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# Psychiatric and Chemical Dependency Treatment of Minors: The Myth of Voluntary Treatment and the Capacity to Consent

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## I. Introduction

The involuntary treatment of individuals for mental health and chemical dependency problems has generated considerable debate and controversy. Questions concerning a state's right to forcibly treat someone against his will, the circumstances and standards required to invoke this treatment, the decision-making process to determine if those standards have been met, consent, and the patient's rights throughout this procedure have resulted in much litigation as well as legislative activity.

Conflicting interests and the resulting controversy are even more pronounced when the person subjected to the involuntary treatment is a minor. The confinement of juveniles for treatment is an extremely complex and controversial issue. It is the focus of debate on the part of policy makers, professionals, public interest groups, child advocates, and the public at large. This debate has intensified as recent data has become available indicating a sharp rise in admissions for such treatment, primarily in private hospitals and free-standing residential facilities.

Since minors, by the mere fact of their minority, are deemed to be incompetent to consent to treatment (with some statutory exceptions), parents and guardians can consent for them, thus making the

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confinement "voluntary" although the person being confined has not consented. This situation has resulted in the development of mental health and chemical dependency placement procedures and treatment programs for minors characterized by little supervision or judicial review. Admission, consent, treatment, release, and the right to refuse treatment are proper topics for legal inquiry. While these issues have a clinical therapeutic dimension, they also involve legal questions, statutory and constitutional rights, and social and public policy concerns.

## II. Trends in the Treatment of Juveniles

Statistical data on juvenile psychiatric and chemical dependency inpatient treatment has been difficult to obtain because there are no systematic national or state reporting requirements for admissions to private hospitals and free-standing residential units. Recent research is beginning to shed light on this topic, however, and patterns and trends in admission and confinement that previously were difficult to discover are beginning to emerge. Disturbingly, the data now indicate that the number of juveniles being admitted for inpatient psychiatric and chemical dependency treatment is increasing. The statistics also reflect that juveniles tend to be admitted for less serious diagnoses than adults, and that the average length of stay for juveniles is much greater than for adults.

Nationwide, juvenile admissions to private psychiatric hospitals have more than doubled since 1980.<sup>1</sup> General hospitals also showed an increase in psychiatric admissions, although the increase was substantially less; from 1971 to 1980, juvenile admissions rose 9%. Although juvenile admissions to state and county mental hospitals declined somewhat in the seventies,<sup>2</sup> the trend toward increased inpatient hospitalization of minors for chemical use and mental health problems is alarming and should be carefully examined.

An additional area of concern beyond the increasing numbers of young people admitted to facilities is the primary diagnosis used as the basis for confinement. In 1980, almost half of all juvenile psychiatric admissions to United States hospitals were for the two combined categories of ICD-9-CM diagnoses<sup>3</sup> that the National Institute

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1. Jackson-Beeck, Schwartz & Rutherford, *Trends and Issues in Juvenile Confinement for Psychiatric and Chemical Dependency Treatment*, 10 INT'L J. OF L. & PSYCHIATRY 153, 157 (1987) [hereinafter *Rutherford*].

2. Juvenile admissions to state and county mental hospitals declined from 26,352 in 1971 to 16,612 in 1980. *Id.* at 157.

3. U.S. DEPT. OF HEALTH: HUMAN SERVICES PUBLIC HEALTH SERVICE — HEALTH

of Mental Health calls "preadult" and "other nonpsychotic" disorders.<sup>4</sup> These categories include adjustment reaction, emotional disturbances of childhood and adolescence, conduct disorders, hyperactivity, sexual deviation, unclassifiable depressive disorders, developmental delays, physiological malfunctions arising from psychological conditions, and other "special symptoms or syndromes," such as stammering, stuttering, tics, eating disorders, sleep disorders, and bed wetting.

