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DIAZEPAM DISCORD: A COMPETENT MINOR'S CONSTITUTIONAL RIGHT TO SEEK AND REFUSE PSYCHOTROPIC MEDICATION

Alexa E. Craig

Our legal system values independence, individualism, and personal choice, but we have been slow to cultivate these values in the arena of children's rights. Too much of the focus has been on efficiency: arbitrary cut-off ages provide a simple means for ascertaining a person's competence to exercise rights, but they are not always an accurate means to such an end. Specifically, the law regarding mental health has struggled to reconcile parents' rights in custody and management of their children, the State's interest in raising members that will contribute to society, and competent children's rights of privacy and self-determination. In the context of access to alcohol and cigarettes, cut-off ages are sensible, but in the mental health context, these cut-offs are prone to invade basic constitutional rights.

For roughly two centuries, parents' interests in the welfare of the children were determinative in nearly every circumstance, save when the parents abused or neglected their child, in which case the State intervened with legal recourse. Even in 1979, the Supreme Court affirmed the overriding power of parents' interests with the presumption that parents act in the "best interests" of their children.¹ Surprisingly enough, during the same time period, the Supreme Court recognized a mature minor's right to contraception and abortion, contrary to her parents' wishes, based on the right of privacy.² The recognition of privacy rights through the jurisprudence of substantive due process has encouraged legislatures to pass laws protecting the rights of competent minors, but change has come slowly, especially in the context of a child's wish to consent to, or to refuse, medication. With the development of psychotropic medications, the child's interest in participating in his own mental health treatment is arguably even stronger than in other medical contexts due to the effects these medications can have on his personality, reputation, and socio-cognitive development.

This Note argues that a minor's desire to consent to, or refuse, psychotropic medication should trump his or her parents' (or legal guardians') wishes if the minor is found to be competent. A neutral fact-finder, though not necessarily a judge, should make this finding of competence. Addition-

1. *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (denying children constitutional right to independent judicial review in civil commitment decision).

2. *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Bellotti v. Baird*, 443 U.S. 622 (1979).

ally, counsel and an independent psychiatrist should be provided to the minor in order that he may assert his constitutional rights prior to any competency hearings. This Note also advocates that legislatures codify age presumptions of competency that can be rebutted in a hearing in order that a child might show his competency. For instance, children ages fourteen and up should be presumed competent, so that any person wishing to abridge their constitutional rights should have the burden of proof by clear and convincing evidence to show otherwise. On the other hand, children ages eleven to thirteen should be presumed incompetent but should be provided with counsel attempting to prove their competency. Still, in a system that needs to maintain some level of efficiency, children below eleven should be presumed incompetent with no guarantee of counsel because studies show a drop-off in the level of competence.³ Nothing should bar an advocacy group or non-profit, however, from obtaining counsel for these minors, and the courts should allow them to make a case for competency.

In coming to a decision about psychotropic medication, various rights, interests, and beliefs are at issue. For example, individuals and families differ on their views of mental illness, privacy, self-control, and responsibility.⁴ Existing law is counterproductive long-term for these competing interests and values⁵ because it sets up age as a proxy for a person's competence to exercise free choice. While in some cases age works well as a proxy, in the context of mental health treatment, psychological research tells us that treatment works best when the individual being treated has willingly consented to the treatment,⁶ regardless of age.

In Part I, this Note discusses parents' authority to give and withhold consent to mental health treatment for their children. This Part highlights the constitutional interests at stake and provides examples of parental authority at work in the mental health context. Additionally, it elucidates the State's interests and authority, focusing on the doctrine of *parens patriae*. Part II analyzes the traditional view of children's competence and recent transformations that have taken place in jurisprudential thought on the issue. Subsequently, this Note highlights why we should expand these transformations in the psychotropic medication landscape. In order to translate the theories

3. See Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH & LEE L. REV. 695, 728 (1993).

4. See Therese Powers, *Race for Perfection: Children's Rights and Enhancement Drugs*, 13 J.L. & HEALTH 141, 141-2 (1999) (arguing that our country's focus on "perfection" encourages parents to jump to conclusions regarding the use of Ritalin and Human Growth Hormone).

5. See Jan C. Costello, *"The Trouble is They're Growing, the Trouble is They're Grown": Therapeutic Jurisprudence and Adolescents' Participation in Mental Health Care Decisions*, 29 OHIO N.U.L. REV. 607, 608 (2003). Costello mentions four essential therapeutic tasks to be achieved by a patient: (1) achieving an accurate understanding of his mental illness, (2) understanding the range of available inpatient and outpatient treatment modalities, (3) learning how to maintain stability at home and in the community by using those services, and (4) maximizing his opportunities for the most constructive and satisfying life possible in the least restrictive available setting. *Id.*

6. See *id.* at 633.

into practical approaches, this Note then illustrates current methods of assessing competence in children, including a discussion of emancipated minor statutes and common law mature minor doctrine. In the last Part, a solution is proposed: children ages eleven and up must be provided with counsel and an independent mental health professional before being permitted to demonstrate (or defend) their competency in the presence of a neutral fact-finder. Their *physical* ability to make such an important decision for their lives, rather than an arbitrary number, should be the determining factor in their *legal* ability to consent to or refuse psychotropic medication.

I. PARENTAL AND STATE AUTHORITY OVER CHILDREN

Traditionally, the battle over the authority to consent to or withhold mental health treatment for children has been between parents and the State. At stake are parents' constitutional rights and the State's interest in raising responsible citizens that will contribute to society at large. Society has an interest in maintaining the *family* as a building block of democratic culture, which promotes pluralism.⁷ At tension with this interest, however, is an interest in promoting the life and health of every *individual*. Both interests are compelling, as they play important roles in the wellbeing of the country. The battle, however, proves to be missing one component: namely, the capable minor's input.

A. Parents' Authority to Give and/or Withhold Consent to Mental Health Treatment for their Children

The law has nearly always deemed parents to have primary authority over their children in most areas of the children's lives. The traditional view of parental authority most likely emanates from the common law's view of children as chattel, but practical matters also provide justifications: parents provide for their children and are far closer (both physically and emotionally) to them than the government, so they are generally in a better position to make decisions in their children's place. Other justifications include: a child's interest in intimate relationships and receiving care from those who know him best, and a parent's interest in intimate relationships and in molding a life in accordance with his ideals.⁸ The strongest supporter of parental authority has been the Court, which has focused on constitutional and liberty interests of parents in the custody and management of their children.⁹ While

7. See Powers, *supra* note 4, at 162.

8. *Id.* at 152. In *May v. Anderson*, the Court stated that rights involving custody of one's children are "far more precious . . . than property rights," confirming the connection between children and chattel. 345 U.S. 528, 533 (1953).

9. *Prince v. Massachusetts*, 321 U.S. 158, 166 (1943) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."). "The *Prince* Court treated the danger of the child's welfare as a public policy concern and as a threat to the interest of society as a whole rather than as a threat directly to the child." Powers, *supra* note 4, at 158.

placing parents' constitutional rights above their minors' rights is often a necessary evil, in the mental health setting, this can lead to strange results. For instance, "voluntary" civil commitment of children with mental health conditions is *not* voluntary on the *child's* part at all: it is only voluntary from the perspective of the parent. Thus, this Part will tease out the traditional, and pervasive, idea of parental authority and its role in the administration of psychotropic medication to children.

