Children'S Competence To Provide Informed Consent For Mental Health Treatment

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CHILDREN'S COMPETENCE TO PROVIDE INFORMED CONSENT FOR MENTAL HEALTH TREATMENT

RICHARD E. REDDING*

TABLE OF CONTENTS

Introduction ............................................................................................................. 696
I. Traditional Views of the Adult Role in Decisionmaking for Children .................. 697
   A. Why Parents Do Not Always Act in the Child's Best Interests ......................... 697
   B. Why Mental Health Professionals Do Not Always Act in the Child's Best Interests 701
II. Traditional Views of Children's Competence ...................................................... 704
III. Recent Research on Children's Competence ....................................................... 708
IV. Models of Competence ....................................................................................... 709
   A. Definitions and Standards ............................................................................. 709
   B. Deciding Which Standard to Use .................................................................. 711
   C. State Consent Laws for Minors .................................................................... 712
V. Legal Standards and Presumptions for Determining A Minor's Capacity to Consent: Some New Proposals ................................................................. 713
   A. General Approach ....................................................................................... 713
   B. Legal Standards .......................................................................................... 715
   C. Supreme Court Decisions ........................................................................... 717
VI. Proposed Statutory Scheme ............................................................................... 720
   A. Statutory Presumptions .............................................................................. 720
   B. Age ............................................................................................................. 725
   C. Type of Treatment ....................................................................................... 728
VII. Determining Capacity to Consent ..................................................................... 739
   A. Who Should Decide? ................................................................................... 739
   B. Informing Children ...................................................................................... 740
   C. Ensuring Voluntariness .............................................................................. 742
   D. Enhanced Consent Procedures .................................................................. 743
   E. Practical Tests of Capacity ........................................................................ 744
   F. Assessing Competence .............................................................................. 746
   G. Emotional Factors ....................................................................................... 748
VIII. Conclusion ...................................................................................................... 749
Appendix: Proposed Model Statutes ..................................................................... 751

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INTRODUCTION

"Judicial decisionmaking represents social science in action."1

Controversy continues over whether to allow children unilaterally to consent to mental health treatment2 or, to refuse treatment and thus override parental wishes.3 The question involves diverse constitutional analysis of procedural and substantive due process, privacy, and equal protection, as well as societal values regarding the rights, roles, and responsibilities of parents in deciding about treatment for their children.

While society, as reflected through our laws, has generally viewed children as incapable of mature, adult-like decisionmaking, recent empirical research suggests that even children as young as eleven are able to provide informed consent for treatment and participate meaningfully in treatment decisionmaking.4 Allowing children to provide informed consent for mental health treatment is particularly important because of the potentially significant liberty and privacy interests involved, the potentially significant impact of treatment upon future life choices, and the treatment-enhancing effects of allowing children to participate in treatment decisionmaking. Giving children a voice in deciding treatment options is particularly important in the mental health context because parents do not always act in the child’s best interests.

The purposes of this article are (1) to suggest a new view about the competence of children to provide consent for mental health treatment; (2) to propose needed legal reform by way of a statutory scheme; and (3) to suggest practical approaches for informing children and determining a child’s capacity to provide informed consent. The paper presents proposals for new legal definitions of competence and standards for informed consent when minors are involved. A new statutory scheme is also proposed, based upon empirical research on children’s competence, which presents different standards according to the type of mental health treatment at issue: civil commitment, outpatient psychopharmacological treatment, or outpatient psychotherapy. The framework is designed to help ensure children’s due process rights by giving them a voice in their own treatment planning to the greatest extent possible. No statutory scheme has yet been developed or

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3. While some state statutes require a child’s consent in addition to the parent’s for certain treatments (such as civil commitment), few states allow a child unilaterally to veto a parent’s consent. Gerald P. Koocher, Competence to Consent: Psychotherapy, in CHILDREN’S COMPETENCE TO CONSENT 111, 122 (Gary S. Melton et al. eds., 1983) [hereinafter CHILDREN’S COMPETENCE].
4. See infra notes 66-81 and accompanying text.
proposed that provides children an opportunity to consent to mental health treatment commensurate with their capacity.

This framework underlies an argument that the law should reflect public policy concerns that are based upon scientific data.\(^5\) A balance must be struck between using scientific data as the benchmark for granting decisionmaking rights to children on the one hand, and using positivistic legal and social values on the other. The integrated statutory framework and suggested models for defining capacity are innovative in this respect. The paper also offers a practical paradigm for determining the capacity of an individual child to provide informed consent, for as the suggested statutory presumptions are generally rebuttable, it will still be necessary in most instances to determine the capacity of any particular child.

I. TRADITIONAL VIEWS OF THE ADULT ROLE IN DECISIONMAKING FOR CHILDREN

A. Why Parents Do Not Always Act in the Child’s Best Interests

“Our jurisprudence historically has reflected Western Civilization concepts of the family as a unit with broad parental authority over children. . . . More important, historically it has recognized that natural bonds of affection lead parents to act in the best interest of their children.”\(^6\)

“We can never assume that the people in the situation know what the situation is.”\(^7\)

Courts have typically advanced two reasons to justify denying children the right to consent to, or refuse, mental health treatment. First, the courts perceive that children are not competent to make such life decisions. Second, they assume that parents, in consultation with the clinician, will make treatment decisions based upon the child’s best interests. One of the main theses of this paper, however, is that these assumptions are invalid.

The assumption that parents act in their child’s best interest is intuitively sensible and inherently appealing. It undoubtedly holds true in most families under normal circumstances. However, the legal system has extended this generally valid assumption to one area where it may not be tenable: the

\(^5\) See Michael J. Saks, Legal Policy Analysis and Evaluation, 44 AM. PSYCHOLOGIST 1110 (1989) (arguing that main shortcoming of law is that it represents policy analysis without using empirical data to support its assumptions or conclusions).

\(^6\) Parham v. J.R., 442 U.S. 584, 602 (1979) (explaining denial to children of constitutional right to independent judicial review when they are civilly committed).

\(^7\) R. D. Laing, The Politics of the Family and Other Essays 33 (1971), quoted in James W. Ellis, Volunteering Children: Parental Commitment of Minors to Mental Institutions, 62 CAL. L. REV. 840, 862 (1974) (supporting contention that parents often cannot accurately or objectively perceive nature of their child’s problem or their own causative role).
mental health context. The mental health literature is filled with anecdotal, case-study, and empirical data indicating that parents often act contrary to the best interests of their child in the area of mental health treatment.

In fact, this problem is so widely perceived by mental health professionals that one could fairly say that the legal and mental health communities generally hold inapposite views on the issue. While judges assume parents are acting in the best interests of the child, clinicians often are cynical, or at least cautious, about the role of the parent. As one psychologist states, "I shall assume that the values, needs, desires and so-called best interests of parents and their children are not necessarily congruent. In fact, I expect that the best interests of parents and their children will often be different or even contradictory." The following brief discussion may illustrate why clinicians do not view the parental role so benignly:

**Civil Commitment**

*Case 1.* A boy's mother placed him in a hospital psychiatric unit. The mother had been in outpatient therapy and was diagnosed as having a borderline personality disorder, a serious mental illness characterized primarily by emotional instability and self-destructive behaviors. She was separated from her husband, caring for her four children alone. The boy sought legal help, and the boy's lawyer won his release from the hospital. Later, however, he was refused employment because of the psychiatric hospitalization.9

*Case 2.* A seven-year-old girl was hospitalized on a locked psychiatric ward even though the psychiatric evaluation found "no evidence of thought disorder, impairment in reality testing, [or] depression." Her parents had her hospitalized because she had an older boyfriend of whom her parents disapproved.10

**Psychotherapy**

*Case 3.* A ten-year-old girl was repeatedly recommended for psychiatric treatment by psychiatrists, social workers, and school guidance counselors beginning in first grade. The mother failed to keep her appointments with


therapists, and the school ultimately petitioned the court to have the child declared neglected. The court placed her in foster care, stating that "the mother's failure to provide medical care . . . may be interpreted to include psychiatric medical care where it is necessary to prevent the impairment of the child's emotional condition."11

Case 4. A nine-year-old girl's parents were members of a fundamentalist religious group and had relatively inflexible standards and expectations. They sought psychotherapy for her and were concerned because she wore pants, contradicted her parents in conversations, did not sit still in church, and had been associating with the "wrong crowd." She had no disciplinary problems at school, however, and was doing well academically. A psychological evaluation was within normal limits.12

Medications

Case 5. A ten-year-old was placed on Ritalin for hyperactivity. The prescribing physician was a pediatrician who regularly treated hyperactive children with Ritalin, rather than a psychiatrist. Neither the parents, the referring teacher, nor the pediatrician discussed or even considered alternatives to the Ritalin therapy.13

Case 6. The mother of a retarded girl gave her about four times her prescribed dose of lithium, a potentially lethal dosage. The mother did this hoping it would sedate her so that the mother would not have to cope with her troublesome behaviors.14

The above cases are examples of parents not acting in the child's best interests in three areas discussed in this paper: civil commitment, outpatient psychotherapy, and outpatient treatment with medication. Why did parents in these cases, as in so many others, fail to serve their own child's best interests? Put another way, why are parents themselves often a significant cause of the child's problems?

An important perspective is provided by family-systems theory.15 Its premise, used frequently by family therapists to understand families and based upon considerable empirical support, is that a child's problems cannot be meaningfully separated from those of the family. Childhood emotional disturbances are increasingly viewed as the results of disturbed family systems;16 families of emotionally disturbed children differ significantly from

12. Koocher, supra note 3, at 123.
14. The hypothetical is derived from an actual case based on the experience of the author, while working as a clinical psychologist.
those with "normal" children. The family is the problem, not the child. In dysfunctional families, for example, a "problem child" may allow other family members to avoid dealing with their own problems and to rationalize family difficulties as caused by the child. Thus, a child's behavior may not be related to underlying mental illness, but may reflect adaptation to a home environment that does not provide adequately for him or her.

A wealth of literature suggests that often the child may not be the primary source of the problem. Frequently it is the parent who is mentally ill rather than the child; one study found this true in twenty-five percent of the cases where the parent was presenting the child for treatment. Parents also often blame children for their own problems or project or displace their own feelings onto the child. Parents may use the child as the family scapegoat, blaming all family problems on the child's behavior. The family itself may be dysfunctional, caught in a cycle of mutual psychopathology of which the child is but one part. Many children whose parents request commitment appear to be members of a dysfunctional or disturbed family system. A disturbed family system may be partly responsible for the child's bizarre behaviors which, in turn, cause the parent to misinterpret the child's behaviors and needs.

As several of the above cases illustrate, parents frequently exaggerate the significance of a child's acting-out behaviors or unwillingness to conform to parental expectations. A California Assembly committee investigating juvenile court dockets, for example, found that many parental petitions

18. See, e.g., THOMAS S. SZASZ, LAW, LIBERTY, AND PSYCHIATRY 154 (1963) (stating that psychiatric diagnoses are labels signifying that individual does not act according to expectations); see also Nancy E. Waxler, Culture and Mental Illness: A Social Labeling Perspective, 159 J. NERVOUS & MENTAL DISEASE 379 (1974) (noting that patient receives reinforcement for behaving in accordance with "sick role").

Others similarly question the reliability or validity of psychiatric diagnosis. For example, Kathy Kosnoff, a staff attorney with Minnesota's Mental Health Law Project, observes correctly that "Psychiatry is a soft science... You can find yourself and most of your friends in the DSM-III-R." Metz, supra note 10, at 26. (DSM-III-R is the Diagnostic and Statistical Manual, the diagnostic manual used in psychiatric diagnosis.) See also Erica E. Goode, Sick or Just Quirky?, U.S. NEWS & WORLD REP., Feb. 10, 1992, at 49.
19. WESTMAN, supra note 8, at 12; R. D. LAING, THE POLITICS OF EXPERIENCE 114-15 (1967) (arguing that "without exception the experience and behavior that gets labelled schizophrenic is a special strategy that a person invents in order to live in an unlivable situation") (emphasis in original).
22. For an excellent discussion of the problem, see DAVID W. SIMMONDS, CHILDREN'S RIGHTS AND FAMILY DYSFUNCTION: "DADDY Why Do I Have to be the Crazy One?" IN CHILDREN'S RIGHTS AND THE MENTAL HEALTH PROFESSIONS 33 (Gerald P. Koocher ed., 1976).
23. Hetherington & Martin, supra note 17.
were for relatively "trivial" adolescent acts.24 "Well adjusted youths who need no help whatever from the courts typically at some time or other while growing up get drunk, stay out late, have sex, cut school; others rebel against parental authority. If left alone most survive and become normal adults."25

In the case of civil commitment, parents may place the child in an institution simply to relieve family stress, particularly in situations where single working parents cannot effectively supervise the child. The prevalence of child abuse and neglect26 also suggests that parents do not always act in a child's best interests. Because parents are not typically mental health professionals and also because their concerns must include the well-being of the family as a whole rather than solely that of the child, commitment decisions often are made based upon a misunderstanding of the child's behaviors or a desire to do what is best for the family.

B. Why Mental Health Professionals Do Not Always Act in the Child's Best Interests

"What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case."27

Case 7. A psychiatrist regularly commits a child for periodic stays in a mental hospital when his mentally-ill mother, a patient of the psychiatrist, needs a respite period from her child. Although the child has no mental illness, the psychiatrist creates a diagnosis for purposes of admission. The special committing justice, aware of these facts, nevertheless allows the commitment in the belief that the child is better off away from his mother while her mental state is emotionally fragile.28

Case 8. One private psychiatric hospital in California pays a local psychiatrist a substantial fee for patient admissions, while the marketing director of another children's psychiatric hospital is also a member of a school committee charged with deciding what to do with troublesome students.29

Case 9. An advertisement for a private children's psychiatric hospital includes the following copy: "Is your teenager irresponsibly rebellious, or

25. REPORT OF THE CALIFORNIA ASSEMBLY INTERIM COMMITTEE ON CRIMINAL PROCEDURE, JUVENILE JUSTICE PROCESSES 7 (1971).
out of control? Running with the wrong crowd? Headed down the path of no future? Help your son or daughter before it's too late."

Like parents, mental health professionals do not always act in the child's best interests, making judicial review desirable in many cases. Although the above quotation from *Parham v. J.R.* presents the rationale that mental health professionals act in the child's best interests, the cases described are but several of many which could be used to illustrate the tenuousness of this assumption. While most clinicians do not intentionally act contrary to the child's best interests, pressures from family and institutions or diagnostic error may result in inappropriate treatment recommendations.

Like parents, clinicians may misperceive the need for treatment. It can be difficult for clinicians to determine if the child is being scapegoated by family members, and evidence suggests that clinicians tend to overdiagnose. The often stressful and unfamiliar circumstances under which a child is initially assessed for treatment generally are not ideal for providing an accurate evaluation, further contributing to the already relatively unreliable nature of childhood psychiatric diagnosis. In the case of civil commitment, for example, institutions typically do not conduct an extensive investigation of the child's family or history. Inappropriate commitment or medication of children for relatively mild conditions is common, and has been well documented.