Research compiled by the Commission on Professional and Hospital Activities (CPHA) indicates that only six percent of the adults admitted for psychiatric care to general hospitals fell within the miscellaneous category, which by CPHA's definition includes "special symptoms and syndromes," conduct disorders, emotional disturbances of childhood and adolescence, developmental delays, hyperactivity, and unclassifiable depressive disorders.<sup>5</sup> However, twenty-nine percent of the juveniles admitted fell into this miscellaneous category.<sup>6</sup> For adults, only eight percent were admitted to CPHA's general hospitals for adjustment/stress reaction as compared to twenty-one percent of juveniles.<sup>7</sup>

Equally disturbing is a comparison of the average lengths of stay between juveniles and adults. Juveniles stay longer for all major psychiatric diagnoses in general hospitals.<sup>8</sup> Juveniles' average length of stay for adjustment/stress reaction exceeds that of adults admitted for the same diagnosis by approximately one week.<sup>9</sup> The average length of stay for neurotic depression and miscellaneous mental disorders is over three weeks for juveniles, but less than eleven days for adults.<sup>10</sup> A similar pattern is evident in the area of chemical dependency. Juveniles are admitted to general hospitals for chemical dependency treatment with less precise diagnoses, yet their average length of stay exceeds that of adults.<sup>11</sup>

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CARE FINANCING ADMINISTRATION (ICD-9-CM) INTERNATIONAL CLASSIFICATION OF DISEASES, CLINICAL MODIFICATION (9th Rev. Sept. 2, 1980). The ICD-9-CM is designed for the classification of morbidity and mortality information for statistical purposes and for indexing hospital records by disease and operations for data storage and retrieval. It is required for reporting diagnoses and diseases to all U.S. Public Health Service and Health Care Financing Administration programs.

4. *Rutherford, supra* note 1, at 156.

5. *Id.* at 157.

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

In Minnesota, although the number of hospital beds declined by approximately fifteen percent, admissions for psychiatric and chemical dependency treatment to Twin Cities hospitals increased, particularly among adolescents.<sup>12</sup> The average length of stay also became longer for young persons, but not for adults.<sup>13</sup> One major insurer found the equivalent of fifty-five years of unnecessary inpatient care for juveniles and adults since 1981.<sup>14</sup>

The research, therefore, shows a trend toward increasing hospitalization for juveniles. With diagnoses that are somewhat vague and ill-defined and lengths of stay that exceed those of adults, serious questions arise as to the appropriateness of the present system of "voluntary" admission that provides for little supervision and review while allowing others, chiefly parents and mental health professionals, to consent to the confinement of juveniles. Moreover, although hospitalization of young people for psychiatric and chemical dependency treatment is on the rise, a real question remains as to the efficacy of such treatment for minors. A study conducted by the Office of Technology Assessment of the United States Congress found that there was no systematic study of the effectiveness of psychiatric hospitalization for treating childhood mental disorders. The study found that "available studies do not clearly show which components of hospital treatment contribute to successful outcomes. Neither do they allow conclusions about whether children treated as hospital inpatients would have been better, worse, or [had] similar outcomes with non-hospital treatment."<sup>15</sup>

### III. Case Studies

Statistical information alone does not convey the seriousness of the issue presented by this largely unregulated and unmonitored system. A few case histories will serve to illustrate some of the concerns. The following case histories are taken from Peer Review Determinations completed by Blue Cross Blue Shield of Minnesota as part of their Effective Care Program.<sup>16</sup> The Effective Care Program was instituted in order to undertake a focused study of utilization

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12. *Id.* at 154.

13. *Id.*

14. Flygare, *Civil Commitment of Juveniles — Available Facilities and Funds in Placing Kids in Treatment — Who Has What Rights?* 1986 ADVANCED LEGAL EDUC., HAMLINE U. [hereinafter *Flygare*].

15. U.S. Congress, Office of Technology Assessment (OTA-BP-H-33), *Children's Mental Health: Problems and Services — A Background Paper* (December 1986).

16. *Flygare*, *supra* note 14, at 3.

issues and to determine the medical necessity of inpatient versus outpatient care for psychiatric and chemical dependency treatment.