Since parents have constitutional interests in the management of their children,¹⁰ they have what appears at first to be a "trump" card, at least against the State. In *Bellotti v. Baird*, where the Court actually recognized the right of a mature minor female to get an abortion against her parent's wishes, the Court still emphasized that a parent's authority was "deeply rooted" in American tradition.¹¹ The First Amendment's Free Exercise Clause¹² and the Fourteenth Amendment's Due Process Clause¹³ provided the basis for this authority. For example, in *Troxel v. Granville*, paternal grandparents were unable to petition for more visitation time with their grandchildren because that right would violate the mother's substantive due process rights.¹⁴ Another case, where a state statute requiring public education for all was found to violate the Constitution, followed a similar path: "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."¹⁵ Moreover, the law in this area has operated under two presumptions: (1) parents have a level of maturity that is lacking in children and (2) "natural bonds of affection" cause parents to act in the "best interests" of their children.¹⁶ Comporting with these assumptions, most limits on parental rights derive from parental duties, such as the duty to provide a minimum level of safety and health to the child.¹⁷ Thus, chances of successful treatment, expected duration of treatment, side effects, alternatives, and chance of death can, in a few cases, play a role in limiting parental authority.¹⁸

10. See Powers, *supra* note 4, at 152.

11. 443 U.S. 622, 638 (1979).

12. *Newmark v. Williams*, 588 A.2d 1108, 1109 n.2 (Del. 1991) (looking at U.S. CONST. amend. I).

13. Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 147 (2000) (looking at U.S. CONST. amend. XIV).

14. 530 U.S. 57 (2000). The Court recognized the liberty interest of the parents as "perhaps the oldest of the fundamental liberty interest[s]." *Id.* at 65. Of course, that case discussed why the *State's* interests did not trump the parents', whereas this Note places the substantive due process rights of the *child* against the parents'.

15. *Pierce v. Soc. of the Sisters of the Holy Names of Jesus and Mary v. Hill Military Acad.*, 268 U.S. 510, 535 (1925). Again, notice the focus on the conflict between the *State* and the parents, rather than the *minor* and the parents.

16. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

17. The parent's "first and paramount duty is to consult the welfare of the child." *Custody of a Minor*, 393 N.E.2d 836, 843 (Mass. 1979).

18. See Powers, *supra* note 4, at 152. A New York court, while initially deferring to the parent's wishes in administering metabolic treatment to their child, later used the standard of the "ordinarily prudent and loving parent, 'solicitous for the welfare of his child and anxious to promote [his] recovery'" as a tool against which to measure the parent's choice. *Id.* at 161 (quoting *In re Hofbauer*, 393

In the mental health arena, parental constitutional rights, along with legal presumptions, play out in a few different ways. For example, if a parent requests voluntary civil commitment for his child, and a clinician concurs, then there is no judicial review for the decision in most states.¹⁹ In those states which do allow for judicial review, the standard used to determine the propriety of the parent's decision is whether the child is "likely to benefit."²⁰ If a child then wants to leave hospitalization, he may only do so by parental request, discharge by the hospital director, or a court order.²¹ Of course, these latter two options only occur under extreme circumstances, which will be discussed later. In some states, however, "volunteered" children age twelve and over may apply for judicial review to stay contrary to their parents' wishes, or the director can file a petition.²² In California, an adolescent of age fourteen or above actually has an automatic right to judicial review, but this is uncommon in other states.²³

Consent to, or refusal of, medication operates slightly differently from the civil commitment examples discussed above. Surprisingly, in California, which is progressive in civil commitment cases, minors are specifically prohibited from consenting to psychotropic medication.²⁴ In Illinois, a minor can apply for "voluntary" inpatient treatment, and at that point, she is conferred all mental health treatment rights, including rights to medication.²⁵ Of course, the inpatient treatment requirement may act as a roadblock, as it may deter her from speaking up more than a request for medication would. In other states, the common law "mature minor" doctrine can be utilized in court to show capacity to consent. Without codification of this doctrine, however, minors struggle to translate their rights into action. Emancipation statutes, like those in California, Illinois, and Ohio, can be helpful in this context, but they only apply for a limited time, and if therapy is involved, then the parents are notified,²⁶ which may decrease a child's effort to pursue her rights. Furthermore, children often cannot obtain attorneys who advocate their wishes, but can only obtain guardians *ad litem*, who advocate their "best interests." Later in this Note, past and current laws are further explained, but for now, it is important to note that state laws giving children a role in the decision for their mental health treatment usually act contrary to legal presumptions supporting parental rights of control.

Problems arise with the assumption that parents should absolutely control the mental health treatment of their children. For instance, a parent might merely desire to sedate his child or cure his behavioral issues, when in

N.E.2d 1009 (N.Y. Ct. App. 1979)).

19. Costello, *supra* note 5, at 616.

20. *Id.* at 623.

21. *Id.* at 616.

22. *Id.* at 617.

23. *Id.*

24. *Id.* at 629.

25. *Id.* at 631.

26. *Id.*

actuality, those issues are caused by disturbances at home or dysfunctions in the family.²⁷ Often when a family system is partly responsible for the bizarre behavior, the parent misinterprets that behavior as emanating solely from the child.²⁸ Additionally, he takes into account “what is right for the family,” which in some cases, may override what is right for the child.²⁹

B. *The State’s Interest and Authority in the Welfare of Children*

The State has a compelling interest, termed *parens patriae*, in the “welfare of children” when their physical and/or mental well-being is in jeopardy. Courts only employ this doctrine when parents fail to properly care for their children or when threats to the child’s health and safety appear.³⁰ For example, the State can intervene in order to preserve human life, and in life-threatening situations, “courts uniformly order medical treatment over parental objection.”³¹ In *Jehovah’s Witnesses v. King’s County Hospital*, the district court upheld a statute declaring certain children to be wards of the state in order that they might receive blood transfusions contrary to their parents’ religious wishes.³² The court said, “The right to practice religion freely does not include liberty to expose . . . the child to ill health or death.”³³

When the treatment is “relatively innocuous” compared to the danger of withholding medical care, courts often authorize the treatment over parental objection.³⁴ Lastly, courts will likely order treatment if the parent has no plausible reason for his objection.³⁵ Often, in these circumstances the court orders a state-appointed guardian for the child.³⁶ On the other hand, when the condition experienced by the child is not life-threatening, and the procedure involved is “inherently dangerous and invasive, or involves extreme pain and suffering that overwhelm the benefits of treatment,” courts are not apt to order the procedure.³⁷ Child abuse and neglect laws provide some justification for State intervention, as they require parents to provide children with necessary and appropriate health care.³⁸ A court may declare a child “medically neglected” without declaring her neglected in other areas of her

27. Redding, *supra* note 3, at 700. See also Powers, *supra* note 4, at 143 (“It may become impossible to differentiate ADHD from symptoms of a child’s social environment when a child is subjected to inadequate, disorganized, or chaotic environments.”).