There are also potentially serious conflicts of interest inherent when the parent brings a child for treatment. The child is the identified patient, so the clinician theoretically is bound to serve only the child's best interests. However, the parent is probably paying the fee, which might make it difficult to resist subtle pressures to carry out the parent's wishes. Clinicians may also simply identify more with the concerns of the parents than those of the child. "While the goal of the psychiatrist will be expressed—and perceived—as the best welfare of the child-patient, it is the parent who has come to seek help, whose situation seems most desperate, who seems the most reliable source of information about what is wrong, [and] who is closest to the psychiatrist in age and social outlook ...." Moreover,

30. *Id.* at 21.
35. See infra notes 193-205, 258-59 and accompanying text.
many commentators have reported substantial conflicts of interest when the admitting clinician has a close professional relationship with a private psychiatric hospital.\textsuperscript{37}

Where civil commitment and psychotropic medical treatment are considered, and the child is not competent to consent or refuses to consent to treatment, judicial review would help to ensure greater protection against potentially harmful forced treatment. A judge or administrative review board could hear advocacy on both sides with the benefit of the truth-finding power of an adversarial hearing, and reach a judgment based on legal rather than medical criteria.\textsuperscript{38} Importantly, the decision would not be made solely by one clinician, who may be too close to the problem, who may be in diagnostic or prognostic error, and who may have conflicts of interest. In cases where the patient is provided vigorous advocacy, judicial hearings appear to decrease the incidence of inappropriate hospitalization.\textsuperscript{39}

\textsuperscript{37} For an excellent review of the problem, see Metz, supra note 10, at 28-29 (reporting that legislators, concerned about this problem, introduced bill in Kentucky legislature requiring that evaluating clinician not receive any financial benefit from child’s hospitalization). Adolescent psychiatric hospitals are now a major cottage industry, being very lucrative. \textit{Id.} The article quotes Dr. Lee Combrinck-Graham, former director of the Institute for Juvenile Research in Chicago, who says that the reason for the recent dramatic increases in adolescent psychiatric admissions “is not because the kids need this care but because it’s productive and lucrative.” \textit{Id.}

\textsuperscript{38} \textit{But see} Parham v. J.R., 442 U.S. 584, 609 (1979) (stating that “we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision . . . to an untrained judge . . . . Even after a hearing, the nonspecialist decisionmaker must make a medical-psychoiatric decision”).

In the case of civil commitment, criteria for commitment in most states is either that the child is dangerous to self or to others, or that he is in need of treatment. (The latter criterion, often termed “functional capacity,” typically implies an inability to function in the environment adequately without such treatment.) \textit{See} RICHARD E. REDDING, DUE PROCESS PROTECTIONS FOR JUVENILES IN CIVIL COMMITMENT PROCEDURES 25-26 (Elissa C. Lichtenstein et al. eds., 1991). A large body of research, however, suggests that clinicians cannot predict future dangerousness any more reliably than the untrained layman. \textit{See generally} James C. Beck, \textit{Psychiatric Assessment of Potential Violence: A Reanalysis of the Problem, in THE POTENTIALLY VIOLENT PATIENT AND THE TARASOFF DECISION IN PSYCHIATRIC PRACTICE} 83 (James C. Beck ed., 1985); John Monahan, \textit{The Prediction of Violent Behavior: Developments in Psychology and Law, in PSYCHOLOGY AND THE LAW} (C. James Scheier & Barbara L. Hammonds eds., 1983); Henry J. Steadman, \textit{The Right Not to be a False Positive: Problems in the Application of the Dangerousness Standard, in PSYCHIATRIC PATIENT RIGHTS AND PATIENT ADVOCACY} 129, 143 (Bernard L. Bloom & Shirley J. Asher eds., 1982) (stating that “[n]owhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond the level of chance”). Regarding functional capacity, a judge probably can evaluate a child’s ability to function at school, at home, etc., just as well as a clinician. \textit{See GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS} 15 (1987) (arguing that “[w]hether a person appears sufficiently ‘crazy’ to warrant special legal treatment is an intuitive social and moral judgment. Diagnosis, for example, is largely irrelevant to mental health law questions”).

\textsuperscript{39} \textit{See} Raj K. Gupta, \textit{New York’s Mental Health Information Service: An Experiment in Due Process, 25 RUTGERS L. REV. 405, 438 (1971); Virginia A. Hiday, The Role of Counsel in Civil Commitment: Changes, Effects, and Determinants, 5 J. PSYCHIATRY & L. 551, 560 (1977) (noting that in hearings where attorneys actively challenged commitment recommendation, only 45% of respondents were committed).
II. Traditional Views of Children's Competence

"Most children, even in adolescence, simply are not able to make sound judgments . . . including their need for medical care or treatment. Parents can and must make those judgments."40

Children traditionally have been treated as second-class citizens—viewed by our society and in our courts as incapable of mature decisionmaking.41 Thus, they generally have been denied the right independently to seek or refuse mental health treatment. It has been argued that children are "the most oppressed of all minorities,"42 denied a voice in making their own life decisions and thereby denigrated in their personhood.43 Some children's rights advocates have argued that children should be involved in their own life decisions,44 and that one way to prevent the exploitation of children is to give them a voice in decisions affecting them, perhaps even irrespective of their competence.45

The very practice of disclosing information to patients and obtaining informed consent is rooted in the notion of respect for individual autonomy, an ethical principle which is generally overriding in biomedical decision-making in western societies.46 Respect for autonomy necessitates valuing the

40. Parham v. J.R., 442 U.S. 584, 603 (1979) (explaining denial to children of constitutional right to independent review of commitment decision "[s]imply because the decision of a parent is not agreeable to a child").


43. Melton, Toward "Personhood", supra note 41; Melton, Clashing of Symbols, supra note 41; see also Stuart N. Hart, From Property to Person Status: Historical Perspective on Children's Rights, 46 Am. Psychologist 53, 57 (1991) (arguing that public policy requires "positive ideology of children, valuing them for what they are . . .").

44. See, e.g., JOHN HOLT, ESCAPE FROM CHILDHOOD (1974); Henry H. Foster, Jr. & Doris W. Freed, A Bill of Rights for Children, 6 Fam. L.Q. 343 (1972); Melton, Toward "Personhood," supra note 41.

45. See, e.g., Leon Letwin, After Goss v. Lopez: Student Status as Suspect Classification?, 29 Stan. L. Rev. 627, 641-42 (1977) ("the 'competency' of the claimant bears little or no relationship to the issue of entitlement, primarily where the liberties involved are aimed not at maximizing free choice but at civilizing the process and instruments of state compulsion. . . . Procedural due process does not immunize persons against deprivations of life, liberty or property; it simply insists on a degree of fairness and humanity. . . . To that degree the capacity of children has nothing to do with their right to be treated fairly, decently and humanely by their government. They are entitled to such treatment not because they are competent but because they are persons."); see also Hillary Rodham, Children's Rights: A Legal Perspective, in CHILDREN'S RIGHTS: CONTEMPORARY PERSPECTIVES 21, 21-36 (Patricia A. Vardin & Irene N. Brody eds., 1979) (arguing that child's legal capacity should be presumed unless rebutted); Holt, supra note 44 (arguing that children should be afforded same rights as adults); FRANKLIN E. ZIMRING, THE CHANGING LEGAL WORLD OF ADOLESCENCE 103 (1982).

individual’s competence and preferences and allowing him or her to exercise choice to the fullest extent possible.\textsuperscript{47} The philosopher Immanuel Kant taught that “respect for autonomy flows from the recognition that all persons have unconditional worth.”\textsuperscript{48}

Much of the current law regarding children’s capacity is based upon common lore, traditional assumptions about children’s abilities, and idealistic views about the role of parents in making decisions for their children.\textsuperscript{49} The United States Supreme Court has often viewed children as being in need of benevolent protection\textsuperscript{50} “from the exercise of their own volition.”\textsuperscript{51}

In \textit{Ginsberg v. New York},\textsuperscript{52} Justice Stewart wrote that “a child ... is not possessed of that full capacity for individual choice .... It is only upon such a premise, I should suppose, that a State may deprive children of other rights ... deprivations that would be constitutionally intolerable for adults.”\textsuperscript{53} In \textit{Belotti v. Baird},\textsuperscript{54} the Court observed that “states validly may limit the freedom of children to choose for themselves in the making

\begin{thebibliography}{99}
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\bibitem{47} Id. at 71.
\bibitem{48} Id. (citing IMMANUEL KANT, \textit{GROUNDWORK OF THE METAPHYSICS OF MORALS} (H. J. Paton trans., 1964)).
\bibitem{49} Professor Melton argues that the Court has made many assumptions about children and families that are not supported by, or are contrary to, social science data. These idealistic assumptions and “myths” of our positivist legal system often are presented in judicial opinions as natural law or scientific fact. He points out that when: myths are used to provide ruses for political or legal action, the actual goals of policy are obscured .... [I]f incompetence were the real basis for denial of liberty for adolescents, empirical evidence rebutting the hypothesis should result in a change in policy. Such a result is unlikely, because the statements were intended to promote a particular mythical view of reality derived from a fundamental value of deference to authority.


\bibitem{51} It has been the author’s experience, however, that lawyers also do not have the same degree of confidence in social science research as do mental health professionals. Even where a sizeable and convincing body of reliable research suggests the inaccuracy of a particular legal assumption, this often will not dissuade attorneys from maintaining the positivistic assumption. The lawyer’s response frequently is that social science research findings are unreliable, subject to differing interpretations, and subject to bias as a function of researchers’ own viewpoints on the very questions which the research is designed to address. Lawyers especially distrust the reliance upon statistical analysis. Thus, the scientific method may not have the same appeal to lawyers as it does to social scientists. Legal analysis is shaped more by historical tradition, philosophical and ethical tenets and assumptions, and judicial and political constraints, than it is by scientific research findings.

\bibitem{52} See, e.g., \textit{Goldstein et al.}, supra note 8; Carl M. Rogers & Lawrence S. Wrightsman, \textit{Attitudes Toward Children’s Rights: Nurturance or Self-Determination?}, 34 J. Soc. Issues 59, 63-65 (1978) (noting that survey of 381 persons found that majority disfavored affording greater self-determination rights to juveniles).

\bibitem{53} Paris Adult Theatre I v. Slaton, 413 U.S. 49, 64 (1973).
\bibitem{54} 390 U.S. 629, 649-50 (1968) (Stewart, J., concurring).
\bibitem{55} Id.
\bibitem{56} 443 U.S. 622 (1979) (\textit{Bellotti II}).
\end{thebibliography}
of important affirmative choices with potentially serious consequences [be-
cause] during the formative years of childhood and adolescence, minors
often lack the experience, perspective, and judgment to recognize and avoid
choices that could be detrimental to them.”55 Finally, in Thompson v.
Oklahoma,56 the Court stated that “[i]nexperience, less education, and less
intelligence make the teenager less able to evaluate the consequences of his
or her conduct. . . . The difference that separates children from adults for
most purposes of the law is children’s immature, undeveloped ability to
reason in an adultlike manner.”57 Thus, the Court has afforded children
fewer rights than adults based upon a competency distinction: children are
less competent psychologically than adults.

This incapacity theory of childhood is the basis for much current
constitutional law about children’s rights.58 “[T]he law has generally re-

55. Id. at 635. But see Wisconsin v. Yoder, 406 U.S. 205, 245 (1972) (Douglas, J.,
dissenting) (citing works of Piaget, Elkind, Kohlberg) (stating that “there is substantial
agreement among child psychologists and sociologists that the moral and intellectual maturity
of the 14-year-old approaches that of adults”).
57. Id. at 835-36 n.43 (citing VICTOR L. STREIB, DEATH PENALTY FOR JUVENILES 1987).
58. Numerous commentators, especially those operating within a social science perspec-
tive, have argued that the judiciary fails to consider adequately available social science research
because the findings frequently conflict with common-sense assumptions or fundamental legal
principles. See generally REFORMING THE LAW: IMPACT OF CHILD DEVELOPMENT RESEARCH
(Gary B. Melton ed., 1987) [hereinafter REFORMING THE LAW]; Gary B. Melton, Bringing
Psychology to the Legal System: Opportunities, Obstacles, and Efficacy, 42 AM. PSYCHOLOGIST
488 (1987). Lawyers also generally fail to consider empirical research because they have no
training in scientific methodology. “The heart of the problem, I suspect, is that lawyers and
social scientists come from two different cultures. . . . [L]aw students are typically smart
people who do not like math. The quantitative, empirical social and behavioral sciences exist
in another world.” Saks, supra note 5, at 1115.

One example directly on point concerns the issue of children’s ability to provide informed
consent. The Society for Research in Child Development convened an expert panel which
published a book reviewing research on children’s competence to consent. See REFORMING THE
LAW, supra. Five years later, its impact had been minimal, as measured by its frequency of
citation in judicial opinions. This is unfortunate; the informed consent question provides an
ideal opportunity for the use of social science in shaping legal policy and for interdisciplinary
cooperation, because of the need to determine a child’s psychological competency to provide a
legally valid consent.

Another reason for judges’ reluctance to rely upon social science research may be the
perception that it is relatively unreliable, at least when measured against legal standards. The
American Psychological Association filed amicus briefs in two cases involving minor abortion
statutes (Hartigan v. Zbaraz, 484 U.S. 171 (1987), reh’g denied, 484 U.S. 1082 (1988) and
Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986)),
arguing that minors should be allowed to make abortion decisions because minors 14 years of
age and older are as competent as adults. However, due to the lack of extensive research on
many important questions concerning the competence of children, “[t]he briefs overstated what
is known about the development of decision-making skills.” William Gardner et al., Asserting
Scientific Authority: Cognitive Development and Adolescent Legal Rights, 44 AM. PSYCHOLOGIST
895, 897 (1989). Judge Craven, of the U.S. Court of Appeals for the Fourth Circuit, opined that “courts are uneasy in the presence of the ultimate findings or conclusions of the social
sciences because we have many times consumed large quantities of social science—from Dred
garded minors as having a lesser capacity for making important decisions."
Indeed, the presumption that children are incompetent serves as "a paradigm
for the manner in which the legal system deals with children," typically
denying them any decisionmaking role in their own medical treatment.
Research, however, indicates that children often are capable of making
important life decisions in a rational manner, including decisions about
medical and psychological treatment.

Scott to Lochner—only to have to regurgitate it." J. Braxton Craven, Jr., The Impact of
Social Science Evidence on the Judge: A Personal Comment, 39 L. & CONTEMP. PROBS. 150,
151 (1975). It may be true also that when judges do use social science data, they do so
incompetently. See James R. Acker, Social Science in Supreme Court Criminal Cases and

While currently there is a significant and compelling body of research indicating that
children ages 14-15 are capable of mature decisionmaking, how can we be satisfied that it
provides a sufficiently reliable foundation upon which to base legal policy? Several methods
are available for making this determination. Although these methods are beyond the scope of
the present paper, they are worth mentioning to illustrate their potential feasibility.

Meta-analysis is a powerful method of combining the results of numerous studies in order
to determine what general conclusions are most reliable. See generally Gene V. Glass et al.,
META-ANALYSIS IN SOCIAL RESEARCH (1981); Bert F. Green & Judith A. Hall, Quantitative
Methods for Literature Reviews, 35 ANN. REV. PSYCHOL. 37 (1984). This is useful for
determining whether research results are generally consistent in their findings. In terms of
consistently applying research findings in adjudication, Professors Monahan and Walker have
proposed that data be treated in the same way as legal precedent, with relevant criteria being
relevancy to the case, validity of the methodology (the degree to which the research is accepted
by the scientific community may be largely dispositive), and extent to which other research
also leads to the same conclusions. John Monahan & Laurens Walker, Social Authority:

60. Gerald P. Koocher, Children Under Law: The Paradigm of Consent, in REFORMING
THE LAW, supra note 58, at 6.
61. The right generally to control one's own body and mind is a fundamental right
accorded constitutional protections derived from the right to privacy, as defined by the liberty
interest contained in the Due Process Clause. See, e.g., Jacobson v. Massachusetts, 197 U.S.
11, 26 (1905); Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535, 543-45 (1942) (Stone,
C.J., concurring).

Laws that deprive a psychologically competent child the right to exercise this fundamental
right arguably violate substantive due process in that they are not narrowly tailored. By
establishing absolute minimum age cut-offs which disallow both incompetent as well as
competent children the right to refuse or consent to treatment, such laws are overinclusive. If
a law "significantly interferes with the exercise of a fundamental right, it cannot be upheld
unless it is supported by sufficiently important state interests and is closely tailored to effectuate

It could also be argued that denying a psychologically competent child the right to decide
on his or her own medical treatment violates the Equal Protection Clause, which requires that
individuals similarly situated be treated equally. Although parents have a fundamental right
to make certain childrearing decisions without government interference, see, e.g., Wisconsin
v. Yoder, 406 U.S. 205, 214 (1972); Prince v. Massachusetts, 321 U.S. 158, 166 (1944); Pierce
(1923), it is debatable whether parental rights should override the rights of the child when the
child's psychological competence to decide is not significantly different from that of the
parent(s).

