skilled attorney working
with a social worker to demonstrate; but to expect an incarcerated
minor with no guaranteed access to outside assistance to meet this

93 Id., § 451.
94 Id.
95 Id., § 417 (6).
96 Id., § 417 (5), (6).
97 Id., § 417 (7).
98 Id., § 417 (1).
99 Id., § 417 (4).
burden is obviously futile. This standard is in striking contrast to that provided for the involuntary commitment of adults.\textsuperscript{100}

The proposal is also unsatisfactory to hospital administrators. Those who were interviewed uniformly expressed a fear that a minor who availed himself of the appeal process after being hospitalized would be unresponsive to treatment until after the proceeding was concluded and would have a strong disruptive effect on his ward.\textsuperscript{101} In fact, it was at the request of the hospital administrators that the provision for appeal in advance of hospitalization was added to the law.\textsuperscript{102}

Finally, it is not unlikely that, should the law be challenged, it would be found unconstitutional. While the United States Supreme Court has yet to rule on the issue of whether or not a person faced with civil commitment must be provided with counsel, both federal and state courts have ruled in the affirmative.\textsuperscript{103} This trend, considered in light of the holding in \textit{In re Gault}\textsuperscript{104} that juveniles have a right to counsel in juvenile court proceedings despite their "rehabilitative" nature, indicates that there is little reason to distinguish between minors and adults in this matter.

Briefly, then, the Michigan proposal, while laudable in that it does recognize a theoretical right vested in the minor, is in practice unlikely to provide the minor with any significant degree of protection, is likely to bring some measure of disruption in the hospitals and might well be constitutionally infirm. Given all of this, the question may be asked: To what end? Why make such an

\textsuperscript{100}Id., § 401.

A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation; b) A person who is mentally ill, and who as a result of that mental illness is unable to attend to those of his basic physical needs, such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

\textsuperscript{101} Interview with Dr. William Kirk, Director York Woods Center, Ypsilanti, Mich., November 21, 1973; interview with Dr. Peter Blos, Director, Children’s Psychiatric Hospital, Ann Arbor, Mich.

\textsuperscript{102} Id.


\textsuperscript{104} 387 U.S. 1 (1967). See also \textit{In re Fisher,} 43 L.W. 2050 (Ohio, Aug. 6, 1974). After citing \textit{Gault}, the court observes:

This Court does not believe the fact that civil commitment for the mentally deficient is for treatment and rehabilitation distinguishes this situation from juvenile delinquency proceedings. In both situations the liberty of the individual is at stake.
investment in time and energy to draft and bring about the passage of an essentially nonfunctional piece of legislation?

This question was posed to Larry Owens, General Counsel for the Committee to Redraft the Michigan Mental Health Code. He said first that the statute is far better than nothing. Whatever its failings, it remains true that it is the most far-reaching proposal of its kind ever adopted by a state legislature.\textsuperscript{105} It does provide a mechanism for the protection of the minor’s rights in an area where there was previously no protection at all. It is a basis upon which further progress might be structured. A concerned individual, aware of the plight of a particular child, might be moved to take action on his behalf, which would have been impossible before. A conscientious court, faced with an apparently clear case of “dumping,”\textsuperscript{106} might be moved to appoint a counsel or to convene a hearing for the purpose of finding alternate placement for the minor. Moreover, there is no reason that the law might not be liberalized in the future.

Second, the statute is the most that might be expected to win general acceptance. While the hospital administrators do not care for much of it, they are willing to accept it.\textsuperscript{107} While various other groups within the community do not necessarily favor it, there is the possibility that it may survive, if it is not perceived as too “radical.” Ultimately, this very real political question is the final determinant.

While these may be valid considerations from the point of view of one engaged in the effort of passing specific legislation, the fact remains that the statute as a whole is inadequate. At a minimum, any statute which purports to offer real protection to the minor faced with involuntary hospitalization should incorporate three basic attributes. First, it should provide for the completion of the adjudicative process prior to the hospitalization of the minor, except in emergency situations. Second, instead of requiring the minor to demonstrate his stability, those desiring the admission of the minor should have the burden of proving both his need for hospitalization and that of showing that no alternative\textsuperscript{108} other than hospitalization would suffice. Finally, the minor must be

\textsuperscript{105} This is, of course, a matter of personal judgment.
\textsuperscript{106} A minor who is placed in an institution not because of therapeutic consideration, but because his or her presence in the family is a source of annoyance or inconvenience, is said to have been “dumped”. The term is quite commonly used, and with full connotative import.
\textsuperscript{107} See note 23 and accompanying text supra.
Juvenile Admission Standards

provided both with counsel and the right to an independent psychiatric evaluation from the beginning of the adjudicative process.