28. *Id.*

29. Redding, *supra* note 3, at 699–701 (1993).

30. Susan D. Hawkins, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 *FORDHAM L. REV.* 2075 (1996).

31. *Id.* at 2087.

32. 278 F. Supp. 488 (W.D. Wash. 1967) *aff’d*, 390 U.S. 598 (1968).

33. *Id.* at 504.

34. Hawkins, *supra* note 30, at 2088.

35. *Id.*

36. Schlam, *supra* note 13, at 142.

37. Hawkins, *supra* note 30, at 2088. In addition, the courts have said that the states have *parens patriae* power in cases involving school attendance, child labor, and compelled vaccinations.

38. See e.g. OHIO REV. CODE. ANN. 2151.03 (Anderson 2000).

life, but “neglect” is still a high bar to cross.³⁹

Essentially, the State needs to show a “powerful countervailing interest” in order to override parental rights.⁴⁰ Additionally, the State has an interest in protecting the ethical integrity of the medical profession.⁴¹ In other words, states seek to ensure that medical professionals do not take advantage of parents seeking a quick-fix for their children’s behavioral problems, and in a broader context, states wish to promote mental health treatment, which works best with the consent of the patient.

It is clear that both parents and the State have powerful reasons for being involved in the decision of a child to obtain or refuse psychotropic medication. The Constitution provides parents with rights to the custody and management of their children. Religious, speech, privacy, and autonomy interests provide the foundation for these rights. Courts enforce them through two presumptions: that the parent is more mature and that he or she acts in the best interests of his or her child. On the other side of the coin, the State has *parens patriae* power to override the parents’ decision when they are clearly acting contrary to the safety and health of the child. The conflict between these two authorities is of primary concern in most cases involving access to psychotropic medication for children. The child’s participation in the decision, however, is rarely considered a viable option.

II. OVERVIEW OF CHILDREN’S LEGAL COMPETENCE

Now that we have established the two primary interests at stake in litigation over mental health treatment for children, we must turn to an interest that has been largely ignored: that of the minor herself.⁴² In this part, we will examine the traditional legal view of a child’s competence (or lack thereof) and recent transformations that have occurred in the jurisprudential view of children’s rights. Parental rights have mostly been limited by minors’ due process rights, abuse and neglect laws, medical emancipation statutes, and mature minor doctrine. Subsequently, we will think about how these transformations can be expanded in the context of psychotropic medication use. The trend towards more child involvement in decisions over mental health treatment indicates that this expansion should also occur in decisions about anti-depressants, anti-anxiety medications, and the like.

A. Traditional View of Children’s Competence

The common law endorsed “incapacity theory” in reference to a child’s

39. See Costello, *supra* note 4, at 626-7 (arguing that neglect laws are an “ineffective means” of enforcing a child’s rights of access to mental health treatment).

40. Stanley v. Illinois, 405 U.S. 645, 651 (1972).

41. Hawkins, *supra* note 30, at 2086.

42. “The idea of children having rights is, in many ways, a revolutionary one.” Michael S. Wald, *Children’s Rights: A Framework for Analysis*, 12 U.C. DAVIS L. REV. 255, 256 (1979).

exercise of constitutional rights. In *Paris Adult Theatre I. v. Slaton*,⁴³ the Court employed this theory, presuming that the child was incompetent and requiring “clear and convincing evidence” to rebut that presumption. Few courts recognize that children have any interests independent of their parents’ and the State’s.⁴⁴In the context of older children seeking or refusing mental health treatment, this presumption simply does not make sense, as allowing a mature adolescent to make a medical decision, “entails relatively few risks and potentially great benefits.”⁴⁵ It would be rare that psychologists, parents, and the State would be incapable of proving the incompetence of a child if that were truly the case, and the benefits for the minor include: taking ownership of one’s own treatment and learning a level of responsibility that correlates with competence. Furthermore, the current “incapacity” approach does not show the respect for personhood that is the usual focus of the U.S. legal system.

B. Recent Transformations in Jurisprudential View of Children’s Rights

As substantive due process and privacy jurisprudence have grown, so have “due process” rights for children.⁴⁶ The recognition of common law rights of informed consent and bodily integrity for children has also contributed to this movement.⁴⁷ In *Schmerber v. California*, the Court explained that “[t]he integrity of an individual’s person is a cherished value of our society.”⁴⁸ For example, laws restricting abortion for mature minors are subject to strict scrutiny and thus must have a judicial bypass provision.⁴⁹ The Court also invalidated a New York statute that prohibited the distribution of non-medical contraceptives to children age sixteen and above except through a licensed pharmacist and entirely proscribed their distribution to those under sixteen.⁵⁰ Moreover, courts have recently recognized minors’ rights in other non-life threatening situations, such as in treating disfigurement.⁵¹

Even more interesting, and perhaps controversial, however, are court decisions to permit competent minors to refuse life-saving treatment. A minor’s

43. 413 U.S. 49, 64 (1973).

44. Schlam, *supra* note 12, at 149.

45. Redding, *supra* note 3, at 723.

46. In *In re Gault*, “[t]he Court held that due process requires that a minor be given adequate written notice of the issues, the right to be represented by counsel, the right to confront his or her accusers and the right to cross-examine witnesses.” Powers, *supra* note 4, at 150 (describing 387 U.S. 1 (1967)). In *Griswold v. Connecticut*, the privacy right was used to bar unwanted medical procedures because there was no legitimate state interest with a less intrusive method available to accommodate that interest. 381, U.S. 479 (1965).

47. See Hawkins, *supra* note 30, at 2093. Under this doctrine, a patient must receive all information about the benefits and risks of treatment in order to consent effectively.

48. 384 U.S. 757 (1966).

49. *Bellotti v. Baird*, 443 U.S. 622 (1979).

50. *Carey v. Population Serv. Int’l.*, 431 U.S. 678 (1977). The state failed to demonstrate the required “significant state policy” justifying the total prohibition on the distribution to minors. *Id.* at 697.

51. *In re Sampson*, 317 N.Y.S.2d 641, 657 (Fam. Ct. 1970).

religious freedom justified permitting a 17-year-old Jehovah's Witness to refuse a blood transfusion.⁵² Another minor's wish to be free from extreme, long-lasting pain and discomfort justified permitting him to stop chemotherapy treatment.⁵³ Cases like these present a life-liberty tension. Cases involving psychotropic medication can be analogized to these cases because in extreme circumstances, the consent to, or refusal of, these medications is life-threatening, especially when suicidal thoughts are involved. Despite the existence of safety concerns, we must not forget the precautions in place in a system requiring competence for the exercise of liberties. Nor can we forget the long-term value of liberty itself. According to Henry H. Foster, Jr., author of A "Bill of Rights" for Children, the burden should be on the party wishing to abridge the child's freedom and autonomy to demonstrate that his position is in the "best interests" of the minor.⁵⁴ Of course, Foster's view promotes a more limited view of the child's role in coming to a decision about his medical treatment than this Note. In his view, if the child's decision is not in his own "best interests," then the judge should decide against the competent child's wishes. Still, his writing serves to show a trend in U.S. courts of recognizing the importance of a child's participation in the decision to obtain or refuse psychotropic medication.⁵⁵

C. Reasons for Expanding this Jurisprudence in the Psychotropic Medication Setting

The U.S., as well as the rest of the world,⁵⁶ has finally realized that children, too, have rights. Essentially, there is a "better means for protecting parental autonomy than silencing children."⁵⁷ Substantive due process provides the strongest constitutional argument for recognizing a child's right to make decisions regarding mental health treatment. Due process denotes "not merely freedom from bodily restraint" but also the enjoyment of privileges relating to the "orderly pursuit of happiness by free men."⁵⁸ Decisions regarding psychotropic medication fall into this category of privileges because they affect the way in which a minor thinks, feels, and behaves. Thus, when the law prohibits minors from making this decision, paying no regard to their competency level, it is acting arbitrarily and capriciously to deprive them of their fundamental rights.