The first case involves a fourteen-year-old female who was admitted with a diagnosis of adjustment reaction. Her length of stay was eighty-five days. Her discharge diagnosis was adjustment reaction mixed with depression. The case summary is as follows:

This fourteen-year-old female was admitted to an inpatient adolescent psychiatric program for persistent conflict between herself and her mother. The specific incidents that brought her to the program involved staying out all night without telling her mother and arguments over rules and conduct at home. The peer reviewers found that there was no justification for the admission. There was no evidence that the girl had serious mental health problems requiring hospitalization, that she was a danger to herself or others, or that outpatient services had been exhausted. The peer review further revealed that there were no clear-cut behavioral goals established for the patient and that she exhibited no serious behavioral disorders while hospitalized. The girl was angry and dissatisfied living with her mother, but she exhibited no behaviors justifying inpatient treatment. Hospital records indicate that the patient was discharged "prematurely" after eighty-five days because her insurance ran out.

After reviewing the case, Blue Cross Blue Shield allowed payment for seven days of assessment and evaluation. The hospital did not receive payment for seventy-eight days of this particular patient's care, an amount that was over \$28,000.<sup>17</sup>

The second case involves a fifteen-year-old female who was admitted to a hospital with a diagnosis of atypical conduct disorder with depression. She was confined in the hospital's inpatient psychiatric program for seventeen days. The case summary reads as follows:

This fifteen-year-old female was admitted to an inpatient adolescent psychiatric program for running away, truancy, and failure to obey rules at home. The patient also has a twenty-two-year-old boy friend. Upon peer review of the case, reviewers found that all data in the medical records indicated truancy as the reason for admission. The patient had been exhibiting these symptoms for over three years with no danger to self or to others, and outpatient treatment was never attempted. Peer review found that inpatient treatment was not justified and allowed seven days for evaluation. It re-

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17. *Id.* at 39, 40.

fused to pay for the remaining ten days of confinement.<sup>18</sup>

Finally, in a case involving alcohol/drug dependency, a seventeen-year-old male was admitted for inpatient treatment and remained for thirty-nine days. His admitting diagnosis was drug dependency. The case summary reads as follows:

This seventeen-year-old male was admitted for inpatient treatment based on excessive use of alcohol and marijuana. Peer reviewers determined that there was no need for residential treatment in this case. The patient's chemical use was not truly excessive, and he did not appear to be seriously impaired. A slight drop in grades and sibling fighting were present, but this behavior was not necessarily related to chemical use. His previous success with out-patient treatment and his superior intelligence should have enabled him to benefit from outpatient treatment more easily than many others. Peer reviewers allowed seven days for assessment and evaluation.<sup>19</sup>

These three cases alone resulted in 120 days of unnecessary hospitalization. The cases are not unusual. They represent a disturbing trend toward hospitalization of minors for what are essentially family problems, relatively nonsevere emotional problems, and drug and alcohol abuse. Although the kind of peer review undertaken by Minnesota Blue Cross and Blue Shield is helpful in examining unnecessary hospitalization, it is no substitute for recognizing that the person who is to be the subject of this hospitalization should have the right to consent to the treatment or withhold that consent. Post-treatment review by the insurance company and disallowance of payment to the hospital is little comfort to the confined minor.

Confinement under the guise of medical care allows minors to be deprived of liberty without any semblance of due process. Since minors can no longer be confined to secure institutions in the juvenile justice system for status offenses, psychiatric and chemical dependency treatment facilities are becoming the new institution of choice.<sup>20</sup> Placing one's child in the mental health system instead of

18. *Id.* at 41.

19. *Id.* at 43.

20. The Juvenile Justice Act, passed in 1974, was an attempt at national juvenile justice reform. The Act established the Juvenile Justice and Delinquency Prevention Office as an oversight agency to coordinate and oversee reform in participating states.

One of the standards with which the participating states must comply mandates that states must develop programs that are designed to:

provide within three years of the submission of the initial plan that juveniles who are charged with or who have committed offenses that would not be criminal if committed by an adult or offenses which do not constitute violations of valid court orders, or such non-offenders as dependent or neglected children shall not be placed in secure detention facilities or secure correctional facilities.