That the adjudicative process should, whenever possible, be completed before the minor is hospitalized is both an elemental aspect of due process and a practical advantage to the goal of proper and effective treatment. Unless there is some pressing need for immediate hospitalization, it is hard to see that anyone is harmed by delaying hospitalization of a minor long enough for effective adjudication. In practice, there is often a considerable period of time between the decision to hospitalize and the actual admittance. Thus, in many cases, there would be no additional delay at all. In addition, by having the question of admissibility resolved prior to hospitalization, a number of the disadvantages of having the "objection" process take place after hospitalization are avoided. There is no element of uncertainty in the status of the hospitalized minor, and the prospect of psychiatric "untreatability" because of a belief that he will be released is accordingly diminished. Similarly, the "contamination" of the ward is not a danger. Indeed, in this respect, the minor hospitalized after an adjudicative process would be in very nearly the same position as one hospitalized through the traditional voluntary admission, because in both instances the difficulties inherent in treating an individual who is not compelled to respond in an "appropriate" manner are minimized. The objection to openly involving the hospital in the adjudicatory process because this would destroy the therapeutic relationship between patient and doctor is relevant whether the adjudicatory process occurs before hospitalization or after. Perhaps this effect would even be lessened in the former instance.

It might be possible to further diminish the hospital's involvement in the adversarial process by altering the procedure by

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109 See note 55 supra.
110 See note 82 and accompanying text supra. The notion of "contamination" is a therapeutic one. The suggestion is that one individual expressing a certain behavioral trait may "contaminate" the ward in which he or she is placed, bringing about a situation in which a number of other individuals who might not otherwise manifest that trait to any extent are affected by it. The notion is by no means confined to this situation. Here, however, the thinking appears to be that an individual who does not wish to be treated will be able to successfully resist treatment as long as he or she believes the situation to be temporary, and that the incarceration is about to end. The danger is that he will contaminate the entire ward, bringing about a situation in which a number of other patients begin to manifest this same resistance; the patient thereby undermines the therapeutic relationship for others.
111 See text accompanying notes 101-102 supra.
112 See note 101 supra. This is a frequently voiced fear.
113 See notes 101-102 and accompanying text supra.
which the minor is admitted. Instead of having the hospital agree to admit the minor, as is presently the case, the hospital could agree to do so, provided that upon an independent evaluation in a judicial setting the minor was found to be a statutorily suitable person for such admission. The matter would then be referred to the court, and the hospital would have no further involvement in the decision-making process. Upon receipt of such a referral, the court would appoint an independent psychiatrist to prepare an evaluation of the minor. If this psychiatrist felt that the minor met the statutory standards for hospitalization and that there was no less restrictive alternative available, a hearing would be convened. Prior to the hearing, the minor would receive appointed counsel and the right to his own psychiatric evaluation. At the hearing, the court-appointed psychiatrist, rather than hospital personnel, would testify and be called upon to justify his or her conclusion.

There are several difficulties with this suggestion. If it were implemented, the admissions process would become lengthier and possibly more cumbersome than it is today. A greater burden and greater costs would fall upon the judicial system. In order to protect the minor's right to confrontation it would be necessary to devise safeguards against the possibility of the court psychiatrist forming his opinion on the basis of information obtained from the hospital. Finally, this procedure would be inadequate in any situation where the minor, having been previously admitted, wished to be released. Whether the advantages are of sufficient weight to outweigh these considerations is certainly debatable. Insofar as the burden of proof at the hearing would be assignable, it should rest with those seeking to hospitalize the minor. The alternative, requiring the minor to prove that he need not be hospitalized, is not accepted in the civil commitment of adults. There is no logical reason to distinguish between adults and minors in this respect. Similarly, those seeking hospitalization of the minor should be required to show by convincing evidence that there is no less drastic alternative to hospitalization that would achieve the purposes of hospitalization.