Therapeutic jurisprudence tells us that when one is involved in his own

52. In re E.G., 549 N.E.2d 322, 327-28 (1989).

53. Richard A. Knox, *Billy Best's Case Reveals Gray Area of Patient Rights*, BOSTON GLOBE 1, 19 (Nov. 23, 1994).

54. See Hawkins, *supra* note 30, at 2131.

55. It should be noted, however, that "[c]ourts are more responsive to minor's requests for autonomy when the request involves access to rather than refusal of certain treatment." Powers, *supra* note 4, at 166 (comparing *Bellotti v. Baird* and *Planned Parenthood v. Danforth* with *Parham v. J.R.*).

56. See Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3. This Convention has not been signed by the United States.

57. Hawkins, *supra* note 30, at 2117.

58. *Meyer v. Nebraska*, 43 S. Ct. 625, 626 (1923).

decision about mental health treatment, he has better views about it, his resistance to needed treatment is reduced, he fosters appropriate expectations, and he further develops his decisionmaking competencies.⁵⁹ With the classic “family-based” model gone, the child may have a more stable and balanced viewpoint of the treatment sought.⁶⁰ Moreover, an adverse outcome is easier for a child to accept when his voice has been heard.⁶¹ This idea should not be shocking, as it is consistent with the U.S.’s adversarial model, which emphasizes the fundamental importance of individual autonomy and fairness in human relations.⁶² If we promote these values with those persons who are mentally disabled (courts presume their competency⁶³), then it only makes sense to do so in the context of potentially-capable minors as well. It seems odd that privacy interests, bodily integrity, confidentiality, and self-determination⁶⁴ are all subject to the discretion of the trial court solely because of the age of an individual.⁶⁵ Additionally, it seems strange that a country that values freedom so highly would grant minors rights to abortion but not rights to enter or leave civil commitment, which is, arguably, just as “confining.”⁶⁶ It is likely that uncertainty about medical advances, combined with backward views about mental health, contribute to a legal philosophy in the arena of child access to psychotropic medication that runs counter to the legal philosophy in the arena of other rights belonging to children.

The First Amendment Right of Free Speech also provides a means for minors to enforce their right to consent to medical treatment.⁶⁷ In *Shields v. Burge*, concerning a state statute restricting electroconvulsive therapy and psychosurgery, Judge Cudahy wrote in his concurrence, “Freedom of thought is intimately touched upon by any regulation of procedures affecting thought and feelings.”⁶⁸ Psychological therapy directly involves speech

59. See Redding, *supra* note 3, at 709.

60. Schlam, *supra* note 13, at 150.

61. Hawkins, *supra* note 30, at 2111.

62. See *id.* at 2119.

63. Redding, *supra* note 3, at 715.

64. An individual has a right to his person that is “inviolable.” *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957). Another case expressed, “Among the historic liberties was a right to be free from . . . unjustified intrusions on personal security.” *Ingraham v. Wright*, 430 U.S. 651, 673 (1977).

65. Often, trial judges do not even need to articulate how they came to the conclusion that the minor was not competent to consent to, or refuse, treatment, creating uncertainty for the vindication of rights. See Schlam, *supra* note 13, at 162.

66. Decisions about mental health treatment, as with abortion, “(1) involve critical implications for the minor’s future life, (2) are time-sensitive and cannot be postponed until the minor reaches legal adulthood, and (3) are inextricably linked with the individual’s personal values.” Costello, *supra* note 5, at 619. See also James W. Ellis, *Some Observations on the Juvenile Commitment Cases: Reconceptualizing What the Child Has at Stake*, 31 LOY. L.A. L. REV. 929 (1998) (arguing that children have liberty interests at stake in the mental disability system). Ellis found *Parham v. J.R.*’s rejection of the argument that mature minors should be able to participate in their mental health decisions in contexts not related to abortion or civil commitment “unpersuasive.” *Id.* at 934.

67. Still, children’s First Amendment speech rights are more limited than adults’. See *Tinker v. Des Moines School District*, 393 U.S. 503 (1969); *Hazelwood School District v. Kuhlmeier*, 484 U.S. 260 (1988) (looking at U.S. CONST. amend. 1).

68. 874 F.2d. 1201, 1212–13 (7th Cir. 1989).

rights, so treatments that include both therapy and medication implicate children's speech rights.

Further, policy reasons exist in support of providing minors with enforceable rights to obtain or refuse psychotropic medication. Law is a social force that produces or discourages certain behaviors. If it is applied in a therapeutic way, yet still promotes other important values like justice and due process, it can affect our lives more broadly than it currently does. For instance, if a minor is not permitted to make decisions regarding her mental health treatment, as an adult she may equate asking for help with the status of a child, making her less likely to ask for needed help. On the other side of the coin, if she is forced to take medications now against her wishes, she may in the long-term reject them due to her lack of involvement in the initial decision.⁶⁹ Therapeutic jurisprudence argues that four tasks are involved in enabling adolescents with mental disorders to find success in treatment: identification and acceptance of the illness, learning the risks and benefits of treatments, exploring those treatments in her personal life, and preparing for adulthood.⁷⁰ Ultimately, the goal is to aid the minor is recognizing when she needs treatment and support and to provide her with positive reinforcement in that experience.⁷¹

In order to enforce these legal rights to medical treatment, minors must have access to attorneys. Since guardians *ad litem* typically advocate the minor's best interests rather than his expressed wishes, a new method of counsel is necessary. Client control is an ideological basis of our adversary system, and American Bar Association ethics rules require normal client-lawyer relationships to the extent feasible when dealing with adults, even potentially incompetent ones.⁷² It makes sense to extend this theory to mature minors, especially since several studies have shown their level of competence to be similar to that of many adults.⁷³ Based on these theories, the lawyer should be more than a neutral investigator for the court: he should remain loyal to the child's interests to avoid usurping the judge's role.⁷⁴ Ultimately, the minor's counsel should act a traditional advocate for his client.

III. ASSESSING A MINOR'S COMPETENCE

Legislatures and courts have slowly begun to make changes so that competent minors can have access to psychotropic medication. The most common methods of access are: emancipated minor statutes, mature minor statutes, and age of consent laws. Other exceptions to age-based laws exist as

69. See Costello, *supra* note 5, at 634. See also BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 328-37 (Am. Psychol. Ass'n ed., 1997).