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the juvenile justice system allows the confinement of that child to occur without outside review and without due process protection for the child. Since the law presently views such confinement as "voluntary," the due process protection normally associated with involuntary commitment is not applicable. Thus, the expansion of the medical model in this context permits the deprivation of liberty under the cloak of medical treatment.

It is useful to be reminded of the words of Justice Brandeis who stated:

Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.<sup>21</sup>

### IV. Treatment of Minors and the Age of Consent

Consent is the critical concept that must be addressed when exploring the treatment of minors. Consent in this context consists of three elements: consent must be voluntary, knowing, and competent. "Voluntary" encompasses the element of free choice; consent is not present where there is the threat of force, coercion, duress, etc. "Knowing" concerns the amount and quality of information that is necessary to make an informed decision. "Competent," the most difficult element of consent, focuses on the level of cognitive functioning necessary to give valid consent. Competency is defined differently in different situations, for example, executing a will or signing a binding contract. Generally, however, a child is presumed to be incompetent by the mere fact of his or her age unless the presumption is overcome by marriage, adulthood, legal emancipation, or other statutory provision.<sup>22</sup>

Historically, a child was a chattel of the parent with no separate legal rights;<sup>23</sup> therefore, a child cannot consent to treatment since

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42 U.S.C. § 5633(a)(12)(A) (1974). Section 5633(c) assures that "failure to achieve compliance with the requirements of subsection (a)(12)(A) . . . within the three year's time limitation shall terminate any state's eligibility for funding under this subpart" unless the Administrator makes an exception due to substantial compliance.

21. *Olmstead v. United States*, 277 U.S. 438, 479 (1927).

22. F. ROZOVSKY, *CONSENT TO TREATMENT, A PRACTICAL GUIDE* (1984) [hereinafter *Rozovsky*].

23. I W. BLACKSTONE, *COMMENTARIES* 436. "[E]very man has, or ought to have, by the laws of society, a power over his own property; and as Grotius very well distinguishes, natural right obliges to give a necessary maintenance to children; but what is more than that, they



the child does not have the legal capacity to consent. In addition to the notion that a child is the property of the parent with no separate legal identity, the law views children as too inexperienced, immature, and undeveloped to make decisions regarding treatment.<sup>24</sup> Exceptions to this rule have evolved over time. Courts have found the minor capable of giving consent for treatment in emergency situations, where the minor is emancipated or mature.<sup>25</sup>

Many states have also enacted legislation that recognizes that a minor who is emancipated can consent to treatment.<sup>26</sup> Emancipation may be determined from a number of criteria, including marriage by the minor, giving birth to a child, or living apart from one's family and being financially independent.<sup>27</sup> Some states have also codified the mature minor exception to the general rule that minors are unable to consent to treatment.<sup>28</sup> Moreover, many states have passed legislation that authorizes minors to consent to treatment for specific illnesses or conditions. The most common conditions for which minors can consent to treatment include pregnancy, venereal disease, and drug and alcohol abuse.<sup>29</sup>

It was not until 1967 that the modern notion that children are protected by the constitution and have constitutional rights was clearly articulated by the United States Supreme Court in the case of *In re Gault*.<sup>30</sup> A child is not beyond the protection of the Constitution merely because he is a minor. The Court also stated in a 1976 decision that "constitutional rights do not mature and come into being magically only when one attains the state defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights."<sup>31</sup>

Although courts have now taken the view that children possess certain rights, those rights are not coextensive with the rights of

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have no other right to, than as it is given them by the favour of their parents, or the positive constitutions of law." *Id.*

24. See *Oliver v. Houdlet*, 13 Mass. 237 (1816). "In all cases, the benefit of the infant is the great point to be regarded; the object of the law being to protect his imbecility and indiscretion from injury, through his own imprudence, or by the craft of others." Aristotle, *POLITICS* 32-33, 316; "The law's concept of the family rests on the presumption that parents possess what a child lacks in maturity, experience and capacity for judgment required for making life's difficult decisions." *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

25. ROZOVSKY, *supra* note 22, at § 5.2.

26. *Id.* at § 5.31.