62. See generally CHILDREN'S COMPETENCE, supra note 3 (providing state of the art
III. RECENT RESEARCH ON CHILDREN'S COMPETENCE

"We reject a positivistic approach to the normative ordering of child, family, and state, but we adhere to a belief in empiricism." 63

A sizeable and convincing body of empirical research has accumulated over the last decade suggesting that children have much more competence than has been recognized by the legal community. 64 The general picture which emerges is that children are capable of quite a lot, if you just let them participate in the decisionmaking process. 65

Adolescents, and frequently even younger children, are capable of adult-like understanding and decisionmaking. 66 For instance, children as young as about twelve appear to have a factual understanding and appreciation for the risks and benefits of psychotherapy. Discussing unpleasant or uncomfortable issues, discomfort with the therapist, violations of confidentiality, and poor treatment effectiveness are identified as risks; having someone to talk with, learning things, and solving problems are seen as benefits. 67 Even nine-year-olds appear to understand many basic aspects of treatment, 68 including differences between various diagnoses and prognoses, and treatment risks and benefits. 69 Twelve-year-olds are able to define accurately many basic legal concepts. 70 Significantly, children as young as six can be astute in perceiving procedural injustice; 71 thus, allowing children to participate in decisionmaking regarding their own health may enhance children's perception that they have been treated fairly.

There is also evidence that allowing children to participate in treatment decisionmaking improves treatment by facilitating the child's willingness to cooperate. 72 Such participation may also help reduce the stress of therapy. 73

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64. See infra notes 173-78 and accompanying text.
65. See infra notes 173-78 and accompanying text.
66. The specific capacities of children at different ages are discussed in detail in Part VI-B.
68. Weithorn & Campbell, supra note 62, at 1596.
69. Michael C. Roberts et al., Children's Perceptions of Medical and Psychological Disorders in their Peers, 10 J. OF CLINICAL CHILD PSYCHOL. 76 (1981).
73. Gary B. Melton, Children's Participation in Treatment Planning, in CHILDREN'S COMPETENCE, supra note 3, at 246, 250-51.
lead to better attitudes about treatment, reduce resistance to therapy, and foster appropriate treatment expectations. The child achieves a sense of control and self-efficacy critical for mental health and positive therapeutic outcomes. Clinicians generally agree that treatment outcomes are poor when children are forced to receive treatment.

Researchers have found that merely seeking a child’s informed consent at the outset improves treatment effectiveness significantly. Moreover, permitting children to provide informed consent may actually facilitate competence because children have not had much experience with exercising rights. Allowing children to exercise legal rights may help them to develop decisionmaking competencies relating to legal issues and life choices, and gradually to assume adult-like responsibilities.

IV. MODELS OF COMPETENCE

"The search for a single test of competence is a search for the Holy Grail."  

A. Definitions and Standards

There is no single theory or definition of competency within either the legal or mental health communities. Commentators, however, have pro-

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77. See Bastien & Adelman, supra note 72, at 171.

78. See id. at 178 (stating that adolescents whose consent was sought tended to perceive they had choice even when treatment was mandatory, whereas failure to seek consent led to perceptions of no choice even when treatment was not mandatory).


80. See Sigmund E. Dragastin, Epilogue: Research Themes and Priorities, in ADOLESCENCE AND THE LIFE CYCLE 291, 296 (Sigmund E. Dragastin & Glen H. Elder eds., 1975) (stating that “the main difference in cognitive maturity in adolescents and adults may relate to levels of social participation: the picture one has for himself of what he is authorized to do and empowered to do”).

81. The 1978 Presidential Commission on Mental Health recommended that children be allowed to participate in decisionmaking “as a sound strategy to enable young people to undertake responsible and rewarding involvement in the adult world.” PRESIDENT’S COMM’N ON MENTAL HEALTH, 3 REPORT TO THE PRESIDENT FROM THE PRESIDENT’S COMMISION ON MENTAL HEALTH 638 (1978) (U.S. Gov’t Printing Office No. 040-000-00392-4) (Report of the Task Panel on Mental Health).

82. Loren H. Roth et al., Tests of Competency to Consent to Treatment, 134 AM. J. PSYCHIATRY 279, 283 (1977).

83. Although the terms competence and capacity are sometimes used interchangeably,
posed various models defining competency for treatment decisionmaking, and analogous standards have been adopted in various state statutes\textsuperscript{85} or by various courts.\textsuperscript{86} Typical standards include (1) factual understanding of the problem and the treatment alternatives; (2) rational decisionmaking processes; (3) appreciation for the personal implications of the decision; (4) ability to make and communicate a choice; (5) a reasonable choice; or (6) general competence.

The \textit{factual standard} generally requires an understanding of the diagnosis and the psychological nature of the illness, treatment alternatives available and their probabilities of success, the risks and benefits of each alternative,\textsuperscript{87} and one’s role and rights in the informed consent process.\textsuperscript{88} The \textit{rational decisionmaking standard} may include a determination of whether the person has weighed the risks and benefits, calculated the probabilities, provided sound reasons, or generally shown adult problem-solving capacities.\textsuperscript{89} According to Professors Appelbaum and Grisso, rational decisionmaking is "the ability to reach conclusions that are logically consistent with the starting premises."\textsuperscript{90} The \textit{appreciation standard} requires an appreciation of the relationships between various alternatives to one's own values and present as well as future life situation,\textsuperscript{91} and the ability to draw inferences and think abstractly about future consequences.\textsuperscript{92} Thus, appreciation seems to require not only adult-like cognitive skills but adequate emotional maturity as well. (Several commentators have suggested that these three standards represent increasing levels of maturity, with appreciation being the hardest test to satisfy.)\textsuperscript{93}
The evidence of choice standard requires only that the individual communicate a choice. The reasonable choice standard evaluates decisionmaking according to the outcome, requiring that the choice be reasonable and not the product of mental illness. Finally, the general competency standard considers overall competence, which may be determined with reference to diagnosis, appearance, or prior behavior. Some writers have proposed using general competency as a threshold standard, with one of the other specific competency standards as an added test.

B. Deciding Which Standard to Use

The standard used varies according to the legal issues and the risk, perceived by the clinician or judge, of a poorly made decision. Decision-making about certain options may require relatively greater or lesser experience, emotional readiness, or cognitive maturity. In cases where the individual's capacity is questionable or marginal, a risk-benefit analysis of the treatment is often considered by clinicians in deciding whether to allow the patient unilaterally to consent. Commentators suggest that if the potential benefits significantly outweigh the risks, a demanding standard of capacity is typically used by clinicians when the patient is trying to refuse treatment. Conversely, if the benefits are low and the risks high, a low standard of capacity is more often used in order more readily to allow the patient to refuse treatment. (The reverse situation applies when the patient wishes to consent to the treatment.) Thus, as long as a patient decides as the physician wishes, competency questions generally do not arise.

Regardless of the standard used, however, it is generally recognized that competency includes at least a factual understanding of the illness and treatment alternatives, including their risks and benefits, and the capacity for rational decisionmaking. The factual understanding standard is probably the one most commonly relied upon explicitly in statutory and case law. Most minor consent statutes require an understanding and appreciation of the nature and consequences of treatment alternatives.
C. State Consent Laws for Minors

Traditionally, at common law, minors were incapable of providing consent. Legislatures, however, have enacted statutes allowing "mature minors" to consent to certain treatments. Consent laws for minors relating to mental health treatment are generally of five types: "emancipated minor" laws; "mature minor" laws; "age of consent to medical treatment" laws; "age of consent to voluntary commitment" laws; and "age of consent to outpatient treatment" laws. Often, these categories overlap or coexist.

Emancipated minor laws allow minors to give consent for certain enumerated treatments. State statutes define emancipation differently, but generally the concept applies to children who live on their own away from home, who are married, who have a child, or who are financially self-sufficient. Mature minor laws allow children with a certain level of maturity to give consent; courts have discretion to determine whether the child has the decisionmaking maturity to give consent for the matter in question. (In states without mature minor statutes, minors can frequently be adjudicated "mature" at common law.) Maturity is more likely to be found when the child is near majority and in situations where the court feels that allowing the child to decide will best serve the child's interests. For this reason, courts may be reluctant to find juveniles to be "mature" when their parents seek their commitment, because of the assumption that parents in this situation act in the child's best interests. Age of consent laws, either to medical treatment generally or to voluntary commitment or outpatient treatment, simply stipulate a certain age requirement, usually twelve to fifteen, for minors to give legal consent. Some statutes combine a minimum age requirement for consent along with a mature or emancipated minor provision.
V. Legal Standards and Presumptions for Determining a Minor's Capacity to Consent: Some New Proposals

"The law does not view competence as inherent in the person, but rather as something with which one is vested by society."109

A. General Approach

Although children may be capable of providing informed consent and the beneficial effects of allowing them to do so may be significant under appropriate circumstances, empowering children in this way involves more than simply a scientific determination that children are competent.110 Commentators point out that even though children may be fully competent to consent, social policy considerations might dictate that we distinguish between actual competence (de facto) and legal competence (de jure).111

Reasons frequently cited for not extending to children the right to decide include the child's relative lack of life experiences necessary for fully formed values and sound judgment,112 the child's inability to manage adult responsibilities,113 reluctance to require a child to bear responsibilities of adult decisionmaking,114 the desire to avoid the family disruption caused by parent-child legal conflicts, reluctance to limit or undermine parental authority,115 and the difficulty of determining competence on a case-by-case basis. My perspective, however, is that the child should be allowed to provide informed consent wherever possible. Allowing children to consent enhances treatment efficacy and protects the child's rights. Children must be allowed to participate in treatment decisionmaking because parents do not always act in a child's best interest. In the mental health context, child-parent or parent-child-state conflicts are very common,116 making it necessary that the child be given a voice in decisions affecting him or her. Allowing the child to participate in treatment decisionmaking through informed consent helps protect the child's interests, ensuring fundamental fairness. Adults and


110. See LAWRENCE S. WRIGHTSMAN, PSYCHOLOGY AND THE LEGAL SYSTEM 22-24 (2d ed. 1981) (in contrasting social scientific [psychology, specifically] with legal modes of analyses, states that "law is doctrinal; psychology is empirical" and that "law functions by the case method, psychology by the experimental method").

111. See, e.g., Gaylin, supra note 109, at 38.

112. Id. at 34.

113. See, e.g., WESTMAN, supra note 8, at 250.


116. For a review of such conflicts, see Thomas S. Szasz, Critical Reflections on Child Psychiatry, 1 CHILDREN & YOUTH SERV. REV. 7 (1979).
children are to be afforded due process protections, although the nature of due process may differ somewhat for children versus adults.117 At a minimum, due process includes notice and an opportunity to be heard.118

The United Nations Convention on the Rights of the Child has adopted the position that children be allowed to express their views in proceedings affecting them.119 (The United States, however, is not yet a signatory to the Convention.)120 Article 12, sections 1 and 2 state:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law. (emphasis added).121

The Convention duly recognizes, however, that the weight given to the child’s views and preferences must vary according to the child’s age and maturity, and contains numerous references to the “evolving capacities of the child.” Article 5 states that parents should “provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized,” suggesting perhaps a shared decisionmaking approach between children and their parents.122

Of course, many would argue that the parents alone should decide on treatment for their children. However, it is the child and not the adult who is faced with a possible deprivation of liberty in the cases of civil commit-

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117. See, e.g., McKeiver v. Pennsylvania, 403 U.S. 528, 543 (1971) (holding that due process standard for children is simply "fundamental fairness," which does not require a jury trial in delinquency proceedings).


118. Grannis v. Ordean, 234 U.S. 385, 394 (1914) (stating that "[t]he fundamental requisite of due process of law is the opportunity to be heard").


ment and psychopharmacological treatment, and possible intrusion on pri-
vacy in the context of outpatient psychotherapy.

The perspective of this paper is that state laws regarding a minor's
ability to provide informed consent should differ depending upon the type
of mental health treatment. Additionally, adult authority should be circums-
scribed by the child's age; an adult's right to veto a child's treatment
decisions should decrease as the child grows older. Research suggests that
the decisionmaking competency of children differs as a function of age,
with critical age ranges appearing to be early (eleven to fourteen years) and
late adolescence (fifteen and over).123

Although all children should be allowed to participate in treatment
decisionmaking to the extent commensurate with their competence,124 the
threshold issue of principal legal significance is whether the minor can
provide informed consent.125 This paper will present some new proposals,
based on recent research findings in psychology, for allowing minors to
consent to mental health treatment. First, however, it is necessary to define
what is meant by "competence" to consent. This is not a simple task.

B. Legal Standards

In many states, minors can consent to treatment only upon a showing
that they are "emancipated" or "mature."126 Emancipation is determined
largely by factors other than competency. The following discussion concerns
a minor's capacity to consent, pursuant to the "mature minor" paradigm.

Unlike mentally disabled adults, who are presumed competent to con-
sent,127 nondisabled minors seeking to give consent pursuant to a mature
minor statute must make an affirmative showing of competence. The
capacity of a child is also more open to question than that of an adult;
courts generally are deferential to parental wishes.128 Courts may therefore
require a thorough demonstration of capacity on the part of the child before
being willing to override or bypass parental authority.129

123. See infra notes 172-85 and accompanying text.
124. Citing empirical evidence regarding beneficial effects of preparing children for psy-
chotherapy, one commentator notes that limited informed consent may be possible with children
as young as six. Koocher, supra note 3, at 121. When individuals such as young children are
able of participating in treatment decisionmaking but not able to provide full informed
consent, the term "assent" is commonly used. See, e.g., Sanford L. Leiken, Minors' Assent
or Dissent to Medical Treatment, 102 J. PEDIATRICS 169 (1983).
125. Note that allowing a child to provide informed consent should not preclude the child
from exercising the option to have his or her parents help the child make the decision. Professor
Weithorn suggests this may be the best alternative in most cases, facilitating parent-child
cooperation and problem-solving. Weithorn, supra note 76, at 253-54.
126. See supra notes 105-07 and accompanying text.
127. See infra note 313 and accompanying text.
129. The Supreme Court has not articulated any standards for determining whether a
minor is mature. See generally Katherine M. Waters, Note, Judicial Consent to Abort: Assessing
These considerations suggest that the legal standard for defining capacity should be one which includes all elements of competence. Therefore, the "reasonable decisionmaking" standard, which is generally understood to require (1) factual understanding, (2) rational decisionmaking, and (3) ability to make and communicate a choice, should be applied to juveniles. The child must understand the right to consent or not to consent to treatment. Treatment concepts which the child must understand will vary according to the proposed treatment, but the child should be able to (1) weigh risks and benefits of each treatment alternative; (2) weigh the probabilities of treatment success; and (3) provide reasoning to support each decision.

Additionally, the juvenile should demonstrate "appreciation"—an understanding of the relationship of various treatment options to one's own values and the ability to draw inferences as related to the particular situation. Commentators have also pointed out the importance of "good judgment," which includes emotional components such as the ability to regulate impulses and to use and process information in an emotionally mature manner, particularly under the taxing circumstances often present when deciding important treatment issues.130

These criteria require rational decisionmaking capacity, but do not require that the decisionmaking process or choice be logical in all respects; such a standard would be impossible to meet even for adults. Research demonstrates that adult decisionmaking is subject to many cognitive biases which defy logic.131 A seemingly irrational decision made by a rational individual does not, therefore, indicate legal incapacity,132 even if that individual suffers from a mental illness.133 Additionally, even adults typically will not demonstrate perfect competence,134 with most adult patients showing

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132. See Rozovska, supra note 105, at 21-22.
133. But see Joanne Lynn, Informed Consent: An Overview, 1 BEHAV. SCI. & L. 29, 35 (1983) (asserting that "[s]ome decisions [may be] so unreasonable that they are evidence per se of incompetence").
134. See, e.g., Stanley, supra note 93, at 71 (noting that review of research indicates that adult patients' comprehension of disclosure information varies from about 35% to 80% of information they are told).
only mid-level competence. The relevant issue is not whether children are capable of completely rational and competent decisionmaking in all respects. Rather, "we must ask what capacities adults use to exercise their rights," and then determine whether children have similar capabilities.