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114 See note 108 and accompanying text supra.
115 See notes 119-126 and accompanying text infra.
116 See Appendix infra.
117 There are two possible advantages: the preservation of psychiatric resources and the elimination of the "adversariness" from the doctor-patient relationship. As to the former, it is not immediately clear that having one psychiatrist testify in the place of another results in a very great savings.
118 See note 108 and accompanying text supra. This is particularly so where the admissions standard does not require a showing of dangerousness.
Courts have uniformly held that if a hearing in which incarceration is likely is to meet the requirements of fundamental due process, the person so threatened must be given access to counsel. As the Supreme Court said in *Powell v. Alabama*, which first established the right to counsel for indigents charged with felonies:

> If in any case, civil or criminal, a state or federal court were arbitrarily to refuse to hear a party by counsel . . . such refusal would be a denial of a hearing, and therefore, of due process . . . .

The logic of the case is clear: the ordinary citizen, confronted by the power of the state, is simply not competent to defend himself without expert assistance. If he is poor, it must be made available to him, for otherwise the hearing is impartial in form only. This same logic applies *a fortiori* to the position of a minor confronted with civil incarceration. If anything, a minor is less able to fend for himself in a judicial setting than is an indigent adult.

Traditionally, of course, minors have not been represented by counsel. The results of this policy, which is founded upon the assumption that someone other than the minor is in a better position to speak for his or her interests, have been unfortunate:

> ... [I]t appears that a very high proportion of statutes affecting infants have never or rarely been construed by state courts of last resort . . . . Many cases which raise substantial questions of the rights of infants have been decided on other bases without adverision to those rights . . . . apparently because a parent or some other party did battle with briefs . . . solely on the basis of their own interest. In the areas of law where infants traditionally have been unrepresented, many of the rules seem crude and careless with regard to their interests. Yet none of these observations have any validity for areas where infants generally have been represented, such as probate law . . . . These impressions, if they are correct, suggest that without counsel, rights not only fail to be vindicated; they fail also to be created.

In almost any context in which the status, position, or future placement of a minor is involved, the minor should be provided with counsel. It is simply unrealistic for another party to an

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119 See note 103 *infra*.
120 287 U.S. 45 (1932).
121 Id. at 69.
action, who has his own interests with which to be concerned, to be expected to adequately safeguard those of a minor involved in the matter.

Crucial, then, to the informed implementation of the guideline to child placement is not only party status for the child as a person in his own right but also adequate provision for his personal representation by counsel who has no other goal than to determine what is the least detrimental alternative for his client. In proceedings before the court or administrative agency, counsel for the child must independently interpret and formulate his client's interests, including the need for a speedy and final determination.\textsuperscript{123}

It is necessary that counsel be well versed in the legal and medical parameters of a situation in which a parent wished to place a child in a mental hospital against the child's wishes.\textsuperscript{124} The difficulties facing an attorney in such a position are, to be sure, legion.\textsuperscript{125}

These special difficulties do not, however, suggest that courts should develop a different conception of the lawyer's role in civil commitment. . . . What the difficulties do suggest is that the attorneys working in the area need to develop not only special knowledge about psychiatric issues but also a high degree of self-awareness and sophisticated skills in interviewing and counseling. These special demands, in turn, indicate that wherever possible states should create systems of counsel that rely on persons who specialize in civil commitment matters on a full time basis.\textsuperscript{126}

\section*{APPENDIX: DRAFT OF A PROPOSED STATUTE}

1. A person less than 18 years of age may be hospitalized\textsuperscript{127} either by voluntary admission, as defined herein, or by involuntary admission.

2. A person less than 18 years of age may be hospitalized as a voluntary admission if he or she consents to such hospitalization, and if the director of the hospital deems him or her clinically suitable for that hospitalization.

\textsuperscript{123} A. Freud, J. Goldstein & A. Solnit, Beyond the Best Interests of the Child 66 (1973).
\textsuperscript{126} Andalman & Chambers, supra note 100, at 54.
\textsuperscript{127} Hospital is to be understood to refer not only to psychiatric hospitals themselves, but to residential treatment facilities as well.
form of hospitalization. If the person is less than 13 years of age, the consent of the person or persons who are his or her parents or guardians shall also be required. Prior to admission, a written application for admission as a voluntary patient shall be executed by the minor, and, if he or she is less than 13 years of age, by his or her parent or guardian. Such application must be signed by the minor.