27. *Id.*

28. *Id.*

29. Pilpel, *Minor's Rights to Medical Care*, 36 ALB. L. REV. 462 (1972); Wadlington, *Minors and Health Care: The Age of Consent*, 11 OSGOOD HALL L.J. 115 (1973).

30. *In re Gault*, 387 U.S. 1 (1967).

31. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 74 (1976).

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adults. The Supreme Court, distinguishing between the scope of the rights of adults and the rights of children, relies on three reasons to constrict the full panoply of rights from application to minors. First, the unique role of the family in our society serves as the basis for flexibility and particular sensitivity in applying constitutional rights to minors. Second, children have a peculiar vulnerability due to their inability to make critical decisions in an informed, mature manner. Third, the importance of the parental role in child rearing justifies, in the Court's view, a limitation on the rights of children.<sup>32</sup>

In discussing the specific issue of decision-making by minors, the Supreme Court held:

. . . the States validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences. These rulings have been grounded in the recognition that, 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.<sup>33</sup>

Thus, while the Supreme Court has recognized that minors have certain rights based on the Constitution and the Bill of Rights, the extent of those rights is not clear. Competing interests of the family and the view that minors do not have the capability of making informed intelligent decisions have led the Court to limit a minor's rights. The exact nature and extent of that limitation, however, is not clear.

In 1979, the United States Supreme Court decided the leading case dealing with the commitment of minors for mental health treatment.<sup>34</sup> The statutory scheme in question permitted voluntary commitment of children under the age of eighteen to state mental hospitals upon the application of a parent or guardian. Upon such application, the superintendent of the hospital was authorized to admit a minor for observation and diagnosis. If, after diagnosis and observation, the superintendent concluded that the minor was mentally ill and suitable for treatment in the hospital, the minor could be admitted for such a period and under such conditions as was authorized by law.

The statute's provisions also allowed the parent or guardian and the superintendent control over when the minor would be discharged.

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

33. *Id.* at 635.

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

Any minor who had been hospitalized for more than five days could be discharged upon the request of a parent or guardian. The superintendent had an affirmative duty to release any minor who had recovered from his mental illness or who had sufficiently improved to the extent that hospitalization was no longer desirable.<sup>35</sup> The plaintiff class challenged this voluntary commitment process for children under the age of eighteen on the grounds that it violated the due process clause of the fourteenth amendment.<sup>36</sup>

In analyzing the issue, the Supreme Court first articulated its approach for testing state procedures under a due process claim. If there is a protected liberty or property interest involved, the Court balances three competing interests: 1) the private interest that will be affected by the official action; 2) the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and 3) the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.<sup>37</sup>

The Court began by stating that it must first consider the child's interest in not being committed. Rather than analyzing that interest from the minor's individual perspective, however, the Court declared that since the minor's interest is inextricably linked with the parents' interest, the private interest at stake is a combination of the child's and parents' concerns.<sup>38</sup> This approach echoes the notion, dating back to Blackstone and his predecessors, that children do not have a legally recognized identity separate from their parents. The Court does recognize that a child, like an adult, has a substantial liberty interest in not being confined unnecessarily for medical treatment and that the state's involvement in the commitment decision constitutes state action under the fourteenth amendment.<sup>39</sup>

Although the Court stated that it recognized a protectable interest of a minor in being free from unnecessary restraints and erroneous labeling, it went on to subordinate those constitutional interests to the interests of parents. Relying on what it termed "Western civilization concepts of the family as a unit with broad parental au-

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35. *Id.* at 590, 591.

36. *Id.* at 588.

37. *Id.* at 599, 600.

38. *Id.* at 600.