Thus, although children should be assessed on all the relevant competence standards, this does not imply that the child must evidence perfect competence relative to each standard. Whether or not the child is deemed to possess sufficient capacity will depend upon the treatment and legal issues involved, and the judgment of the evaluator.

C. Supreme Court Decisions

The Supreme Court has in fact applied different standards depending upon the treatment in question. In Planned Parenthood of Central Missouri v. Danforth, the Court held that minors must be able to bypass parental consent in order independently to obtain an abortion, if a court finds the minor to be capable of mature decisionmaking regarding the abortion, or if a court decides the abortion to be in the child's best interests. In contrast, the Court has not upheld a mature minor's right to provide informed consent in the civil commitment context, where significant liberty interests are implicated and where the risk of harm from an erroneous decision may be just as great. Additionally, parental choice should not necessarily be preferred in civil commitment cases, in which it has been well documented that parents do not always act in the child's best interest. In Parham v. J.R., however, the Court held that a child may be civilly committed if a physician independently concurs with the parents that the child requires admission; all that is required is a physician's co-signature.

Thus, although the Court felt that a competent minor's privacy rights outweighed parental rights in the area of abortion, it did not feel that a minor's liberty interests outweighed the rights of the parents in the civil commitment context. The Parham Court seems to have considered the "mentally ill" child facing commitment to be incompetent. The Court also

135. Appelbaum & Grisso, supra note 87, at 1637.
136. HOWARD COHEN, EQUAL RIGHTS FOR CHILDREN (1980).
137. See supra notes 99-100 and accompanying text.
139. See supra notes 8-10, 15-26 and accompanying text.
140. 442 U.S. 584 (1979).
141. One commentator also notes that the Court appears more willing to grant minors decisionmaking rights when the child is seeking to consent to treatment (as with abortion) than when the minor is seeking to refuse treatment (as commitment). Weithorn, supra note 76, at 250. Another commentator argues that the Court simply wants to limit the role of judges in managing mental health services or institutions. "The immediate future of psychiatric concerns before the Court . . . is likely to hinge on the justices' perceptions of the proper role of the judiciary in a society increasingly dependent on specialized groups possessed of specialized skills. Judges' roles, not psychiatrists' roles, are what are really at stake." Paul Appelbaum, The Supreme Court Looks at Psychiatry, 141 Am. J. Psychiatry 827, 834 (1984).
placed great reliance on medical judgment, holding that lack of judicial review is constitutional insofar as the determination is made by a "neutral physician." This deference to professional judgment may explain the apparent inconsistency between the decisions allowing minors to seek abortions without parental notification, and the Parham decision denying the right to consent to or refuse civil commitment. In the cases of both abortion and civil commitment, the Court appears to rely ultimately upon the judgment of the professional. As discussed earlier, however, professional judgment in the mental health context may be relatively unreliable and not completely "neutral," particularly when only one clinician makes the determination.

In the Parham decision, in its exercise of judicial notice (citing the "pages of human experience" and "common human experience"), the majority made "no fewer than fifteen empirical assumptions, many of them directly contrary to existing social science research." Empirical

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142. Parham v. J.R., 442 U.S. 584, 611 (1979). Compare this decision, however, to the Court's opinion in Fure v. Michael C., 442 U.S. 707, reh'g denied, 442 U.S. 887 (1979). In Michael C., the Court held that a probation officer could not waive Miranda rights on behalf of a child under his supervision. Id. at 724. Irene M. Rosenberg, The Constitutional Rights of Children Charged with Crime: Proposal for a Return to the Not So Distant Past, 27 UCLA L. Rev. 656, 698-99 (1980). This apparent discrepancy between the two decisions perhaps is explained by the fact that the Parham children were allegedly "mentally ill," therefore deemed incapable of mature decisionmaking.

143. Parham, 442 U.S. at 606-07.


145. See Parham, 442 U.S. 584, 608 ("What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case").

146. See supra notes 32-37 and accompanying text.


148. Id. at 609.

149. One author notes with concern the layman's willingness to rely upon one's own experience in making psychological judgments: There is probably no topic in connection with which the average layman is more ready to pronounce a judgment or express an opinion than that of psychology. We may be content to leave the intricacies of physics or chemistry or any other of the fundamental natural sciences to experts in these fields ... [but] [w]e are all under the necessity of acquiring and pressing into service a workable set of conceptions of human nature. Moreover, the materials with which psychology attempts to come to grips are immediately available in the form of our own thoughts and feelings and in the actions of others. We come readily to generalize from our experiences and to develop a set of beliefs concerning the operation of the human mind. The demand for working principles is so insistent that it is not surprising that hasty convictions, half-truths, even superstitions become lodged in our mental constitutions and sometimes are modified or expelled only with the greatest difficulty. ... In fact, unless we turn the searchlight of self-criticism upon these beliefs we may go on indefinitely, trusting our crude observations, never pausing to draw into question the processes whereby we form our prejudices and set up our standards.


150. Perry & Melton, supra note 8, at 635.
evidence refutes the assumptions that interests of the parents and child coincide, that children are not “dumped” into hospitals, that psychiatric hospitals are generally well-staffed and provide quality care, that children and family relationships will be harmed by an adversarial hearing, and that procedural safeguards do not decrease the incidence of inappropriate admissions.\textsuperscript{151}

If bypass procedures are provided to minors in the abortion context because of the privacy interests and potential harm involved, judicial review and bypass should also be available in the mental health context. (The dissent in Parham similarly suggested that Planned Parenthood, which afforded mature minors a right to make abortion decisions, should control.\textsuperscript{152}) Bypass procedures may be necessary to protect the child’s rights because parents often may not act in the child’s best interests\textsuperscript{153} and also because one clinician should not determine suitability for commitment, given the relatively unreliable nature of psychiatric diagnosis\textsuperscript{154} when measured against legal standards\textsuperscript{155} and potential conflicts of interest.\textsuperscript{156} Moreover, findings of mental illness or need for commitment are legal rather than medical conclusions.\textsuperscript{157}

In any case, it is clear that the Court has applied different standards for allowing minors to participate in treatment decisionmaking depending upon the Court’s balancing of parental rights, rights of the child, and the potential harm. Legal presumptions regarding the capacity of an individual child unilaterally to provide a legally valid consent, that is, one that is voluntary, knowing, and intelligent, should differ depending upon (1) the child’s age, (2) the type of treatment, and (3) who seeks to have the child treated. This approach is generally consistent with current legal practice, where courts weigh the child’s age, the potential for harm of a bad decision, and the type of treatment, in determining whether the minor is sufficiently “mature”\textsuperscript{158} to consent to treatment.

\textsuperscript{151} Id. at 634 n.8; \textit{see also} Redding, supra note 38.


\textsuperscript{153} See supra notes 8-26 and accompanying text.

\textsuperscript{154} See supra note 34 and accompanying text; \textit{see also} John E. Helzer et al., Reliability of Psychiatric Diagnosis II: The Test-Retest Reliability of Diagnostic Classification, 34 ARCH. GEN. PSYCHIATRY 136 (1977).

\textsuperscript{155} See, e.g., O’Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, J., concurring) ("There can be little responsible debate regarding the uncertainties of [psychiatric] diagnosis . . . and the tentativeness of professional judgment."); Addington v. Texas, 441 U.S. 418, 429 (1979) ("Given the lack of certainty and the fallibility of psychiatric diagnosis, there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and . . . dangerous.") (explaining rationale for applying lower "clear and convincing" evidentiary standard in civil commitment cases).

\textsuperscript{156} See supra notes 36-37 and accompanying text.

\textsuperscript{157} “Mental illness” is a legal label insofar as many state commitment statutes require that the individual be “mentally ill” and “dangerous,” and that the “dangerousness” be due to the mental illness. A legal determination must be made in moving from a diagnosis or behavioral description to a finding of “mentally ill” under the relevant statute.

\textsuperscript{158} Rozovsky, supra note 105, at 265-66.
VI. PROPOSED STATUTORY SCHEME

A. Statutory Presumptions

"It would be wiser to approach the child in quest of competency, rather than by presuming incompetence." 159

The statutory scheme outlined below represents guidelines for determining, either at common law or under a mature minor statute, whether a minor is mature enough to provide consent. Many states allow minors to consent to certain enumerated mental health treatments if the minor is deemed to be "mature." Other than defining in broad terms what is meant by maturity—for example, whether the minor can "understand and appreciate the consequences of the proposed treatment" 160—these laws provide no guidance on how actually to determine if a particular child is mature. The proposed statutory scheme is designed to meet this need. The statutory scheme could also be used to enact new state statutes or to reform age of consent-mature minor laws.

Absent clear and convincing evidence 161 either of capacity 162 (which would rebut a presumption of incompetence) or incapacity (which would rebut a presumption of competence), the following legal presumptions would operate for guiding the clinician's initial determination of "maturity" as well as a judge's determination, if there is judicial review. 163 The statutory presumptions regarding a minor's capacity to consent are specified for each type of treatment, with presumptions differing within each age group. 164 Presumptions also differ depending upon who is seeking the treatment, specifically, whether the child is independently seeking treatment or an adult is seeking treatment for the child.

The statutory scheme is based upon a balancing approach that considers the risks and benefits of the treatment, the competence of the child, the legal rights afforded the consenting individual, the rights of the child, and parental rights. One or more of these key factors may be especially relevant

160. See, e.g., Ark. Code Ann. § 82-363(q) (Michie 1985) (defining maturity as ability to "understand and appreciate the consequences of the proposed treatment").
161. The "clear and convincing" standard of proof is used in determining capacity, as this is the legal standard most commonly required in competency proceedings, John Parry, Incompetency, Guardianship, and Restoration, in The Mentally Disabled and the Law 369, 382 (Samuel J. Brakel et al. eds., 3d ed. 1985), and is the constitutionally required standard of proof for civil commitment. Addington v. Texas, 441 U.S. 418, 432-33 (1979).
162. See supra note 83 and accompanying text.
163. Note that the term "consent" here refers to a child's voluntary consent either to receive or to refuse treatment.
164. The proposed scheme suggests legal presumptions which should operate to determine a minor's maturity, but they differ according to the age ranges specified, thus combining a minimum age approach with a maturity or capacity approach.
in a particular situation, and one factor may be controlling or of greater importance than the others (indicated in bold):

I. VOLUNTARY CIVIL COMMITMENT

A. Age 15 and over

1. If state law requires child's consent for voluntary commitment, it should be presumed that the child is not competent to consent. This triggers involuntary commitment procedures in most cases that provide for judicial review. Effect: Child cannot be committed without judicial review, unless there is clear and convincing evidence that the child is psychologically competent to consent to voluntary commitment, and the child does so.

   Key factors:
   Age: Children may have difficulty giving voluntary consent at this age, given the treatment.
   Treatment: Potentially very risky, with few advantages over other types of treatment.
   Parent v. child: Parent may seek commitment for the child and coerce the child to consent.

2. If state law does not require child's consent for voluntary commitment, the child can provide consent. This provides the child with the possibility of participating in the decision. Effect: The parent can have the child committed without his or her consent and without any judicial review. However, by voluntarily consenting, the child can exercise the right independently to seek discharge and petition for judicial review, or refuse certain medical treatments while in the hospital.

   Key factors:
   Treatment: Potentially very risky, with few advantages over other types of treatment.

B. Age 11-14

1. If state law requires child's consent for voluntary commitment, the child cannot provide consent.

   Effect: Child cannot be committed without judicial review.

   Key factors:

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165. See, e.g., N.M. STAT. ANN. § 43-1-16(c) (Michie 1978):
To have a minor voluntarily admitted for residential treatment in a residential program for a mental disorder, the minor and his parent or guardian shall knowingly and voluntarily execute, prior to admission, a minor's voluntary consent to admission document. The document shall include a clear statement of the minor's right to voluntarily consent or refuse to consent to his admission, his right to request an immediate discharge from the residential treatment program at any time and his rights should he request a discharge and his physician, certified psychologist or the director of the residential treatment facility determines the minor needs continued treatment. Each statement shall be clearly explained, and each statement shall be initialed by the minor and his parent or guardian.

(emphasis added).
Age: Children of this age probably will not be able to resist coercive pressures, and thus will be unable to provide voluntary consent.

Treatment: Potentially very risky, with few advantages over other types of treatment.

Parents v. child: Parent may seek commitment for child and coerce child to consent.

2. If state law does not require child's consent for voluntary commitment, the child can provide consent.

Effect: The parent can have the child committed without his or her consent and without any judicial review. However, by voluntarily consenting, the child can exercise the right independently to seek discharge and petition for judicial review, or refuse certain medical treatments while in the hospital.

Key factors:

Treatment: Potentially very risky, with few advantages over other types of treatment.

C. Under 11

1. If state law requires child’s consent for voluntary commitment, the child cannot provide consent.

Effect: Child cannot be committed without judicial review.

Key factors:

Age: Children at this age will not be able to resist coercive pressures.

Treatment: Potentially very risky, with few advantages over other types of treatment.

Parents v. child: Parent may seek commitment for child and coerce child to consent.

2. If state law does not require child’s consent for voluntary commitment, the child can provide consent.

Effect: The parent can have the child committed without his or her consent and without any judicial review. However, by voluntarily consenting, the child can exercise the right independently to seek discharge and petition for judicial review, or refuse certain medical treatments while in the hospital.

Key factors:

Treatment: Potentially very risky, with few advantages over other types of treatment.

II. OUTPATIENT PSYCHOTHERAPY

A. Age 15 and over

1. When sought by the child: The child can provide consent.

Effect: A child can unilaterally seek and receive treatment, even when the child’s psychological competence to consent may be questionable.166

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166. Allowing children of questionable competence to seek treatment effectively gives
Key factors:
*Age:* Children 15 and over are psychologically competent.
*Personhood:* Even if competency is questionable, children of this age should be allowed independently to seek this form of treatment, out of respect for their "personhood."
*Treatment:* Entails relatively few risks and potentially great benefits.
*Privacy:* Adolescents might not seek treatment if no guarantee of confidentiality.

2. **When sought by the parent or guardian:** It should be presumed that the child is *competent* to consent.

*Effect:* A child can refuse treatment against a parent’s wishes, unless there is clear and convincing evidence that the child is psychologically incompetent to do so.

Key factors:
*Age:* Children 15 and over generally are psychologically competent.
*Treatment:* Entails relatively few risks and potentially great benefits.
*Parents v. child:* Parents often may seek therapy for their child when the child needs it but does not want it. Because of the relatively few risks entailed, a child should not be able to veto the parent’s consent when the child’s competence clearly is questionable.

B. **Age 11-14**

1. **When sought by the child:** It should be presumed that the child is *competent* to consent.

*Effect:* A child can unilaterally seek and receive treatment, unless there is clear and convincing evidence that the child is psychologically incompetent to do so.

Key factors:
*Age:* Many children at this age are likely to be psychologically competent.
*Treatment:* Entails relatively few risks and potentially great benefits.
*Privacy:* Adolescents might not seek treatment if no guarantee of confidentiality.

2. **When sought by the parent or guardian:** It should be presumed that the child is *not competent* to consent.

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Children at this age the same right to seek treatment as adults. Adults are presumed legally competent generally, and not just in certain limited contexts, as with minors. Adults who are cognitively incompetent are routinely allowed to provide consent, out of respect for their "personhood" as adults. With children, however, questions of psychological competency frequently arise even when laws allow "mature" minors to consent and even when the minor appears relatively competent. *But see* Zinermon v. Burch, 494 U.S. 113 (1990) (holding that consent obtained from patient not competent to provide consent for voluntary commitment to state hospital violates due process rights, giving rise to civil rights claim under 42 U.S.C. § 1981).
Effect: A child cannot refuse treatment against the parent’s wishes, unless there is clear and convincing evidence that the child is competent to do so.

Key factors:
Treatment: Entails relatively few risks and potentially great benefits.
Parents v. child: Parents often may seek therapy for their child when the child needs it but does not want it. Because of the relatively few risks entailed, a child should not be able to veto the parent’s consent, unless he or she clearly is competent to do so.

C. Under 11

1. When sought by the child: It should be presumed that the child is not competent to consent.

Effect: A child cannot independently consent to treatment unless there is clear and convincing evidence that the child is competent to do so.