3. Before accepting a minor for admission as a voluntary patient, the hospital director shall explain to the minor in clear and simple language, that the application is voluntary, and that the minor need not execute it if he or she does not wish to do so. The hospital director shall ascertain that the minor understands the nature of the application and is making an informed consent, before accepting the application.

4. If at any time subsequent to admission, the minor desires to leave the hospital, he or she may so inform the hospital director. If the minor is at this time less than 16 years of age, the consent of his or her parents or guardian shall also be required. If the minor desires to leave the hospital, and the consent of his or her parents or guardian is not forthcoming, the hospital director shall notify the court. The hospital director may, at his or her discretion, notify the court that he or she does not deem it appropriate to release the minor from the hospital. Unless such notification is given to the court within five days of the request, the hospital shall discharge the minor.

5. Upon receiving such notification from the hospital director, the court shall immediately schedule a hearing, which shall be conducted in the manner set forth for an involuntary admission. At the same time, the court shall appoint counsel for the minor. Due provision shall be made for consultation between the minor and his or her attorney prior to the hearing. The hearing shall be held within five days of the hospital’s notification to the court of its objection to the release of the minor.

6. A person less than 18 years of age may be hospitalized as an involuntary admission if, after an appropriately conducted hearing, the court concludes that such placement would be the least detrimental alternative for the minor. A compromise must be made here. It is recognized that there are minors who seek hospitalization without the consent of their parents. Hence the age at which one is entitled to be voluntarily admitted to a mental hospital for treatment without parental consent is reduced from 18 to 13 years of age. However, this does not address itself to the minor under the age of 13 who seeks such admission. Arguably, it would be possible to devise a system whereby a minor under the age of 13 would have access to a process through which he or she could obtain admission to a mental hospital despite parental opposition, perhaps through the intervention of school counselors or other informed and concerned persons. Several factors counsel against such a process. First it must be acknowledged very few minors would avail themselves of such a system. Second, any such system would of necessity be procedurally unwieldy, and would create the danger of unwarranted or overzealous intervention. Third, difficult obstacles with respect to parental rights over their young children would first have to be surmounted. Finally, a satisfactory method of identifying informed consent as expressed by a young child would have to be devised.

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129 See A. FRED et al. supra note 128, 53-64.
7. Application for admission to a hospital as an involuntary admission shall first be made to the hospital by the parents or guardians of the child. If the hospital director deems the minor suitable for admission, he or she may tentatively agree to admit the minor, subject to the decision of the court. The hospital director shall immediately notify the court of the application for admission.

8. The court shall schedule a hearing to be held not less than five days nor more than thirty days from receipt of such notification. At the same time the court shall appoint counsel for the minor. Due provision shall be made for consultation between the minor and his or her attorney prior to the hearing, and for an independent psychiatric examination of the minor. Compensation in an amount which is reasonable and based upon time and expenses for the attorney and for the individual or individuals conducting the independent psychiatric examination shall be made from court funds. Counsel for the minor shall be allowed adequate time for investigation of the matters at issue and for preparation, and shall be permitted to present such evidence as counsel believes necessary, including evidence as to alternatives to hospitalization.

9. The minor shall have the right to be present at the hearing, the right to be represented by counsel, the right to an independent psychiatric evaluation, the right to present documents and witnesses and to cross-examine witnesses, and the right to have the question of whether he requires treatment be heard by a jury.

10. Unwillingness or inability of the parent, guardian, or person in loco parentis to provide for the management, care or residence of the minor shall not be grounds for ordering the involuntary admission of the minor. In that event the court may cause a proceeding to be convened to ensure that appropriate management, care, or residence is provided.

11. The minor may not be found to require treatment unless at least one qualified person who has personally examined him testifies in person at the hearing.

12. If the court finds, on the basis of clear and convincing evidence, that the minor is in need of such treatment as is available at the hospital, and that there is no other treatment program that does not involve hospitalization which is available and appropriate for the minor, it shall approve the application for involuntary admission.

13. A minor involuntarily admitted to a hospital may not request a new hearing on the matter of his release for a period of three months following the date of the original hospitalization.