39. *Id.* The Court also recognized that commitment sometimes produces adverse social consequences for the child because of the reaction of some persons to the discovery that the child has received psychiatric care. However, the Court goes on to minimize the stigma that might result from such treatment. *Id.* at 600, 601.

thority over minor children," the Court justified diminishing the rights of the minor by accepting the presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment, all of which are required for making life's difficult decisions.<sup>40</sup>

Along with the historically-based notion that natural bonds of affection lead parents to act in the best interests of their children, the Court emphasized that, in its view, "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment."<sup>41</sup> The Court concluded that parents retain a substantial if not dominant role in the decision to commit, absent a finding of abuse or neglect. Although parents cannot always exercise absolute and unreviewable discretion to decide to institutionalize a child, they retain plenary authority to seek such treatment for their children, subject to medical judgment.<sup>42</sup>

The Court further held that an inquiry by a neutral fact finder is sufficient protection from an erroneous admission decision.<sup>43</sup> Moreover, since this is a medical decision, a staff physician will suffice. When the State acts on behalf of its ward for admission to a state mental hospital, no different procedures are required. An independent medical judgment after an investigation is an acceptable means of justifying voluntary commitment.<sup>44</sup> Thus, the Court minimized the constitutional implications in confinement to an institution and its resulting stigma by emphasizing the inability of minors to make such decisions for themselves and by characterizing the process as a medical one.

Justice Stewart, in his concurring opinion, emphasized even more explicitly the long-standing tradition that parents speak for their children.<sup>45</sup> In Justice Stewart's view, when parents invoke voluntary admission procedures on behalf of their children, no state

40. *Parham v. J.R.*, 442 U.S. at 602.

41. *Id.* at 603.

42. *Id.* at 604. See also *Schall v. Martin*, 467 U.S. 253 (1984), in which the Court upheld preventive detention of juveniles. The Court held that while the juveniles' interest in freedom from institutional restraint is substantial, that interest must be qualified by the recognition that juveniles, unlike adults, are always in some form of custody and are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents; and if parental control falters, the State must play its part as *parens patriae*. In this respect, the juvenile's liberty may, in appropriate circumstances, be subordinated to the States' *parens patriae* interest in preserving and promoting the welfare of the child." *Id.* at 265 (quoting *Santosky v. Kramer*, 455 U.S. 745, 766 (1982)).

43. *Parham v. J.R.*, 442 U.S. at 606, 607.

44. *Id.* at 618.

45. *Id.* at 621.

deprivation of liberty occurs.<sup>46</sup> The constitution does not compel state intervention between the parent and child. Justice Stewart accepts the presumption that minors are incapable of making treatment decisions for themselves, and that parents act in the best interests of their children.<sup>47</sup>

This Supreme Court decision embodies the presumption that minors are incapable of making treatment decisions for themselves. This presumption comports with the long held common law principle that children do not have a separate voice from that of their parents.<sup>48</sup> Nonetheless, this unexamined presumption is open to question. Psychological and cognitive research suggests that minors are in fact capable of engaging in a reasoned and thoughtful decision-making process.

#### V. Minors' Consent—A Cognitive View

The Supreme Court based its decisions limiting minors' rights on the notion that adolescents do not have the capability of making informed, intelligent decisions because of their age. It is therefore critical to examine the research that has been done in this area. Simply put, the question to be examined is whether there is, in fact, an empirical basis for the Court's reliance on this traditional view of minors' lack of maturity and their presumed cognitive limitations.

Several of the cognitive capacities that are required for consent, such as abstract reasoning, inductive and deductive logical processes, and cognitive complexity, correspond with the capacities that Piaget associated with the emergence of the formal operations stage of cognitive development.<sup>49</sup> Piaget's theory of cognitive development in children posits a series of stages through which a child passes, with each subsequent stage representing a higher level of comprehension and achievement. First appearing during early adolescence, the formal operations stage includes the development of an increased cognitive capacity to bring certain operations to bear on abstract concepts in problem-solving situations.<sup>50</sup> Piaget and subsequent researchers

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46. *Id.* at 623.

47. *Id.*

48. *Id.* at 621. See also 1 W. BLACKSTONE, COMMENTARIES 436, *supra* note 23.