Key factors:
Age: Most children under the age of 11 are generally not psychologically competent.

2. When sought by the parent or guardian: The child cannot provide consent.

Effect: A child cannot refuse treatment against the parent’s wishes.

Key factors:
Age: Most children under the age of 11 are generally not psychologically competent.
Treatment: Entails relatively few risks and potentially great benefits.
Parents v. child: Parents often may seek therapy for their child when the child needs it but does not want it. Because of the relatively few risks entailed, a young child should not be able to override parental wishes that the child receive treatment.

III. OUTPATIENT PSYCHOTROPIC MEDICATION

A. Age 15 and over

It should be presumed that the child is competent to consent.

Effect: A child can refuse treatment against a parent’s wishes, unless there is clear and convincing evidence that the child is psychologically incompetent to do so.

Key factors:
Age: Children 15 and over generally are psychologically competent.
Treatment: Potentially quite risky, but does not entail same curtailment of liberty as does civil commitment.

167. The author is assuming that a child would not independently seek this type of treatment, as in the case of outpatient psychotherapy.
Parents v. child: Parents may seek such treatment for the child, using it as an easy mechanism of behavior control.

B. Age 11-14

It should be presumed that the child is not competent to consent. Effect: A child cannot refuse treatment against a parent’s wishes, unless there is clear and convincing evidence that the child is psychologically competent to do so.

Key factors:
Treatment: Potentially quite risky, but does not entail same curtailment of liberty as does civil commitment.

Parents v. child: Parents may seek such treatment for the child, using it as an easy mechanism of behavior control. Often, however, parents may seek treatment for their child when the child needs it but does not want it. Because the treatment does not involve the same liberty interests as civil commitment and because it may be very effective, a child should not be able to veto the parents’ consent unless clearly competent to do so.

C. Under 11

It should be presumed that the child is not competent to consent. Effect: A child cannot refuse treatment against a parent’s wishes, unless there is clear and convincing evidence that the child is psychologically competent to do so.

Key factors:
Treatment: Potentially quite risky, but does not entail same curtailment of liberty as does civil commitment.

Parents v. child: Parents may seek such treatment for the child, using it as a mechanism of behavior control. Often, however, parents may seek therapy for their child when the child needs it but does not want it. Because the treatment does not involve the same liberty interests as civil commitment and because it may be very effective, a child should not be able to veto the parent’s consent unless clearly competent to do so.

Several considerations guided the formulation of the stated presumptions (see the Appendix for proposed model statutes), derived from a balancing of factors. These factors—age and type of treatment (and who seeks the treatment)—are discussed below.

B. Age

"It is easy to tell when an individual is eighteen; it is hard to know when an individual is mature."
Age-related presumptions should be based upon current scientific evidence on children's abilities at various ages. First, it is important to note that there is variability in how children's abilities develop and change, with some children being below or above the relative age-norm. Age-related presumptions, therefore, should be rebuttable, allowing a child of any age to consent if capacity can be clearly demonstrated. For reasons discussed below, civil commitment of minors under the age of fifteen would be the one exception.

There appear to be important differences in children's competence among definable age ranges, beginning with pre-adolescence (below age eleven), followed by early adolescence (ages eleven through fourteen), and late adolescence (fifteen and older). The age ranges correspond very roughly to the concrete-operational (pre-adolescence) and formal operational stages of cognitive development a la Piagetian stage theory.

**Age 15 and Above.** Regardless of the standard of capacity used, research shows that by the age of about fourteen or fifteen, most children will demonstrate full adult competence. For this reason, the general presumption is that children fifteen and over are capable of providing informed consent. Children at this age can hypothesize about future events and consider long-term consequences, weigh multiple factors simultaneously in

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170. When considering scientific evidence on children's abilities, it should also be noted that since most current research on children's competence to participate in treatment decision-making has been with reference to white, middle class populations, applying such findings to other ethnic and socioeconomic groups should be done with caution, Weithorn & Campbell, supra note 62, at 1596. Research suggests that children from lower socio-economic groups may be somewhat slower in their development of moral reasoning, Gary B. Melton, Teaching Children About Their Rights [hereinafter Melton, Teaching Children], in The Rights of Children: Legal and Psycholegal Perspectives 163-66 (James S. Henning ed., 1982), and are less likely to understand how they can exercise their rights. Gary B. Melton, Children's Concepts of Their Rights, 9 J. CLINICAL CHILD PSYCHOL. 186 (1980) [hereinafter Melton, Children's Concepts].


172. For a summary of children's understandings and abilities at various ages based upon a Piagetian approach, see Thomas Grisso & Linda Vierling, Minors' Consent to Treatment: A Developmental Perspective, PROF. PSYCHOL., Aug. 1978, at 412; REDDING, supra note 38; Judith V. Torney, Socialization of Attitudes Toward the Legal System, in LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY 134 (June L. Tapp & Felice J. Levine eds., 1977); see also Roger Bibace & Mary E. Walsh, Developmental Stages in Children's Concepts of Illness, in HEALTH PSYCHOLOGY—A HANDBOOK (George C. Stone et al. eds., 1980).

173. See Grisso & Vierling, supra note 172, at 412; Weithorn & Campbell, supra note 62, at 1596.

174. Although 14 is generally cited as the age by which most children are able to participate fully in treatment decisionmaking, one well-designed and frequently cited study found that while children 16 and older understood their legal rights as well as adults, children under 15 had significantly lower levels of understanding. Thomas Grisso, Juveniles' Capacity to Waive Miranda Rights: An Empirical Analysis, 68 CAL. L. REV. 1134 (1980).
making a decision, understand probabilities, and fully understand the links between actions and consequences. As a result, they generally will be able to understand, appreciate, and evaluate the more abstract treatment and legal concepts, and understand how the vested interests of various professionals can affect the advice they give.

Ages 11 to 14. Children between the ages of ten or eleven and fourteen often are capable of mature decisionmaking, but this depends greatly upon situational factors and the complexity of the issues. For example, twelve-year-olds are able to define accurately relatively simple legal terms, for example, witness, evidence, objection, but there is great variability between children in their ability to define and understand more difficult legal terms, for example, testify, charges, allegation. For this reason, the general presumption for children in this age range is that they are probably capable of providing informed consent. Because the capacity of a child at this age is much more uncertain, however, the presumptions for this group err on the side of caution, framed in terms of what best protects the child’s legal due process rights.

Below Age 11. Below the age of about eleven, research suggests that most children are not capable of providing informed consent. Because younger children have difficulty in imagining circumstances that differ from prior experience, in understanding abstract concepts, and in thinking hypothetically, they may not be able to understand long-term risks and benefits or the right to consent or refuse to consent. Nine-year-olds, for instance, appear to have a minimally adequate factual understanding of treatment risks and benefits and of the differences between various diagnoses and prognoses; but they often lack appreciation of the practical significance of their legal rights and have difficulty in evaluating treatment risks, benefits, and alternatives. Additionally, younger children are especially

175. Weithorn & Campbell, supra note 62, at 1590.
176. Catherine C. Lewis, How Adolescents Approach Decision: Changes Over Grades Seven to Twelve and Policy Implications, 52 Child Dev. 538 (1981) (finding significant increase in tendency to seek second opinion between grades seven and twelve).
177. See generally CHILDREN'S COMPETENCE, supra note 3; Gardner et al., supra note 58; Grisso & Vierling, supra note 172; Lewis, supra note 176.
178. Saywitz et al., supra note 70, at 527-29. For a developmental theory of children’s understanding of legal rights and the legal system, see LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY, supra note 172. For empirical research on children's understanding of the legal system, see Karen Saywitz, Children's Conceptions of the Legal System: “Court is a Place to Play Basketball,” in PERSPECTIVES ON CHILDREN'S TESTIMONY 131 (S.J. Ceci et al. eds., 1989); Amye Warren-Leubecker et al., What Do Children Know About the Legal System and When Do They Know It? First Steps Down a Less Traveled Path in Child Witness Research, in PERSPECTIVES ON CHILDREN'S TESTIMONY, supra, at 158.
179. See, e.g., Lewis, supra note 176.
180. Weithorn & Campbell, supra note 62.
181. Roberts et al., supra note 69.
183. Weithorn & Campbell, supra note 62.
susceptible to coercive pressures from authority figures\textsuperscript{184} and base their decisionmaking upon the desire to avoid punishment or criticism.\textsuperscript{185} These factors make it difficult for them to provide truly voluntary consent.

Thus, the general presumption for children below age eleven is that they will not be able to provide informed consent. However, because some children will have the capacity to provide consent in certain contexts, the presumptions are not conclusive, except for civil commitment, discussed below, and therefore may be rebutted by clear and convincing evidence. This approach is consistent with the view that maturation is a process that develops at different rates for different individuals; there is no arbitrary boundary between the incompetent child and the competent child-or adult.\textsuperscript{186}

\textbf{C. Type of Treatment}

"Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent... The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."\textsuperscript{187}

A particularly important consideration is the potential harm likely to result either from an erroneous determination of competence or from an erroneous treatment decision by the child. In large measure, the degree of danger is a function of the type of treatment at issue and who seeks the treatment.\textsuperscript{188}

\textit{Voluntary Civil Commitment.} Civil commitment to a mental institution, even for a short time period, constitutes a "massive curtailment of liberty."\textsuperscript{189} Given this fact, the law should discourage the inpatient treatment of children as a matter of public policy.\textsuperscript{190} While commitment may be the best dispositional alternative for a small percentage of children for whom


\textsuperscript{185} See \textit{LAW, JUSTICE, AND THE INDIVIDUAL IN SOCIETY}, supra note 172.

\textsuperscript{186} See \textit{ZIMRING}, supra note 45, at 103-04.


\textsuperscript{188} The issue of who is seeking treatment involves the distinction between the right to choose for oneself versus the right to be free from the decisions of others. Andrew J. Kleinfield, \textit{The Balance of Power Among Infants, Their Parents, and the State}, 4, 5 \textit{FAM. L.Q.} 320-49, 410-43, 64-107 (1970, 1971).

\textsuperscript{189} Humphrey v. Cady, 405 U.S. 504, 509 (1972). \textit{But see Parham v. J.R.}, 442 U.S. 584, 624 (1979) (Stewart, J., concurring) ("I can perceive no basic constitutional differences between commitment to a mental hospital and other parental decisions that result in a child's loss of liberty").

\textsuperscript{190} Melton, \textit{supra} note 122, at 69 (interpreting Preamble, Articles 9 and 25, and other provisions of \textit{U.N. Convention on the Rights of the Child} as implying a presumption against residential placement). The Preamble states that children should "grow up in a family environment." Article 9 provides for judicial review when a child is placed outside the home, and Article 25 provides for periodic judicial review following institutionalization.
it is sought, it is not so for the great majority. A large percentage of hospitalized youth are inappropriately placed, as they are simply delinquent or difficult to handle and do not have severe disabilities. United States Senator Daniel Inouye stated that "our traditional emphasis on inpatient care may be inappropriate and even detrimental for many mentally disturbed children. A large percentage of children placed in hospitals either never should have been admitted to the institution or remain too long."

Many commentators have noted with concern the very dramatic increase over the last decade in the inpatient treatment of children. Reasons for this increase may include a lack of adequate community mental health services and an increase in profit-making children's psychiatric hospitals.

191. AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY, CHILD AND ADOLESCENT PSYCHIATRIC ILLNESS: GUIDELINES FOR TREATMENT RESOURCES, QUALITY ASSURANCE, PEER REVIEW AND REIMBURSEMENT (1987) (commitment is alternative of last resort, appropriately restricted to children who are dangerous or who exhibit severe functional impairment).


193. Emerging Trends in Mental Health Care for Adolescents: Hearing on H.R. 32, 99th Cong., 1st Sess. (1985); Metz, supra note 10, at 22, 28 (reporting results of recent Children's Defense Fund study finding that 40% or more of juvenile admissions to private psychiatric hospitals are inappropriate, and that in 1988, Blue Cross and Blue Shield of Minnesota found that adolescents were hospitalized on average twice as long as was necessary); Lois A. Weithorn, Mental Hospitalization of Troublesome Youth, An Analysis of Skyrocketing Admission Rates, 40 STAN. L. REV. 773, 831-34 (1988).


195. The term "children with disabilities" is used rather than "mentally ill," to emphasize that the term "mental illness" can be stigmatizing.


198. See Metz, supra note 10, at 28; Weithorn, supra note 193, at 816-20, 829-30.
Such factors may bias clinicians’ judgments regarding the suitability of commitment and may be used to rationalize commitments which do not meet statutory criteria.

Moreover, inpatient treatment may be of questionable efficacy even for children with severe mental disabilities. Community-based treatment is often more effective than hospitalization, since those receiving community-based care generally have fewer symptoms and greater life satisfaction, particularly as compared to institutionalized patients having similar or identical diagnoses and prognoses. The very significant potential negative effects of psychiatric hospitalization, abuse of the commitment process by parents and even clinicians, as well as problems of inappropriate admissions because of frequent diagnostic and prognostic errors by the admitting clinician, have all been well documented. In spite of these concerns, under the voluntary commitment procedures of many states, the child can be committed indefinitely simply upon the parent’s request and as long as a clinician or facility director concurs, with no judicial review required upon initial commitment.

These are all reasons to favor a presumption of incapacity in states where a child’s consent or assent is necessary for voluntary commitment.


200. See, e.g., Charles D.H. Parry et al., Commitment and Recommitment: Shortcomings in the Application of the Law, 9 Developments in Mental Health L. 25 (1989) (noting that as much as 55% of time, jurisdictions in Virginia do not comply with statutory requirement that less restrictive treatment alternatives be explored).


204. An older, but very famous study, found that hospital psychiatrists misdiagnosed ostensibly “normal” individuals (who were actually “confederates” of the scientists conducting the study) as mentally ill and in need of hospitalization. Even after they were admitted to the hospital, the psychiatrists did not discover the diagnostic error. D. L. Rosenhan, On Being Sane in Insane Places, 179 Science 250 (1973); see also Douglas A. Davis, On Being Detectably Sane in Insane Places: Base Rates and Psychodiagnosis, 38 J. Abnormal Psychol. 416 (1976).

205. For reviews, see Redding, supra note 38; Weithorn, supra note 193. See also Perry & Melton, supra note 8, at 648-60.

206. Under Parham v. J.R., 442 U.S. 584, 616, 619 (1979), periodic institutional review of the need for continuing confinement is required, however. The Court also intimated that greater due process protections might be necessary for children who are committed as wards of the state.

Voluntary commitment, where the individual is coerced or threatened into voluntarily consenting, is frequently used as a vehicle for avoiding the hearing typically required for an involuntary commitment.\(^{208}\) Therefore, in order to protect a child's due process rights,\(^{209}\) the presumption for children fifteen and over should be that the child is not competent to consent voluntarily.\(^{210}\) This would trigger a judicial or administrative review\(^{211}\) under the involuntary commitment procedures of most states,\(^{212}\) and thus possibly provide the child the opportunity to express his or her views.\(^{213}\)

may be admitted for inpatient treatment only if application is signed by both minor and parent or guardian; Iowa Code Ann. § 229.2 (West 1985 & Supp. 1992) (stating that if parent requests admission for child and medical officer determines it is appropriate, but minor objects, parent must petition juvenile court for approval); WA. Rev. Code Ann. § 71.34.030 (West 1985 & Supp. 1992) (stating that to commit minor over age of 13 voluntarily, child must provide written consent, and that once voluntarily admitted, minor has right to release upon next judicial day, unless treatment facility files petition in juvenile court).


209. Article 9, § 1 of the United Nations Convention on Rights of the Child states in part that "States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child." G.A. Res. 44/25, supra note 119, at 12, *reprinted in* 28 I.L.M. 1460. Section 2 further provides that "In any proceedings pursuant to [section] 1, all interested parties shall be given an opportunity to participate in the proceedings and make their views known." *Id.*

210. The distinction between voluntary and involuntary commitment is important, but often illusory. Voluntary patients can leave the hospital, while involuntary patients must seek discharge through habeas corpus petition to the courts or at periodic institutional review hearings. "Voluntary" admissions, however, are usually coerced under threat of involuntary commitment, and juveniles who are voluntarily committed nevertheless often need parental consent for discharge. *See generally* Ellis, supra note 32, at 845-48; Brakel, supra note 208.