70. Costello, *supra* note 5, at 633.

71. *Id.*

72. MODEL RULES OF PROF'L CONDUCT R. 1.4(b) (1983).

73. See Redding, *supra* note 3, at 742.

74. See Hawkins, *supra* note 30, at 2107.

well. In addition, psychologists are developing methods of testing competence. These will likely be codified in future laws, allowing mature minors to have more freedom in deciding whether to accept or refuse psychotropic medication.

A. Current Status of the Law

Since at common law minors could not consent to medical treatment, legislatures developed emancipated minor laws in order to permit minors to consent to enumerated treatments.⁷⁵ Generally, these laws require minors to live on their own, be married, serve in the military, have a child, or be financially self-sufficient, thus the minors must establish their “emancipated” state. Usually this status requires a “judicial determination⁷⁶” or “court order.⁷⁷” The target populace are those minors whose “parents (have) relinquished control over their [] behavior and personal affairs.”⁷⁸

Mature minor laws are slightly different, as they do not require an “emancipated” status. Still, the minor must be near the age of maturity, and courts have discretion to determine whether permitting him to decide would serve his best interests.⁷⁹ In general, only certain medical conditions are covered, such as “pregnancy, sexually transmitted diseases (“STDs”), contraception, substance, abuse, and mental illness.⁸⁰ These statutes’ primary purpose is to encourage minors to seek confidential medical care, so they do not require a finding of maturity *per se*.⁸¹ While these laws are beneficial when parents are unaware of the treatment sought, they are not extremely helpful when parent and child interests are directly in conflict. Some statutes, on the other hand, require an affirmative showing of competence; therefore, they cover these latter situations with more certainty. Even if a state does not have a mature minor statute, courts can use the doctrine established at common law.⁸² In the *Bellotti* case, the Court recommended a maturity test,⁸³ and in *In re E.G.*, the Illinois Supreme Court held that the common law doctrine required the plaintiff to establish by clear and convincing evidence that she was “mature enough to appreciate the consequence of her actions” and “mature

75. Redding, *supra* note 3, at 712

76. Hawkins, *supra* note 30, at 2123.

77. Schlam, *supra* note 13, at 165.

78. Nancy Betterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 *Touro L. Rev.* 637, 672 (1994).

79. *Id.* at 712.

80. Hawkins, *supra* note 32, at 2123 (summarizing Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 *J. PEDIATRICS* 520, 521 (1991)). Twenty-three states allow minors to get birth control without parental consent. Forty-nine allow minors twelve and older to receive treatment for STDs without parental consent. Some states allow treatment for infectious, communicable, or contagious diseases. See Schlam, *supra* note 13, at 166.

81. Schlam, *supra* note 13, at 166.

82. *Id.*

83. *Bellotti v. Baird*, 443 U.S. 622, 622 (1979).

enough to exercise the judgment of an adult.”⁸⁴ Unfortunately, “no court or statute has ever articulated a precise standard for determining whether a minor is mature,”⁸⁵ posing significant problems for application of the mature minor doctrine.

Age of consent laws stipulate certain age requirements, usually ages twelve to fifteen, for minors to obtain treatment.⁸⁶ They can refer to all medical treatments or to more specific treatments, such as voluntary commitment or outpatient services. These consent laws can also be combined with the two former doctrines in special circumstances. As the risk to the minor increases, greater evidence of maturity is needed with the two former doctrines,⁸⁷ whereas with age of consent laws, no evidence of maturity is required.

Courts, too, have stretched common law doctrines in order to grant the right of consent to medical treatment to minors. Still, a court has never granted a patient under fourteen the right to consent to medical treatment.⁸⁸ The rule of sevens has been utilized in many courts: children under seven have no capacity to consent, children seven to fourteen are presumed incapable of consent, and children age fourteen and up are presumed capable of consent.⁸⁹ The use of this rule, however, has been sporadic.

While legislatures and courts are working hard to protect the rights of competent minors, the aforementioned methods create uncertainty for minors who wish to exercise their rights. Codification of these doctrines would enhance predictability, leading to discussions that would eventually bring consistency across state lines. Established methods of determining competence would also help create this consistency.

B. Suggested Methods of Determining Competence

Since there is no true age boundary between an incompetent child and a competent child or adult,⁹⁰ we need to develop standards to determine competency. Researcher Jean Piaget found that children ages eleven and up can exercise independent thought, analyze outcomes, and think logically and deductively.⁹¹ Similarly, Lawrence Kohlberg found that “moral thinking” occurs around age thirteen or fourteen.⁹² These studies indicate that minors

84. *In re E.G.*, 549 N.E.2d 322, 327–28 (Ill. 1989).

85. Hawkins, *supra* note 30, at 2124.

86. *Id.*

87. Schlam, *supra* note 13, at 158.

88. *Id.*

89. *Id.* at 158–59 (citing *Lacey v. Laird*, 139 N.E.2d 25, 33 (Ohio 1956) (holding that physician is not liable for battery for performing surgery on a mature minor if he has her consent)).

90. Schlam, *supra* note 13, at 153; see also Joan Margaret Kun, *Rejecting the Adage “Children Should be Seen and Not Heard” –the Mature Minor Doctrine*, 16 PACE L. REV. 423 (1996).

91. See Wallace J. Mlyniec, *A Judge’s Ethical Dilemma: Assessing a Child’s Capacity to Choose*, 64 FORDHAM L. REV. 1873, 1879 (1996).

92. See JOHN W. SANTROCK, *ADOLESCENCE* 407 (Jane Vaicunas, 7th ed. 1998).

age fourteen and above are likely competent.⁹³ The minor's informed consent then, should be based on a competency exam that considers as the primary factor his understanding of the nature, extent, and probable outcome of treatment.⁹⁴

While legal and scientific communities have failed to reach a consensus regarding the definition of competency, state legislatures and courts have developed standards based on: (1) factual understanding of the problem and treatment alternatives; (2) rational decision-making processes; (3) appreciation for the personal implications of the decision; (4) ability to make and communicate a choice; (5) a reasonable choice; and (6) general competence.⁹⁵ For the most part, factual understanding is required in a legal finding of competency.⁹⁶ Minor consent statutes also consider the appreciation standard to be highly important,⁹⁷ and psychologists prefer to use this standard over the "factual understanding" standard.⁹⁸ More specifically, it refers to a "minor's set of values concerning the treatment, or her 'conception of the good.'"⁹⁹ Consensus exists that a sliding-scale approach is useful in determining the requisite level of competence: when the "potential benefits significantly outweigh the risks, a demanding standard of capacity" should be used for a patient refusing medication.¹⁰⁰ The converse is true with a patient seeking medication. Informed consent doctrine provides another vital factor in determining competency for medical treatment: voluntariness, or "the degree to which the patient's decision is free from coercion and manipulation by others."¹⁰¹ To assess voluntariness, the examiner should consider family dynamics.

Once legislatures establish a standard, they must create practical tests.