49. J. PIAGET, INTELLIGENCE AND AFFECTIVITY 69 (Brown ed. 1981). The last stage of intellectual development is that of the formal operations. It begins around eleven or twelve and attains equilibrium around fourteen or fifteen. It is during this stage that the capacity for hypothetic-deductive reasoning first appears. *Id.*

50. *Id.* "Henceforth, intelligence will be able to operate not only on objects and situations but also on hypotheses and, therefore, on the possible as well as on the real. Formal operations are not concerned only with operations on classes and relations as the concrete

have noted the age range of eleven to thirteen as a period for the appearance of thought that is characteristic of formal operations.<sup>51</sup> If this research is accurate and minors begin to possess the cognitive ability to consent in an intelligent manner near the age of twelve, then the Supreme Court's reliance on the notion that minors are not capable of such decision-making as a basis for its determination of limited constitutional rights is called into question.

A review undertaken by Grisso and Vierling concludes that a substantial percentage of minors have attained a stage of cognitive development (formal operations) at age twelve that predominates in the general adult population.<sup>52</sup> If this is true, there is no justification for denying to minors age twelve and older the same rights regarding consent that are applied to adults. Admittedly, not all minors possess the same cognitive abilities at the same age, so not all minors are intellectually able to provide consent. Nonetheless, the same variations in ability apply to a random sample of the adult population and there is no clear evidence that variation in ability is any greater in adolescence than in adulthood.<sup>53</sup>

Grisso and Vierling also review the research concerning the ability of minors to comply with the voluntary element of consent. Deference to authority and the need for conformity can affect whether a minor's consent is truly voluntary. They conclude that the likelihood of deferent responses to authority in order to avoid negative consequences is apparently great in the preadolescent years and remains high in early adolescence. This deferential behavior is accompanied by an increased concern for social expectations.<sup>54</sup> Thus, while there is a greater tendency toward conformity in early adolescence, this behavior diminishes by middle adolescence.

The research also suggests that minors fifteen and older possess sufficient cognitive abilities and independence to make decisions that are intelligent and voluntary. Therefore, no sound basis in fact sup-

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operations were. They operate on propositions and involve implication, disjunction, etc. They make possible for the content of reasoning to be dissociated from its form. To simple operations . . . they add operations to the second power or operations on operations. This makes reflection in the strict sense possible; it allows thought to turn upon itself." *Id.* at 69.

51. Grisso and Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOLOGY 412 (1978) (citing B. INHELDER AND J. PIAGET, *THE GROWTH OF LOGICAL THINKING* (1958)) [hereinafter *Grisso*]; see also Elkind, *Conceptual Orientation Shifts In Children and Adolescents*, 37 CHILD DEV. 493-498 (1966); Neimark and Lewis, *Development of Logical Problem Solving: A One-Year Retest*, 39 CHILD DEV. 527-538 (1968); Webb, *Concrete and Formal Operations In 6 to 11 Year Olds*, 17 HUM. DEV. 292-300 (1974).

52. *Grisso, supra* note 51.

53. *Id.* at 421.

54. *Id.* at 422, 423.

ports the limited right of consent for those adolescents.

Minors between the ages of eleven and fourteen are more problematic. Cognitive abilities are in the developing stages during this period. Although, it may not be reasonable to make a blanket statement that all minors in this age range can give intelligent and voluntary consent, it is equally unreasonable to categorically deny that right to all minors. There should be an individual determination of competence for each minor in this age range.

Once it is accepted that minors, at least by the age of fifteen, have the capacity to make informed decisions, to comprehend information, and thus to give informed consent, the question then becomes whether minors can act on that information to protect their rights. Theoretical understanding, without the ability to apply that understanding in a meaningful way to protect one's rights and to recognize when one's rights have been violated, provides little benefit from a practical perspective.