211. A survey of 316 clinical psychologists found that most felt a patient's rights would best be protected if a commitment decision were made by an independent review board consisting of lawyers and clinicians not associated with the case or the institution. Lynn R. Kahle & Bruce D. Sales, *Attitudes of Clinical Psychologists Toward Involuntary Civil Commitment Law*, Prof. Psychol. 428, 433-34 (1978).

212. *See, e.g.*, Mont. Code Ann. § 53-21-112(4) (1989 & Supp. 1991) (if minor age 16 or over does not consent to commitment, involuntary commitment procedures are automatically triggered). It should be noted that in the case of the adult respondent, there are disadvantages to being committed involuntarily. A voluntary adult patient can sign him- or herself out of the hospital upon giving notice. Although some state statutes provide that minors can consent to voluntary commitment and can also voluntarily sign out of the hospital, few expressly allow for the latter. *Contra, e.g.*, Mont. Code Ann. § 53-21-112(3) (1989 & Supp. 1991) (minor who applied for admission may request discharge on own behalf); W. Va. Code § 27-4-1 (1986). Even where the child is able to voluntarily seek discharge, it is unlikely that a child would independently seek to do so, or that continued commitment would not then be sought under the involuntary commitment procedures. *But see* Melville v. Sabbatino, 313 A.2d 886 (Conn. Super. Ct. 1973) (17-year-old minor petitions for release under voluntary admission statute despite parental objections).

213. It should be noted that in some states, the right to judicial review under the involuntary commitment procedures applies only to state institutions, not private psychiatric hospitals. This is consistent with the principle that constitutional due process concerns need attach only when there is some state action involved.
One study which presented children with a hypothetical situation concerning a child suffering depression, and treatment, options found that while none of the twenty-one-year-olds and only sixteen percent of the fourteen-year-olds preferred inpatient over outpatient or no treatment, fifty percent of the nine-year-olds chose inpatient commitment. The researchers speculated that this is due to the dependency typical of younger children.214 For this reason, as well as the uncertainty surrounding their competence to provide informed consent, children below the age of fifteen should not be allowed to consent to voluntary commitment.

However, the presumptions should differ when state law does not require the child’s consent or assent for voluntary commitment.215 Such laws allow parents to commit their child without the child’s consent and without any initial judicial review. Given this, a child’s refusal to consent would not trigger the involuntary commitment procedures that require judicial review. Allowing the child to consent under these circumstances, however, may have some potential benefits once the child is hospitalized. In many states, when the child consents to voluntary commitment, he or she can independently seek discharge216 or refuse certain inpatient treatments.

Outpatient Psychotherapy. Outpatient psychotherapy or counseling raises quite different concerns than does inpatient commitment. First, it is a much less restrictive alternative.217 Second, there is no significant deprivation of liberty, although significant privacy interests are involved. Third, while few children capable of mature decisionmaking desire commitment,218 troubled youths do voluntarily seek out counseling services.219 Children seeking treatment without parental involvement can be served at government-funded community mental health centers, which will typically charge the minor either a nominal fee or no fee. Even if the child is only marginally competent, the benefits of allowing a child unilaterally to seek outpatient therapy may be substantial.220 Many states, for example, allow minors as

214. Weithorn & Campbell, supra note 62, at 1596.
216. See supra note 212.
217. It should be noted that involuntary outpatient commitment has received increasing attention recently as an alternative to civil commitment. As court-ordered outpatient treatment, it typically requires lower standards of proof and includes more expansive eligibility criteria than does inpatient commitment. See generally Edward P. Mulvey et al., The Promise and Peril of Involuntary Outpatient Commitment, 42 AM. PSYCHOLOGIST 571 (1987).
218. See supra note 214 and accompanying text.
219. See Melton, supra note 79, at 34; Gary B. Melton, Effects of a State Law Permitting Minors to Consent to Psychotherapy, 12 PROF. PSYCHOL. 647 (1981) [hereinafter Melton, Effects of a State Law].
220. Psychotherapy is not risk-free, however. Some have argued that even verbal psychotherapy can sometimes have serious iatrogenic effects, including a deterioration in the symptoms or functioning in a small percentage of patients, due to the stress of therapy or changes in behavior, affect, or attitude induced by the therapy. This so-called “deterioration effect” has been found in a number of studies. See, e.g., Allen E. Bergin, The Evaluation of Therapeutic Outcomes, in HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE 217 (Allen E. Bergin &
young as twelve independently to seek treatment for substance abuse because of the strong policy interests in promoting health in these areas. Six to eight million children have a mental health problem requiring treatment, but fewer than one-half receive treatment.

There are similar important policy interests in encouraging children in need to seek therapy. One way to do this is to protect their privacy in the therapeutic relationship by allowing them independently to seek outpatient treatment. Research has shown that even very young children value their privacy. In fact, data suggests that adolescents may be more likely to seek therapy if their privacy was protected by a policy of not notifying their parents.

Courts have recognized the very personal nature of psychotherapy, and requiring parental consent may be countertherapeutic in a variety of situations.

Sol L. Garfield eds., 1971) (reviewing over thirty studies which found a deterioration effect); Suzanne W. Hadley & Hans H. Strupp, Contemporary Views of Negative Effects in Psychotherapy, 33 Arch. Gen. Psychiatry 1291 (1976). "Critics for psychotherapy have long recognized that psychotherapy has the potential for harm as well as for cure and that 'therapy may lead one into health, but it may also be a part of the complex process that ends up driving one crazy,'" Barry R. Furrow, Malpractice in Psychotherapy 9 (1980) (citing Bergin, supra, at 251). Some have also questioned the effectiveness of psychotherapy. See, e.g., Martin L. Gross, The Psychological Society (1978). But see Mary L. Smith & Gene V. Glass, Meta-Analysis of Psychotherapy Outcome Studies, 32 Am. Psychologist 752 (1977) (analysis of 400 studies, finding that most patients are helped by therapy). The child may also suffer lifelong stigma and employment discrimination if the psychotherapy results in a psychiatric record or a psychiatric diagnosis, particularly in the case of serious mental illness. Catherine E. Rosen et al., The Stigma of Patienthood, in Psychiatric Patient Rights and Patient Advocacy, supra note 38, at 59-82.


Rozovsky, supra note 105, § 5.4, at 275-76.

Leonard Saxe et al., Children's Mental Health: The Gap Between What We Know and What We Do, 43 Am. Psychologist 800 (1988).


Melton, supra note 79, at 34.

Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955) ("Psychotherapy probes the core of the patient's personality. The patient's most intimate thoughts and emotions are exposed during the course of the treatment ... The psychiatric patient confides [in his therapist] more utterly than anyone else in the world.... [He] lays bare his entire self, his dreams, his fantasies, his sin, and his shame") (quoting Manfred S. Guttman & Henry Weinbogen, Psychiatry and the Law 272 (1952)); Caesar v. Mountanos, 542 F.2d 1064, 1071-72 (9th Cir. 1976) (Hufstedler, J., dissenting) ("[t]he possibility that the psychotherapist could be compelled to reveal those communications to anyone ... can deter persons from seeking needed treatment and destroy treatment in progress") (citing Jay Katz et al., Psychoanalysis, Psychiatry, and Law 726-27 (1967).
respects. One survey of forty-one community mental health clinics in Virginia found that the most common problems of children who independently sought treatment were family problems including abuse (twenty-nine percent), drug and alcohol abuse (twenty-seven percent) and sexual matters including pregnancy and incest (twenty-four percent).228 Requiring parental consent may deter the child from seeking treatment, particularly concerning these types of problems. It may also intensify family conflict and stress,229 or in some cases even result in greater psychological problems for the child if parents reject the child’s plea for help or become overly intrusive in his or her affairs. One commentator notes, however, that minors who seek therapy independently may be the very ones with parents most likely to sue a therapist if they do learn that their child is undergoing treatment.230

Because constitutional privacy rights may be implicated in the therapist-patient relationship, allowing a child independently to consent to outpatient therapy may have a constitutional basis. First Amendment rights are also potentially implicated in allowing children independently to seek treatment.231 Verbal therapies arguably entail First Amendment freedom of speech. Moreover, an untreated mental illness may impair freedom of thought, just as involuntary treatment may.232 For this reason, several state and federal courts have found a constitutional right independently to seek to control one's mental health treatment.233 Moreover, in Whalen v. Roe,234 the United States Supreme Court identified two distinct privacy interests grounded in the Fourteenth Amendment: avoiding disclosure of personal confidential matters, and individual autonomy in decisionmaking involving fundamental rights.235 Allowing children to provide unilateral informed consent protects

228. Melton, Effects of a State Law, supra note 219, at 652.

229. See Peter Freilberg, Parental-notification Laws Termed Harmful, APA MONITOR, Mar. 1991, at 28 (citing recent testimony to Congress by Jeanne Marecek, chairwoman of psychology department at Swarthmore College, discussing laws requiring minors to obtain parental notification to obtain abortion).

230. John E.B. Myers, Legal Issues Surrounding Psychotherapy with Minor Clients, 10 CLINICAL SOC. WORK J. 303, 308 (1982) (arguing that “parents unable or unwilling to communicate effectively with their troubled child may be the very ones most readily to seek redress against the therapist for ‘interfering’”).


232. Shields v. Burge, 874 F.2d 1201, 1212-13 (7th Cir. 1989) (Cudahy, J., concurring) (“Freedom of thought is intimately touched upon by any regulation of procedures affecting thought and feelings. . . . [T]he state has put procedural and substantive obstacles in the path of those who both need and desire certain forms of treatment, and in that way their freedom of thought remains impaired because they cannot get treatment. . . .”) (citing Aden v. Younger, 57 Cal. App. 3d 662, 679-80 (1976), concerning state statute restricting electroconvulsive therapy and psychosurgery).


235. Id. But see Fadjo v. Coon, 633 F.2d 1172, 1175-77 (5th Cir. 1981) (commenting that privacy interest in confidentiality is broader than privacy interest in autonomous decisionmaking because latter is limited to fundamental rights involving family privacy).
CHILDREN'S COMPETENCE

both privacy interests. Several courts have held that these privacy rights extend to the relationship between psychiatrist and patient. Preserving the confidentiality and privacy of this special relationship recognizes the personhood of children, and courts have recognized doctor-patient privilege when the patient was a minor. Some would argue, however, that parents also should have certain basic rights, including the right to be informed when their child is receiving treatment or to be involved in such treatment.

For these reasons, and also because outpatient treatment does not involve a deprivation of liberty, as does inpatient commitment, it is suggested that children ages fifteen and over be given the unqualified right to consent unilaterally to outpatient treatment on an unlimited basis or, refuse treatment if therapy is requested by the parent. Since it appears that therapists often treat minors without parental consent, the proposed law simply conforms to widespread clinical practice. The Pediatric Bill of Rights,

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236. Although the right to privacy has been extended to minors, it has been circumscribed. See Carey v. Population Servs. Int'l, 431 U.S. 678, 693 n.15 (1977). The Court stated that State restrictions inhibiting privacy rights of minors are valid only if they serve any significant state interest . . . that is not present in the case of an adult. This test is apparently less rigorous than the 'compelling state interest' test applied to restrictions on the privacy rights of adults. Such lesser scrutiny is appropriate both because of the States' greater latitude to regulate the conduct of children, and because the right of privacy implicated here is the interest in independence in making certain kinds of important decisions, and the law has generally regarded minors as having a lesser capability for making important decisions.

Id.


238. See AMERICAN PSYCHOLOGICAL ASSOCIATION, Ethical Principles, Principle 5: Confidentiality, § d (1985) ("When working with minors . . . psychologists take special care to protect these persons' best interests.").


240. See, e.g., CAL. CIVIL CODE § 25.9 (West 1982) ("Consent of the parents is not required but the professional shall attempt to involve the minor's parents unless such involvement would be inappropriate." (providing that mature minors 12 and over may consent to outpatient treatment if a victim of incest or abuse, or dangerous to self or others)).

241. One survey of 41 community mental health clinics in Virginia found that many clinics treated minors without parental consent or notification well before a law was passed providing children with this right, and only about 12% notified the parents. (This is consistent with a much older survey showing that about 75% of mental health services in Massachusetts treated adolescents without parental consent). About 20% of the clinics, however, try to determine the reasons why the child does not want parental involvement, and about 29% limit the number of sessions which the child can attend without notifying parents. Melton, Effects of a State Law, supra note 219; see also JOHN P. WILSON, THE RIGHTS OF ADOLESCENTS IN THE MENTAL HEALTH SYSTEM (1978).
promulgated by the National Association of the Children's Hospital, provides that "[e]very person, regardless of age, shall have the right to seek out and receive psychiatric care and counseling."\textsuperscript{242} The Juvenile Justice Standards promulgated by the American Bar Association suggest that minors fourteen and older be allowed to consent to outpatient treatment, but only for three sessions, for the limited purposes of crisis intervention or diagnosis.\textsuperscript{243} Currently, however, only New Mexico and Virginia allow children of any age the unqualified right unilaterally to consent to outpatient psychotherapy without parental notification.\textsuperscript{244} For children between eleven and fourteen, the presumption should be that the child is competent to consent, if the child unilaterally and voluntarily seeks treatment.

When treatment is sought by the parent on behalf of the child, however, the presumption should be that the child is not competent to consent, that is, unable to refuse treatment against parental wishes.\textsuperscript{245} This presumption avoids placing undue obstacles on obtaining treatment for children who need it. Undue obstacles should be avoided with older children, also, but because of the compelling evidence of their competence, the age factor should control. Thus, older children should be presumed competent, whereas younger children should be presumed incompetent, or not allowed to provide consent when treatment is sought by the parent.

Indeed, a key consideration of the \textit{Parham} Court was to avoid placing obstacles in the way of needed commitment. Because of the very significant liberty interest involved in civil commitment, the child's best interests are promoted when some obstacles are placed in the road to commitment— it should not be easy to institutionalize a child. There are no compelling reasons, however, for placing procedural obstacles in the way of outpatient care.\textsuperscript{246} Children's interests would seem to be best served when they are allowed to seek outpatient treatment when they feel they need it, but not generally afforded the absolute right to refuse it\textsuperscript{247} when parents feel they

\textsuperscript{242} National Association of the Children's Hospital, Pediatric Bill of Rights, Canon V (1974).
\textsuperscript{243} Standards Relating to Rights of Minors Part IV, § 4.9 (Institute of Judicial Administration—ABA Joint Comm’n on Juvenile Justice Standards (1980)).
\textsuperscript{244} N.M. Stat. Ann. § 43-1-17A (Michie 1978); Va. Code Ann. § 54.1-2969(D)(4) (Michie 1991); see also N.Y. Mental Hyg. Law § 33.21 (McKinney 1988) (providing that minors may consent to outpatient treatment if the treatment is necessary and notifying the parents would be detrimental to treatment). But see Mo. Ann. Stat. § 632.110 (Vernon 1988) (expressly stipulating that person must be 18 to consent to outpatient treatment).
\textsuperscript{245} Note, however, that one survey of community mental health clinics found that the child's case was dropped about 46% of the time when the child refused to consent, even though his parents had requested treatment for the child. Melton, \textit{Effect of a State Law}, supra note 219, at 651.
\textsuperscript{246} In cases where both the parent and child refuse to consent but treatment is considered necessary by the school, the Education for all Handicapped Children Act, Pub. L. 94-142 (1975), 20 U.S.C. §§ 1400 et seq. (1988), can be used to ensure treatment is provided. Schools must provide mental health services to children who require it.
\textsuperscript{247} This is not merely a speculative concern; one study found that almost one-third of
CHILDREN'S COMPETENCE

need treatment, except for those fifteen and older, because their competence is that of an adult.

Outpatient Psychotropic Medication. While the issue of an adult’s right to refuse medication in the context of civil or criminal commitment has received a good deal of attention lately, scant attention has been given to the right of a juvenile to refuse psychotropic medication on an outpatient basis.