93. See Schlam, *supra* note 13, at 156.

94. *Id.* At 155.

95. Redding, *supra* note 3, at 710-11

The factual standard generally requires 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, and one's role and rights in the informed consent process. The rational decision-making 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.

Id. at 710 (The appreciation standard requires emotional maturity, while the reasonable choice standard ensures that the choice is not the product of mental illness. Finally, the general competency standard is determined by diagnosis, appearance, and prior behavior. Some commentators suggest using general competency as the threshold, then one of the more specific standards as an added test.).

96. Researchers have created the "Measuring Understanding of Disclosure" test for assessing factual understanding. It consists of three subtests: uninterrupted disclosure, single-unit disclosure, and single-unit recognition. *Id.* at 745.

97. *Id.* at 711.

98. *Id.* at 747. Psychiatrists did not test factual understanding in 81% of cases, but they tested "appreciation" in 86% of cases, resulting in underestimations of capacity. See Karen McKinnon et al., *Rivers in Practice: Clinicians' Assessments of Patients' Decision-Making Capacity*, 40 HOSP. AND COMMUNITY PSYCHIATRY 1159, 1161-62 (1989).

99. Hawkins, *supra* note 30, at 2128.

100. *Id.*

101. *Id.* at 2127.

The “most common and practical” approach, which has been used with adults, is to ask the client questions or have him provide treatment facts, risks, benefits, and factors he would use in making his decision.¹⁰² Variations in this approach can be utilized for children. For instance, a clinician may use a scoring method, where a point is given for each response based on an adequate, partial, or poor understanding.¹⁰³ With legal questions, the clinician can present the child with scenarios where rights are violated, asking the child to explain what right is violated and how it was violated.¹⁰⁴ For assessing the understanding of risks and benefits, the clinician can ask the child to define the meanings of these terms by giving examples.

With minors, competence can be both over- and underestimated. For example, a minor may believe he understands a word that has different common and legal usages. On the other hand, he may be capable of understanding a concept without recognizing the words used by the examiner. Therefore, the examiner should use simple vocabulary and probe deeply into the child’s decision to ensure that it is not a “transient one.”¹⁰⁵ Additionally, competency must be viewed as separate from mental illness.¹⁰⁶ Since children’s cognitive abilities do not develop simultaneously, an overall “competency” standard is “misleading.”¹⁰⁷ Competency is domain-specific, an aspect that the law recognizes, so tests of competency must be tailored to the circumstances.¹⁰⁸

Still, it seems to be common knowledge that children behave irrationally and emotionally, raising concerns about giving children the opportunity to make such drastic decisions for themselves. For example, a child may understand certain issues but not “deal with them emotionally in ways that result in mature decision-making.”¹⁰⁹ “Much depends on the individual, the particular issues, and the context.”¹¹⁰ In these situations, the “reasonable choice” standard may provide a solution, where the evaluator can throw out a decision that is too irrational. Analogize this to an abuse of discretion standard utilized by a court. Of course, when the evaluator’s judgment enters the picture, there is always a chance that he will merely substitute his own judgment for that of the minor’s. This may be an inevitable risk, but it can be minimized with safeguards. For instance, even if the child experiences delusions, the

102. Redding, *supra* note 3, at 745.

103. *Id.*

104. *Id.* A “Waiver Expectancy Interview” can be useful in this situation: it measures the child’s expectations regarding the effects of waiving rights in certain circumstances. *Id.* at 746.

105. *Id.* at 747.

106. “[C]ognitive deficits tend to impair competence more than do emotional problems.” *Id.* at n. 315 (analyzing Thomas Grisso & Paul S. Appelbaum, *Mentally Ill and Non-Mentally-Ill Patients’ Abilities to Understand Informed Consent Disclosures for Medication*, 15 L. & Human Behav. 377, 385–387 (1991)); see also Lisa Grossman & Frank Summers, *A Study of the Capacity of Schizophrenic Patients to Give Informed Consent*, 31 HOSP. & COMMUNITY PSYCHIATRY 205 (1980).

107. Redding, *supra* note 3, at 747–48.

108. *Id.* at 748.

109. *Id.*

110. *Id.*

evaluator can have a policy that only delusions relating to treatment decision-making become relevant for informed consent purposes.¹¹¹

Critics also suggest that “peer influence” and a child’s focus on “short-term consequences” can pose problems.¹¹² Well-developed competency tests, however, should weed out decisions based on these factors. Even if they do not, “[n]o empirical evidence . . . supports the view that psychosocial factors directly affect individual medical decision-making.”¹¹³ These factors, along with the desire to avoid punishment and criticism, probably come into play with children under the age of eleven,¹¹⁴ which explains why this Note supports maintaining a cut-off age of eleven. Of course, this cut-off age should not be conclusive—it still *permits* a minor to obtain counsel to prove his competence.

Although minors ages eleven to fourteen differ greatly in their ability to make rational and informed decisions, it is more consistent with our adversarial system to err on the side of protecting due process rights. Moreover, *Miranda*-type warnings can be used in all cases to create a standardized method of informing minors and assessing their competence.¹¹⁵ Lastly, we need not think of the competency exam as the determining factor in a judge’s decision to grant consent rights to a minor. For example, the minor’s counsel can advise the minor to reconsider his opinion, and he may be able to do this better than a parent would. It is necessary to keep each part of the process of assessing competence in context.

Throughout this section, we have briefly reviewed legislatures’ and courts’ methods of granting consent and refusal rights to minors for medical treatment. We have also examined legal, medical, and psychological approaches to assessing the level of competence required in order to exercise these rights. While difficulties exist when dealing with minors, psychologists have developed ways to minimize the risks that minors are acting under coercion, social pressure, and misunderstandings. Now that we understand the legal landscape underlying a child’s right to consent to, or refuse, mental health treatment (and thus psychotropic medication), it is time to develop a comprehensive and consistent way of protecting that child’s rights while still promoting healthy family relationships.

IV. PROPOSED SOLUTIONS

In this Section, I propose two fundamental changes in the law: substantive due process rights for minors to access or refuse mental health treatment and procedures that better ensure the exercise of those rights. Specifically,

111. *Id.* at 749.

112. Schlam, *supra* note 13, at 156.

113. *Id.* (citing Elizabeth Cauffman & Lawrence Steinberg, *The Cognitive & Affective Influences on Adolescent Decision-Making*, 68 TEMP. L. REV. 1763, 1788 (1965)).

114. Redding, *supra* note 3, at 728.

115. *Id.* at 742–43.

minors age eleven and up should be provided with counsel advocating their competency to make decisions about psychotropic medication. If minors are found to be competent, the ultimate decision should be theirs. Still, I recommend that the Supreme Court exercise judicial restraint and caution to allow states to figure out the best way to protect children's rights in this context.

A. Procedural Due Process Rights – The Right to be Heard

Before minors can exercise their right to consent to or refuse psychotropic medication, they must have the opportunity to be heard. A quasi-judicial trial is not necessary, but the minor must be able to present evidence to a neutral fact-finder. One possibility is an administrative hearing, which would have relaxed evidentiary procedures that would help the minor.¹¹⁶ The problem in this circumstance, of course, is who would raise the issue: the child or the parents? Since the law presumes parental control, the minor has to raise the issue. State legislatures could enact statutes requiring mental health professionals to report when there is substantial disagreement between parents and a child regarding the child's mental health treatment. Additionally, these laws could require professionals to inform the minor of his right of access to an attorney for these decisions.

In order to curb excessive litigation, Therese Powers suggests using factors from the case *Matthews v. Eldridge*¹¹⁷ to determine the amount of procedural protection a child should receive: the importance of the hearing to the person demanding it, the importance of the governmental interest, and the value of a hearing in ascertaining the truth.¹¹⁸ Still, legislatures and courts are "reluctant to intrude on the sanctity of the family" and hearings can be expensive and wasteful.¹¹⁹ Even more problematic, children may demand hearings in order to use legal fees as a bargaining chip.¹²⁰ For these reasons, there should be no guarantee for children under eleven to receive counsel at the outset; under that age marker, a guarantee is too inefficient as the risks outweigh the few benefits. Hardly any of the children will be found competent to make the decision about medication, so the cut-off age is at least rational.¹²¹ For older children, however, counsel should still be guaranteed. First, the cost-benefit analysis is different, especially for children ages fourteen and up, as they are more likely to be found competent to make their own medical decisions.¹²² Second, the risk of a minor taking advantage of the system should not alone be sufficient to take away his *constitutionally guaranteed*

116. Powers, *supra* note 4, at 167–68.

117. 424 U.S. 319 (1976) (holding due process did not require a hearing prior to termination of Social Security benefits).

118. *Id.* at 341–46.

119. Powers, *supra* note 4, at 168.

120. *Id.*

121. Children under eleven should still be *permitted* to acquire counsel—they simply will not be *guaranteed* it.

122. See *supra* text accompanying notes 86–89.

due process rights. Third, safeguards can be put into place in order to minimize cost and waste. For example, options analogous to motions to dismiss and summary judgment should be a part of the administrative process in order that only cases involving real factual issues reach a hearing.

Some scholars prefer the true trial setting. This setting is most apt to protect the minor's due process rights to the full extent, and its evidentiary requirements ensure that decisions are more accurate. In some disputes, a trial might be necessary, but an administrative hearing would be a better option, especially if the law seeks to promote family values. The ultimate adversarial setting of a courtroom would probably increase family strife, potentially causing even more problems for the child seeking to assert his rights. An administrative hearing, on the other hand, is less formal and less adversarial, providing the two parties an opportunity to work out their differences more amicably. Even a "hearing" less formal than an administrative one could be desirable, so long as a neutral fact-finder and counsel are present. Other scholars believe that it is counterproductive to the family unit to have an adversarial hearing at all, in which case something like mediation or conciliation may be the best primary options. Still, the belief that a trial creates too much tension is less applicable in a situation where tension has already arisen on its own, through normal family discussions. The legal question appears only after the parents and child have failed to resolve the situation on their own. While in some mental health instances the "concern of family and friends generally will provide continuous opportunities" for erroneous decisions to be "corrected," in the case of psychotropic medication, it is likely that family and friends will not even be aware of the decision being made.¹²³

At this juncture, it is important to confront many arguments presented by critics of child's rights advocates. Lynn D. Wardle, for example, writes that we have a "cult of rights" that is especially "troubling" in family law.¹²⁴ He claims that child advocates make two common errors: undervaluing the institutions of marriage and parenting, and overvaluing children's rights.¹²⁵ I propose that the arguments set forth in this Note do not fall into either of those traps. With regard to "undervaluing" family institutions, there is little risk that recognizing a competent, mature minor's right to obtain or refuse psychotropic medication will destroy families or tell parents that they are not important decision-makers in their children's lives. With a presumption of competence at age fourteen, this proposal merely reflects the reality that minors and parents should be moving towards a more "equal" playing field in making decisions, collaborating rather than mandating and following orders as children mature. Moreover, legal recognition of minors' rights in this lim-

123. The quoted phrase refers to civil commitment cases, which inherently alert other family members and friends (more than a decision to use psychotropic medication) because the parents must offer an explanation of where their child is. Ellis, *supra* note 66, at 931.

124. Lynn D. Wardle, *The Use and Abuse of Rights Rhetoric: the Constitutional Rights of Children*, 27 LOY. U. CHI. L.J. 321 (1996).

125. *Id.* at 327-37.

ited context should encourage parents to involve their children in the decisions before litigation is even anticipated. In reference to “overvaluing” children’s rights, Ellis comments broadly on the changing landscape of rights and the opportunity for activist groups to use “rights” language to protect their own interests.¹²⁶ She also compares rights with virtues, saying that “the most important right we can give our children is the right to be taught virtue”¹²⁷ in a family setting. These arguments certainly remind us to be thoughtful and wary in recognizing rights, but they do not answer the legal question in particular cases like the one at hand. Respect for the family institution simply does not require abrogation of a mature, competent minor’s fundamental right to choose whether to place psychotropic medication into his or her body.

A defense of children’s rights has been presented by James G. Dwyer, who claims that it is not legitimate to even recognize parents’ rights over their children.¹²⁸ He argues that only children, as individuals, have rights to themselves, and parents have only a “privilege.”¹²⁹ He notes that a jurisprudential shift like this does not translate to increased State intervention.¹³⁰ This Note does not wish to go as far as Mr. Dwyer proposes, as it focuses on the importance of competence in determining who can make a decision relating to psychotropic medication; however, Mr. Dwyer points out the flaw in Ms. Wardle’s view: historical habits and the value of family life are not sufficient justifications for restricting liberty of self. Another concern one could raise in this context is that a minor who truly needs medication will not receive it, endangering his life. This concern, however, is not legitimate. First, it seems to assume that the minor is not competent to make the decision himself. Even if competency is accepted, the reasoning is still flawed in that it fails to give due weight to the fundamental right of the minor to make this decision, right or wrong. When it comes to adults, we do not question their right to make this choice (assuming they are competent and do not qualify for State intervention because they pose a threat to others or an imminent and almost certain threat to themselves), so it is irrational to ignore the value of this fundamental right when it comes to competent minors, simply because of their age. The Constitution, through the Fifth and Fourteenth Amendments, has already made that value judgment: the benefit of liberty is worth the cost that people will occasionally make wrong decisions. Unless this cost-benefit analysis is reversed for adults, it should not be reversed with regard to competent children.

The last due process requirement proposed by this Note is that minors

126. *Id.* at 333-37.

127. *Id.* at 342.

128. James G. Dwyer, *Parents’ Religion and Children’s Welfare: Debunking the Doctrine of Parents’ Rights*, 82 CALIF. L. REV. 1371 (1994).

129. *Id.* at 1374.