Although their side effects can be significant, medications given on an outpatient basis generally are not as confining to the individual as is institutionalization. Additionally, outpatient psychopharmacological treatment can be very effective and is often used to maintain the patient in order to avoid commitment or readmission. Unlike civil commitment, antipsychotic medication may arguably be the “single most effective treatment for psychosis.”

On the other hand, there can also be serious long-term side effects from the prolonged use of such drugs. Many psychotropic medications represent a restrictive treatment alternative because of their restraining and mind-altering effects. While some side effects are mild, others are debilitating


248. This illustrates the important distinction between a child’s consent to treatment when there is no parental consent or notification, and a child’s consent without parental consent but with parental notification. While the former may present fewer constitutional concerns, the latter approach may be more appealing to legislators and their constituents.


250. Antipsychotic drugs most commonly used include Haldol, Mellaril, Navane, Compazine, Prolixin, and Thorazine. Amicus Curiae Brief of American Psychological Association at 6, n.11, Washington v. Harper (No. 88-599) [hereinafter Amicus Brief]; see also PHYSICIAN’S DESK REFERENCE (46th ed. 1992), at 1373 (Haldol), 2011 (Mellaril), 1954 (Navane), 2201 (Compazine), 1793 (Prolixin), and 2234 (Thorazine).


or even deadly. Some commentators have also argued that antipsychotic drugs are frequently used indiscriminately simply to control problem behaviors rather than to treat mental illness. This argument is more commonly made with reference to inpatients, however. Indiscriminate use of medication is less likely to occur in outpatient treatment because there are not the pressures inherent in understaffed institutions to use medication simply to control patient behavior or as a substitute for psychotherapy, and also because the treating psychiatrist is likely to be better qualified.

On balance, then, the case of outpatient medication perhaps is best viewed as involving liberty interests midway between inpatient commitment and outpatient psychotherapy. Given this, older children should be presumed competent to consent, whereas younger children (under age fifteen) should be presumed incompetent to consent. Effectively, this allows older children the right to refuse treatment against parental wishes unless clearly...
incompetent to do so, but younger children would be able to override parental wishes only if clearly competent.

VII. DETERMINING CAPACITY TO CONSENT

A. Who Should Decide?

The question of who has legal authority for making the determination of capacity is an important issue in assessing a minor's maturity. Statutes which allow mature minors to provide consent, but which also require judicial review, suggest a role for judges in making the determination. Most mature minor statutes, however, simply require that the minor be mature, with the initial determination to be made by a physician, psychologist, or admitting officer.

For a variety of reasons, it is preferable for a determination of maturity to be made by an independent clinician. Clinicians have greater familiarity with the child, have specialized training, and are likely to have more time to make the determination than would a judge at an expedited proceeding. Administrative convenience and judicial economy would also dictate minimizing judicial involvement.

Determining a child's capacity to understand legal rights, make treatment decisions, and provide informed consent is a difficult task involving psychological and legal considerations. Ideally, an independent mental health professional and attorney would work as a team in making the determination. The attorney would have responsibility for ensuring that legal rights are accurately explained to the child and that the consent is legally valid, whereas the clinician would assess the child's abilities. Disclosure procedures related to obtaining informed consent should be conducted by the lawyer in the presence of the clinician. Clinicians can obtain valuable information about the child's understanding and capacity by observing his or her comments, questions, and emotional reactions.

Often times, however, an attorney will not be readily available, so clinicians should receive forensic training relating to minor consent laws and standards. It is important to recognize that neither clinical nor legal training alone is sufficient to enable a professional to determine capacity to provide informed consent. Determining a child's capacity to provide a legally valid informed consent requires specialized knowledge in areas such as children's cognitive development, psychological assessment, and the rel-


264. Appelbaum & Grisso, supra note 87, at 1637.

265. See Gary B. Melton et al., Community Mental Health Centers and the Courts: An Evaluation of Community-Based Forensic Services 44-45 (1985).
evant legal standards to be applied. Ideally, the clinician performing the evaluation would have training in these areas.

B. Informing Children

If children are to be allowed to provide informed consent to treatment, we must ask what it means to inform a child. A legally valid consent must be voluntary, knowing, and competent; the absence of any one of these components invalidates the consent.266 “Voluntary” means without coercion or undue influence. Relatively complete information is essential to make a “knowing” decision. The ability to make an “intelligent” decision is determined by cognitive capacity. The same legal standards of voluntary, knowing, and intelligent that are required for an adult’s consent would apply to children.

Commentators, however, point out that physicians generally fail adequately to inform patients267 of treatment alternatives and risks,268 that explanations of treatment options are presented in a manner designed to convince the patient to follow the physician’s recommendation, and that physicians do not probe patients’ understanding to ensure that their consent is truly informed.269 Because of these shortcomings, patients are seldom given complete decisionmaking autonomy.270 In Planned Parenthood of Missouri v. Danforth, for example, Justice Stewart noted with concern the fact that the minor seeking the abortion received only perfunctory counseling at the clinic regarding the abortion procedure.271 While evidence regarding possible harmful psychological effects of full disclosure is still somewhat


267. Failure to inform patients of risks may be partly due to the historical tradition within the medical professions of emphasizing paternalism and treatment over patient autonomy. See Martin S. Pernick, The Patient’s Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy, in 3 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient Practitioner Relationship, Apps., Studies on the Foundations of Informed Consent 1-35 (1982) [hereinafter President’s Study].

268. But see Elizabeth Loftus & James F. Fries, Informed Consent May Be Hazardous to Your Health, Science, Apr. 1979, at 1 (arguing that slight risks should not be routinely disclosed due to the potentially harmful suggestive effects, similar to a “placebo effect”).

269. See, e.g., Cathy J. Jones, Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy, 47 Wash. & Lee L. Rev. 379, 399-400, 423-424 (1990); Charles W. Lidz & Allan Meisel, Informed Consent and the Structure of Medical Care, in President’s Study, supra note 267, at App. C.


271. Planned Parenthood of Missouri v. Danforth, 428 U.S. 52, 91-92 n.2 (“The counseling ... occurs entirely on the day the abortion is to be performed. ... It lasts for two hours and takes place in groups that include both minors and adults who are strangers to one another. ... The physician takes no part in this counseling process. ...”).
CHILDREN'S COMPETENCE

unclear, the growing consensus is that disclosure is seldom harmful and frequently is beneficial.272

If physicians do not adequately inform their adult patients about medical procedures, it is unlikely that mental health professionals will do better when informing their minor clients about the risks, benefits, and treatment alternatives regarding mental health treatment.273 For instance, one study found that only eight out of one hundred patients who voluntarily consented to inpatient commitment had been adequately informed.274 This presents a serious problem, since children will often require more extensive information than adults if their consent is to be informed, as children have not had much actual experience in exercising rights or in adult decisionmaking.

It may thus be necessary to use more elaborate consent procedures when dealing with minors,275 exercising special care to ensure that the child's consent is voluntary, knowing, and intelligent and that the child is adequately informed. Young children are especially susceptible to coercive pressures from adults,276 may feel that such pressures exist even when they do not, and may tend to equate adult recommendations with the "right choice."277 Children may also tend to confuse legal rights with privileges that are to be exercised only at the pleasure of adults.278 Care should be exercised to determine that a decision is voluntary,279 that it reflects the child's wishes and independent judgment, and that the child appreciates the significance of his or her legal rights. Routinely providing juveniles with legal counsel or advice from a clinician who has had forensic training, in a private setting away from the parents,280 may help to accomplish this.

272. See Myron K. Denney et al., Informed Consent: Emotional Responses of Patients, 60 POSTGRADUATE MED. 205 (1975); Lynn, supra note 133, at 35.

273. Perhaps a less pessimistic view is warranted with regard to mental health professionals, however. Ruth Macklin, a well-known biomedical ethicist, noted that specialists who must deal regularly with a patient's emotional needs are generally more receptive to such ethical issues. N.Y. TIMES, Aug. 5, 1990, §6 (Magazine), at 64. But see infra note 312 and accompanying text; supra notes 36-37 and accompanying text.


275. Walter J. Wadlington, Consent to Medical Care for Minors, in CHILDREN'S COMPETENCE, supra note 3, at 66.

276. See Berndt, supra note 184; Koocher, supra note 60, at 10.

277. See Gary B. Melton, Children's Competence to Testify, 5 LAW & HUM. BEHAV. 73, 80 (1981).

278. Melton, Children's Concepts, supra note 170.

279. Some have suggested that, in the context of civil commitment, for instance, judicial review should always be provided in order to determine the voluntariness of the child's consent. Weithorn, supra note 193, at 834-35. Some state statutes include such provisions. See, e.g., FLA. STAT. ANN. § 394.465(1) (West 1986) (minors may consent to inpatient treatment provided there is a hearing to determine voluntariness); FLA. STAT. ANN. §394.56(1) (minors twelve and older may consent to outpatient treatment if there is a hearing to determine voluntariness). An alternative method, perhaps preferable when the child voluntarily consents to treatment, is simply to require the clinician or attorney to certify in good faith that the consent is voluntary. See, e.g., Ellis, supra note 32, at 906.

280. Similarly, some experts have urged that all juveniles facing delinquency charges be
C. Ensuring Voluntariness

Even when a child is clearly capable of providing informed consent, serious concerns with respect to the voluntariness of the decision must sometimes be overcome. The 1982 President's Commission examining ethical problems in medicine concluded that clinicians have an ethical duty to ensure, to the extent possible, that patient decisionmaking is free of coercion.281

Voluntariness relates more closely to experience, maturity, and self-efficacy than to cognitive capacity.282 Given children's sensitivity to appearances, social expectations, and peer pressures during adolescence,283 as well as their emotional and financial dependency upon parents, and inexperience in adult decisionmaking, commentators have questioned whether a minor's consent can ever be entirely free of coercion, persuasion, or manipulation.284 Therefore, it is important to develop procedures to ensure voluntariness which will emphasize to the child his or her rights and opportunity to choose, and which will provide social and emotional support for the child to do so.285

Several recent studies286 provide encouraging, albeit preliminary, data suggesting that fourteen- and fifteen-year-old adolescents are able to resist coercive pressures from parents. These studies found that children's decisions regarding various hypothetical treatment situations did not differ significantly from those of adults. Interestingly, adolescents did not typically challenge parental directives on relatively insignificant treatment decisions. They were generally willing to do so only in cases involving serious treatment issues having serious consequences. This finding is also encouraging to those who feel that providing children with decisionmaking power might result in ongoing disruption of parent-child relationships.

Inexperience in making choices may make it difficult for children to believe that they can participate meaningfully in treatment decisionmaking.287


281. President's Study, supra note 267.

282. See, e.g., P. Kieh-Spiegel, Children and Consent to Participate in Research, in Children's Competence, supra note 3, at 194.

283. See, e.g., Grisso & Vierling, supra note 172, at 421-22.

284. See, e.g., Michael A. Grodin & Joel J. Alpert, Informed Consent and Pediatric Care, in Children's Competence, supra note 3, at 93.

285. See, e.g., Grisso & Vierling, supra note 172, at 421 ("consent or dissent is a social act").


Juveniles' inexperience in exercising legal rights may hinder their ability actually to assert their rights, even though they may fully understand them, and there is some research to support this. Professor Grisso suggests that rights be explained in a manner similar to the use of Miranda warnings: inform the child of the right, explain the effects of waiving the right, and ascertain if the child understands the right.

D. Enhanced Consent Procedures

The result of enhanced procedures may be that children are actually better informed than most adult patients, which accords with the subjective standard of informed consent and the "dual-maximal" approach. This approach provides minors with all rights necessary to ensure fundamental fairness, as well as any additional protections necessary to make the exercise of their legal rights functionally equivalent to that of adults. Since children have less experience in treatment decisionmaking and in exercising legal rights, enhanced consent procedures are necessary to ensure that they are able to exercise rights in an adult manner.

Use of such enhanced procedures may also, paradoxically, require the juvenile to demonstrate capacity to a greater extent than is typically required of the adult because such procedures would extensively probe the child's understanding. Yet, this is not inconsistent with the law: while adults are presumed competent (an affirmative ruling of incompetence by the court is generally necessary to deprive an adult of the right to provide informed consent), children must generally make an affirmative showing of com-

288. Melton, Teaching Children, supra note 170; Melton, Children's Concepts, supra note 170.
291. With adults, informed consent is generally judged by an objective, reasonable person standard, rather than whether the particular patient actually understood. See, e.g., Canterbury v. Spence, 464 F.2d 772, 780, n.15 (D.C. Cir. 1972) ("physician discharges the duty when he makes a reasonable effort to convey sufficient information although the patient without fault of the physician, may not fully grasp it"); Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972). But see AMERICAN PSYCHOLOGICAL ASSOCIATION, supra note 238. The Ethical Principles state that:
When working with minors or other persons who are unable to give voluntary, informed consent, psychologists take special care to protect the minors' best interests. Within this context, even in states which clearly allow minors to seek treatment independently, the clinician probably has an ethical duty to determine the actual competence of the client to consent.
Id.
292. Under the subjective standard, adequacy of the disclosure depends upon the needs of the patient and is judged on a case-by-case basis. See generally BEAUCHAMP & CHILDRESS, supra note 46, at 90-91. With minors, the subjective standard may be more appropriate, given the difficulty in knowing what a "reasonable child" would want to know at various ages.
293. Rosenberg, supra note 142, at 661-73.
294. See generally Parry, supra note 161.
petence. While the statutory presumptions for minors proposed herein would also extend the same "adult" presumption of competence to minors of certain ages for outpatient therapy, presumptions of incompetence still remain within this framework in order to protect the child's rights and interests.

Use of enhanced consent procedures may also be necessary in order to avoid potential tort liability or the overturning of capacity determinations upon judicial review.295 Although the execution of an informed consent authorization by the patient generally gives rise to a presumption that the patient's consent was legally valid296 (voluntary, knowing, intelligent), it is possible that courts may be reluctant to extend such a presumption in the case of a minor, due to the minor's inexperience and relatively unequal bargaining power. As of 1986, there appears not to have been a single reported case where a physician has been held liable for treating a minor without informed consent.297 Such cases might begin to occur, however, where mental health professionals routinely provide treatment upon children's unilateral consent but the informed consent procedures are inadequate. Perhaps clinicians who treat minors under a reasonable, good-faith belief that the minor is capable of consenting should be immune from liability against claims that the consent was invalid.

Finally, the value of informing children about prospective treatment, even in cases where the child cannot provide consent, should not be overlooked. In such cases, the minor should nevertheless be kept fully informed and allowed to participate in treatment decisionmaking. Numerous studies have found therapy to be more effective when the patient is allowed to help plan or select his or her own treatment.298

E. Practical Tests of Capacity

Although no generic model or test has yet been developed for assessing capacity to give consent, various techniques have been used.299 Most tests developed to date have been used in research to measure the factual understanding or appreciation components of competence and have been

295. If the therapist fails to inform the patient about the therapy and does not obtain informed consent, or if disclosure is made but is inadequate, the therapist may be liable for negligence. See generally Rozovsky, supra note 105, at 73-89, §§ 1.15, 1.16; Barry R. Furrow, Malpractice in Psychotherapy 66-70 (1980).


297. Morrissey et al., supra note 221, at 15.


299. For general guidelines for assessing children, see Redding, supra note 38, at 22-27.
sufficiently validated for clinical use. Tests need to be developed which also assess the rational decisionmaking aspect of competence, and validation studies using large and diverse samples are needed. Any test of capacity should be amenable to administration by lawyers as well as clinicians and should be objectively reliable by scoring verbal responses directly related to the treatment question.\textsuperscript{300} Perhaps the most common and practical approach, often used with adults in medical settings, has been simply to ask the client to answer questions or provide explanations regarding treatment facts, risks and benefits, and factors the client would consider in reaching a decision.\textsuperscript{301}

Variations on this approach have been used in research on children's decisionmaking. A structured interview format, followed by specific probe questions, is frequently used. These questions include asking the child what he or she considered and thought about in the decision, with a point given for each relevant factor considered;\textsuperscript{302} asking about the disadvantages of therapy and what someone might discuss with a therapist, and scoring each response based upon adequate, partial, or poor understanding;\textsuperscript{303} or presenting children with scenarios in which a right is violated, and asking the child to explain what right was violated and how.\textsuperscript{304}

Another approach is to ask the child to define the meanings of "risk" and "benefit" by giving examples.\textsuperscript{305} If the child is unable to do this, the examiner does so. The child is then asked again to define the words and give examples. Once the child demonstrates understanding, the proposed treatment is explained. The child is then asked to identify all the possible risks and benefits of the treatment. This approach is thus a means for assessing the factual understanding and appreciation components of competence, but it is a demanding test: the child must infer the risks and benefits rather than simply paraphrase risks and benefits already explained.

Researchers have developed an assessment instrument to test factual understanding for use after disclosure to the patient.\textsuperscript{306} The test, called "MUD"—Measuring Understanding of Disclosure—includes three subtests, called "uninterrupted disclosure," "single-unit disclosure," and "single-unit recognition." The two disclosure subtests ask the individual questions, requiring him or her to paraphrase information given in the disclosure; questions are asked immediately following each paragraph in single-unit disclosure. Thus, the single-unit subtest is somewhat less demanding. The single-unit recognition subtest requires the individual to identify similar and dissimilar statements.

\textsuperscript{300} See, e.g., Roth et al., supra note 82, at 280.
\textsuperscript{302} Weithorn & Campbell, supra note 62, at 1592-93.
\textsuperscript{303} \textit{Id}.
\textsuperscript{304} See, e.g., Belter & Grisso, supra note 182, at 902-03.
\textsuperscript{305} Kaser-Boyd et al., supra note 62, at 413.
Professor Grisso has developed an assessment instrument to test children's factual understanding of legal rights. The child is shown drawings of, for example, an attorney-client consultation or a courtroom scene. The child is then asked to explain the scene in his or her own words, to define relevant concepts, and to answer true-false questions about the legal rights involved. A "Waiver Expectancy Interview" was also developed to measure the child's expectations about the effects of waiving a right, given his or her situation. This would seem to measure appreciation—the effects of a decision upon one's own situation.

Similar procedures could be used to determine a child's capacity to consent to mental health treatment. In civil commitment, for instance, the following facts should be explained to the child: reasons the commitment was sought; less restrictive alternatives; benefits and risks of commitment; conditions at the hospital; and what treatments are likely to be given at the hospital. The child could then be asked to explain each one of these facts and how he or she might weigh them in making a decision. A test could be given to determine if the child then understands the legal and practical effects of consenting, or refusing to consent, to a particular mental health treatment.

**F. Assessing Competence**

When informing children and assessing their understanding, use of age-appropriate vocabulary and extensive probing into their understanding are particularly important. Research shows that younger children will often respond "yes" when asked if they know the meaning of a legal term, but often think they understand because they have confused the legal term with a familiar everyday term, for example, hearing or minor. Similarly, competence may be underestimated if the child is required to know or understand certain words, rather than simply the underlying concepts.

307. Grisso, supra note 290, at 47-55.
308. Id. at 57, App. E.
309. See AMERICAN HOSPITAL ASSOCIATION, A PATIENT'S BILL OF RIGHTS (1973). The Patient's Bill of Rights states that:

The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf.... The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information.

Id.
310. Saywitz et al., supra note 70.
311. REDDING, supra note 38, at 26.
Thus, relatively deep probing into the child’s responses and the use of several different tests or testing methods are warranted. Additionally, it is worthwhile to ensure that the child’s decision is not simply a transient one by asking the child about his or her choice at various points in time.

It was suggested in Part IV-B that a relatively demanding standard of competence be used with children—one which includes all the potential elements of competence: factual understanding, rational decisionmaking, and the ability to make and communicate a choice. In assessing capacity, it is necessary to relate the testing procedures and results obtained to the relevant standard(s) of competence. This can pose problems, however. A recent study found that psychiatrists have difficulty assessing competence in terms of capacity standards. Surprisingly, psychiatrists did not assess factual understanding in eighty-one percent of the cases, whereas the most difficult test to meet—appreciation—was assessed the most frequently, in eighty-six percent of the cases. This often resulted in underestimations of capacity.312

Regardless of how capacity is determined, there should be no presumption that mental illness implies incompetence. This principle has been recognized statutorily or in the case law of most states.313 Second, capacity should be viewed as an issue separate from the child’s mental illness and the treatment decision.314 This may seem counterintuitive. However, even children with disabilities are often cognitively competent to participate in decisionmaking.315

Competency should also not be viewed as static or unidimensional. A growing body of research indicates that children’s abilities do not develop simultaneously, developing instead at different rates.316 Thus, viewing a

314. Parry, supra note 161, at 375.
315. Although there have been few studies investigating the effects of various mental illnesses upon decisionmaking competence, one recent study found mixed results when comparing hospitalized schizophrenics and major depressives with non-mentally ill hospitalized patients. While on average the schizophrenic group showed significantly poorer understanding of information about medication given during the course of informed consent procedures, there was great variability between patients, with some demonstrating competence comparable to the comparison group. The study also found that cognitive deficits tend to impair competence more than do emotional problems. Grisso & Appelbaum, supra note 306, at 385-87.

Several older studies have also found that schizophrenics did not differ significantly from non mentally-ill patients in their ability to understand facts or weigh risks and benefits. See, e.g., Lisa Grossman & Frank Summers, A Study of the Capacity of Schizophrenic Patients to Give Informed Consent, 31 Hosp. & COMMUNITY PSYCHIATRY 205 (1980); David A. Soskis, Schizophrenic and Medical Inpatients as Informed Drug Consumers, 35 ARCH. OF GENERAL PSYCHIATRY 645 (1978); David A. Soskis & Richard L. Jaffe, Communicating with Patients about Antipsychotic Drugs, 20 COMP. PSYCHIATRY 126 (1979).
316. See generally Flavell, supra note 171; Gelman & Baillargeon, supra note 171.
child's abilities in terms of an overall "competency" factor is misleading. Rather, competency is domain-specific; children may be fully capable of understanding and decisionmaking in some areas, partially capable or incapable in others. Indeed, the law recognizes that an individual can be legally competent in some areas while incompetent in others. 317 Any assessment of competency should therefore focus on the specific cognitive skills required to provide informed consent for the particular treatment in question. 318 Unfortunately, however, clinicians appear to base capacity decisions upon the individual's overall competence or psychiatric status, rather than the person's capacity to consent to the particular treatment. 319

Finally, it may also be possible to facilitate children's ability to understand legal terms and concepts by explaining them in relationship to what children already know about courts, judges, and lawyers. Decisionmaking ability might be enhanced by teaching them decisionmaking skills relating to their legal rights 320 and health. A curriculum module has been developed to teach health decisionmaking skills to elementary school children. 321 Similar programs could be developed for use in schools or mental health clinics specific to decisionmaking related to mental health issues. However, since such decisions frequently must be made in emergency situations, there may not be enough time to teach the child such skills before the decision must be made.

G. Emotional Factors

Although studies demonstrate that many children, at least normal adolescents, can understand their legal rights and make mature decisions, this does not mean that they will always be able to do so. Much depends on the individual, the particular issues, and context. Interestingly, however, one study suggests that children who are less competent, or the most uncertain about their decisions, are the ones most likely to seek parental advice. 322 This suggests that children may be able effectively to recognize when they need to seek parental advice and to self-regulate their own advice-seeking behavior.

A child may also be able to understand certain issues but not deal with them emotionally in ways that result in mature decisionmaking. Children's

317. Rozovsky, supra note 105, § 6.2, at 365-66; Roth et al., supra note 82, at 279.

318. Additionally, researchers increasingly speculate that children may possess many competencies which are obscured because of extraneous factors. See generally Gelman & Baillargeon, supra note 171; Alternatives to Piaget: Critical Essays on the Theory (Linda S. Siegel & Charles J. Brainerd eds., 1978).

319. McKinnon et al., supra note 312, at 1162 (many evaluations included comments unrelated to capacity to consent, such as "patient believes his food is poisoned," with only 6% of evaluations directly assessing capacity to consent to proposed treatment).

320. See generally June L. Tapp & Gary B. Melton, Preparing Children for Decisionmaking, in Children's Competence, supra note 3, at 215-34.

321. Lewis, supra note 176, at 84-89; de la Sota et al., Actions for Health (1980).

decisionmaking abilities appear to decline in emotionally laden situations which have personal significance, where the stress and emotional factors might cause even adults to make decisions which do not truly reflect their own values. Although such factors can result in "nonautonomous," or nonvoluntary decisionmaking, it is unclear how to evaluate the effects of a patient's emotional state upon treatment decisionmaking.

Even if such an evaluation were possible, however, it potentially raises concerns about the proper role of the evaluator—whether the evaluator's judgment as to the minor's capacity would be influenced by the perceived reasonableness of the choice made. That is, when the choice made appears to be illogical, there may be a tendency to conclude that it is the result of stress or emotional factors and therefore should be discounted, even if the child has been found to be cognitively capable of consenting. Such an approach would diminish the freedom to make risky, unpopular, or non-traditional choices, and could easily be used simply to justify substitute decisionmaking.

Psychopathology, however, can degrade a child’s capacity. Psychotic children may hallucinate or have particular difficulty in separating reality from fantasy, although even these children may have moments of lucidity in which they are able to participate in decisionmaking. Only delusions related to treatment decisionmaking are relevant for informed consent purposes. One commentator has suggested that any evaluation should consider whether there are any delusions, emotional problems, pathological motivations, or any pathological relationships such as passive dependency on others, that may interfere with the individual’s capacity to consent.

VIII. CONCLUSION

Many reforms in the law are necessary if society is to recognize the "personhood" of children. An important part of affording due process rights to children is to give them a voice in their own life decisions. Allowing
children to provide informed consent for mental health treatment is particularly important because of the potentially significant liberty and privacy interests involved, the potentially significant impact of treatment upon future life choices such as employment opportunities, and the treatment-enhancing effects of allowing children to participate meaningfully in treatment decisionmaking. Particularly in the case of outpatient treatment, allowing children unilaterally to consent to treatment serves the public policy interest in facilitating access to needed treatment.

Legal reform is necessary in many states to enact minor consent statutes that provide due process protections to juveniles by allowing them to participate in treatment decisionmaking if competent to do so, and by providing for judicial review in cases where significant liberty interests are involved—civil commitment and possibly psychopharmacological treatment. Reform should not end merely with legislation, however. Not only must laws be enacted, but outreach programs should be developed in the schools which inform children of their rights. If children are to be given the right independently to seek, and consent to, outpatient psychotherapy, they need to be informed that this right exists. The Virginia statute was found to have a negligible impact upon the percentage of minors seeking outpatient treatment, largely because most minors were unaware of the right. 329

We need additional research concerning children's competence to participate in treatment decisionmaking and to provide informed consent. Critical areas remain to be explored. How do various mental illnesses and emotional states affect decisionmaking ability? How can a child's competence to participate in treatment decisionmaking be enhanced or facilitated? The development of a robust body of research on these and other issues would permit development and validation of a generic, easy-to-use test for the lawyer to determine a child's capacity to consent to treatment.

More research is needed to provide guidance to the legal community and society about the extent to which decisionmaking rights can and should be extended to children of various ages. While emerging research indicates that young adolescents are probably capable of providing informed consent for treatment, more empirical research and theoretical development are still required if we are to be confident of these findings and also to investigate competence in a wider variety of contexts. While a sizeable and convincing body of research, some of which has been reviewed in this paper, indicates young adolescents to be capable of mature decisionmaking, we are not yet at a point approaching certitude in our conclusions.

Finally, and perhaps most importantly, society itself must decide the extent to which it is willing to empower children by giving them certain rights and responsibilities heretofore enjoyed solely by the adult ruling class. 330 Rousseau observed that though "Man is born free," society limits
his freedom, so that "everywhere he is in chains." Let us not as a society limit unnecessarily the freedom of our children to develop and exercise their decisionmaking capabilities, to obtain needed treatment in confidentiality, and to refuse treatment when it may be harmful to their personhood and individuality.

concerning what rights should be extended to children. In general, however, younger, better educated adults tended to favor affording more rights to children, while older, less educated adults tended not to favor children's rights. George W. Bohnstedt et al., Adult Perspectives on Children's Autonomy, 45 PUB. OPINION Q. 443, 459 (1981). Given this, it is possible that adults may increasingly favor extending rights to children, as the educational level of the population increases and as younger generations assume greater responsibility.

APPENDIX

PROPOSED MODEL STATUTES

SECTION 1: COMPETENCE OF MINORS TO CONSENT TO MENTAL HEALTH TREATMENT, GENERALLY.

(a) Any minor, subject to statutorily-mandated minimum age requirements or presumptions, is competent to provide effective consent, provided he or she can sufficiently understand, evaluate, and appreciate the nature and consequences of the proposed treatment, including risks, benefits, and alternatives, and consents voluntarily. Any duly authorized mental health professional may provide such services in reliance upon such a consent.

(b) A clinical psychologist or psychiatrist licensed to practice in the state must determine whether the minor is competent. If a clinical psychologist or psychiatrist is unavailable, an attorney may make the determination in an emergency situation.

(c) The professional making the determination pursuant to subsection (a) must certify that the minor is competent pursuant to subsection (a), and that the consent is fully voluntary.

(d) “Consent” means either (1) consenting to treatment, or (2) refusing to consent to treatment. Where a minor is competent to provide an effective consent pursuant to subsection (a), but refuses to do so, the treatment cannot be provided without court order.

SECTION 2: INPATIENT TREATMENT (For States Requiring Child’s Consent for Voluntary Commitment).

(a) Minors under the age of 15 shall not be able to provide consent to voluntary inpatient mental health treatment.

(b) For minors age 15 and over, the presumption shall be that the minor is not competent to consent. This presumption may be rebutted by clear and convincing evidence pursuant to Section 1.

(c) If a minor fails to join in the consent of his parents or guardian to the voluntary admission, the application for admission shall be treated as a petition for involuntary commitment.332

SECTION 3: INPATIENT TREATMENT (For States Not Requiring Child’s Consent for Voluntary Commitment).

(a) Any minor may provide consent for voluntary inpatient mental health treatment.

SECTION 4: OUTPATIENT COUNSELING OR PSYCHOTHERAPY

(a) Any competent minor may consent to counseling or psychotherapy on an unlimited outpatient basis, subject to subsections (b), (c), and (d).

(b) For minors under the age of 11, the presumption shall be that the minor is not competent to consent. The presumption may be rebutted by clear and convincing evidence pursuant to Section 1. If the minor’s parent, guardian or person standing in loco parentis requests treatment for the minor, the minor cannot provide consent.

(c) For minors between the ages of 11 and 14, the presumption shall be that the minor is competent to consent. If the minor’s parent, guardian or person standing in loco parentis requests treatment for the minor, the presumption shall be that the minor is not competent to consent. These presumptions may be rebutted by clear and convincing evidence pursuant to Section 1.

(d) Minors 15 and over may consent to treatment. If the minor’s parent, guardian, or person standing in loco parentis requests treatment for the minor, the presumption shall be that the minor is competent to consent. This presumption may be rebutted by clear and convincing evidence pursuant to Section 1.

(e) If the minor is competent to consent, the minor’s parent, guardian, or person standing in loco parentis shall not be informed of the outpatient counseling or psychotherapy without the consent of the minor unless the mental health professional reasonably believes such disclosure is necessary for the child’s safety or emotional wellbeing. If the mental health professional intends to disclose the fact of counseling or psychotherapy, the minor shall be so informed prior to the intended disclosure. If the minor objects to the intended disclosure and discontinues treatment, the mental health professional shall not so disclose. The minor shall be informed of the right to discontinue treatment to prevent the intended disclosure.

(f) Parents, guardians, or persons standing in loco parentis are not liable for payment of services to which they did not consent.

SECTION 5: MEDICATION PROVIDED ON OUTPATIENT BASIS FOR MENTAL HEALTH TREATMENT

(a) For minors under the age of 15, the presumption shall be that the minor is not competent to consent. This presumption may be rebutted by clear and convincing evidence pursuant to Section 1.

(b) For minors age 15 and over, the presumption shall be that the minor is competent to consent. This presumption may be rebutted by clear and convincing evidence pursuant to Section 1.

334. Id.