130. *Id.* at 1376; see also Michael Wald, *State Intervention on Behalf of “Neglected” Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985 (1975).

ages eleven and up be provided with legal counsel from the outset of a dispute (before any litigation, hearings, or mediation begin), as they are unable to understand and research legal issues nor represent themselves adequately. This counsel should not act as a champion of their “best interests” or as an independent evaluator: he or she should take on the typical advocate’s role and promote the actual wishes of his or her client.¹³¹ In other words, the attorney will first seek to prove the minor’s competence and then seek to protect the minor’s rights with regard to the medication. Of course, representation includes counseling, so if the attorney disagrees with the minor’s wishes, he has the duty to provide his client with advice. The minor will be more apt to listen to someone seeking to represent his wishes. Once a minor receives procedural guarantees, she can move to the merits of her case.

B. The Merits – A Competent Minor’s “Best Interests” or True Choice?

While recognition of minors’ rights to consent to or refuse psychotropic medication is vital, we should be careful not to move too quickly. For legitimacy concerns, the Court should not move to guarantee every competent child an absolute right to do what he or she wishes with respect to this medication. Instead, the Court should take a case where it can recognize that a child has the privacy and self-determinative interests that provide a foundation for such a right, and that the child’s right is at least equal to the rights of his parents and the State. From there, states should be provided some time to experiment and work out different ways in which that right can be exercised.¹³² If the Court automatically grants an absolute right to all minors, it may not be able to perceive the long-term effects on the judicial system, such as cost and waste of time, nor on the child-patients and families themselves. States can be more flexible to the initial changes that might occur.

State legislatures should begin by codifying mature minor doctrine with specific age brackets. For minors ages eleven and up, counsel and an independent medical examiner (“IME”) should be automatically guaranteed. For minors ages eleven to thirteen, the neutral fact-finder should presume their incompetence, but they should have the opportunity to prove by clear and convincing evidence that they are competent to make their own mental health decisions. The IME should then assess the minor’s competence through the following tests: (1) general competence; (2) specific understanding of the risks and benefits of treatment; and (3) voluntariness.¹³³ General competence should be the minimum pre-requisite for access to psychotropic

131. Hawkins, *supra* note 30, at 2078.

132. For example, Justice Ginsburg, who supports women’s rights to abortion, believes that the Supreme Court moved too quickly in recognizing a fundamental right to an abortion, sparking much opposition. See Allen Pusey, *Ginsburg: Court Should Have Avoided Broad-Based Decision in Roe v. Wade*, ABA JOURNAL (May 13, 2013, 9:20AM), available at http://www.abajournal.com/news/article/ginsburg_expands_on_her_disenchantment_with_roe_v_wade_legacy/. To avoid such a phenomenon, the Court should be more wary in recognizing a child’s constitutional rights regarding medication.

133. See Redding, *supra* note 3, at 710, 742.

medication. Additionally, factual understanding of the treatment, rational decision-making processes, and an appreciation for the personal implications of the decision should be factors in an IME's assessment.¹³⁴ During the assessment, the IME should seek out any extraneous influences, such as peer pressure, coercion from parents, or emotional disturbances.

If the IME does not find the child to be competent, the case should be dismissed. If, however, he finds that the minor is competent, counsel for the minor should begin advocating the minor's competence in the hearing in order to obtain a legal/judicial finding of competence. Here, the neutral fact-finder needs a legal standard for determining competence: the best standard would be one written by the legislature. I propose that the legislature require that (1) the minor understand the implications of his choice, (2) the choice have a reasonable outcome, and (3) the choice have a rational basis. In this proposal, the judge would need to find that all the elements were met. A state could also propose a standard more similar to an evidentiary one, where the trial court considers several factors as a whole and makes a totality-of-the-circumstances determination. This approach, though, would be more similar to the doctrines already employed by courts, which we have determined are not sufficiently protective of minors' constitutional rights.

Once the judge or neutral fact-finder has made a finding of competence, he has two choices: either allow the minor to make the decision regarding mental health treatment or decide what is in the "best interests" of the minor, taking into consideration the minor's wishes. Both are viable options, as they afford the minor an opportunity to be heard and to have his wishes influence the ultimate decision. Thus, both choices protect the constitutional rights of minors. Of course, the latter approach counteracts mistakes in the competency finding and ensures that a reasonable choice is made.¹³⁵ At times, it may be impossible to weed out emotional or short-term factors affecting a minor's decision. Still, it is impossible to weed out irrational effects on just about any human decision, even that of the highest-functioning adult. The former approach is the better alternative because it most fully respects the minor as a capable individual, comporting with our legal system's values of self-determination and autonomy. While it involves some risk, it is subject to the independent judgment of both an IME and a neutral fact-finder. Also, counsel advises the minor throughout the process, minimizing the risk. Lastly, the judge should probably consider the parents' and State's interests when deciding if the choice made by the minor is "reasonable."

One commentator suggests an approach slightly different from this Note's: in seeking a diagnosis, the teen's "yes" should trump the parents' "no" and vice-versa since the "adolescent, parent, and state all have an inter-

134. *Id.* at 716.

135. *See supra* text accompanying note 52.

est in obtaining a correct diagnosis of a mental disability and accurate information about appropriate treatment¹³⁶ While this is true in this instance, the same logic does not apply to obtaining a prescription for psychotropic medication. Certainly we wish to encourage proper diagnoses and increase the amount of information available to parents and their children when a child is experiencing mental health issues. So in the fact-gathering process, the “yes” trumping “no” method is best. However, once a physician has made a diagnosis and offered treatment options, the competent minor’s decision, so long as it is mostly free from extraneous influences, should reflect his autonomy and personal values.

V. CONCLUSION

While recognizing parental rights in the custody of children has proven beneficial over the past couple of centuries, new developments in medicine and increased knowledge of human growth tell us that changes need to be made in the legal system with regard to mental health. State legislatures and courts have already come to this conclusion—creating emancipated minor and mature minor statutes and finding common law doctrines that provide minors with constitutional rights. These attempts at granting minors autonomy, however, have resulted in great uncertainty and inconsistency. In order to ameliorate the situation, the Supreme Court should take a case where it can recognize that competent children also have privacy and self-determination interests equal to those of their parents and the State when it comes to decisions about psychotropic medication. The Court should keep its holding narrow so as to avoid changes it cannot anticipate. The states, then, will be motivated to codify mature minor doctrine. Ideally, states would create age brackets that reflect the results of scientific studies, utilizing age as a proxy for competence in a more logical way.

This Note has proposed that no changes be made for minors ages eleven and under because studies indicate that almost no children in that age group are capable of making informed decisions regarding their mental health care. Minors ages eleven and up, on the other hand, should be provided with counsel advocating their competence, along with an independent mental health examiner who can determine their competency. Those under fourteen in this group, however, should be presumed incompetent but should be provided the opportunity to show by clear and convincing evidence their ability to make the medical decision. Those fourteen and over should be presumed competent, with those claiming otherwise with the burden of proof. With this set-up, the law would actually reflect the reality that older, more mature children are physically and emotionally capable of the level of thought required for a decision about psychotropic medication. The age brackets and burden of proof help to minimize the risk of an inappropriate decision being

136. Costello, *supra* note 5, at 637.

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made by an incapable minor—they resolve the competing values of autonomy and safety. Ultimately, recognition of minors' rights to obtain or refuse psychotropic medication encourages true family discussion, respect for the autonomy of the individual, and proper attitudes about mental health treatment.