Belter and Grisso conducted a study that examined whether informing minors of their rights in a mental health setting would affect their ability to recognize when a right had been violated and their ability to take action to protect that right. They conducted the study using three age groups. The mean ages of the groups were nine years, one month; fifteen years, seven months; and twenty-one years, nine months. The findings of the study indicate that the average fifteen-year old may be "quite capable of understanding rights and forming ideas about protecting rights at a level that is equivalent to most adults."<sup>55</sup> While the authors caution against generalizing from their population of "normal" white, middle-class males of average intelligence to larger populations with different characteristics, it is significant that the findings of this study parallel the previous research regarding the capacity of minors to comprehend and act on information regarding their rights.<sup>56</sup>

Admittedly, more research must be done to further examine these issues. The research that has been completed, however, suggests that minors fifteen years of age and older have not only the cognitive ability to comprehend information, but also the ability to use that information in a practical manner to recognize a violation or potential violation of their rights and to act in a way to protect those

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55. Belter and Grisso, *Children's Recognition of Rights Violations In Counseling*, 15 PROF. PSYCHOLOGY 899, 907 (1984) [hereinafter *Belter*].

56. *Id.* at 909.

rights.

## VI. Policy Implications

The growing body of research in this field, which indicates that older adolescents are capable of understanding their rights and of providing informed consent, calls into question court decisions placing limitations on the rights of minors in this critical area. For reasons that are not entirely clear, the Supreme Court has chosen to ignore relevant research findings and has apparently based its assessment of the maturity and capacity of minors on traditional, widespread, and largely unsupported assumptions.

The failure to consider the relevant research on this topic contributes to a situation in which minors are subject to a system of enforced treatment without the legal capacity to either voluntarily consent to or refuse such treatment. Since minors lack this legal capacity, others can consent for them. For minors, the consenting person is usually a parent or legal guardian. Since the treatment of the minor is accomplished through the consent of the parent or legal guardian, the treatment is viewed as "voluntary" even though the person subject to treatment has not consented. This fiction results in a system of juvenile care and services that is undisturbed by independent review or judicial oversight. It is a system in which minors can be routinely confined without the benefit of due process or procedural protections.

The increasing number of minors being hospitalized for psychiatric and chemical dependency treatment, coupled with the mounting evidence suggesting that older adolescents are indeed capable and competent to make informed decisions about their own treatment, suggests that this issue should be placed high on the public agenda. In particular, policy makers, health care professionals, child welfare officials, child advocates, and public interest groups should strive to develop policies "aimed primarily at differentiating children who are truly dependent and in need of protection from those who are essentially competent and should have their autonomy and privacy respected."<sup>57</sup> For example, state lawmakers should seriously consider enacting legislation affording minors fifteen years of age and older the legal ability to consent or refuse consent to psychiatric or chemical dependency treatment. Lawmakers should clarify that state commitment statutes, which provide due process protection for

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57. G. Melton, I. Schwartz, & M. Resnick, *Emerging Legal Issues in Children's Health Care*, paper presented at Harvard School of Public Health (November, 1986).



those persons judicially determined to be in need of involuntary treatment, apply to minors.

State lawmakers, health care professionals, family and children's law experts, and child welfare officials should also carefully explore whether policies providing older adolescents the right to consent to or refuse psychiatric or chemical dependency treatment need to be coupled with reforms allowing youth independent access to health care services on a confidential basis. Consideration should be given to new and appropriate public and private options for financing health care services as well.

## VII. Conclusion

Providing psychiatric and chemical dependency treatment for minors is extremely complex. A variety of interests are involved, some in conflict. The issue is even further complicated by recent studies indicating that minors, at least by the age of fifteen, possess the intellectual and developmental capability to make important decisions for themselves, particularly decisions regarding health care treatment.<sup>58</sup>

Historically, minors have been viewed as the property of their parents. As a result, they have not possessed a separate legal voice and were often deemed incompetent to make important decisions by reason of their minority. State statutory schemes, as well as the common law, have carved out some exceptions to the general principle that minors are incompetent to consent to treatment. Moreover, treatment for certain conditions, such as venereal disease, pregnancy, and chemical dependency, is sometimes permitted by statute to be provided to minors based solely on the minor's consent.

The United States Supreme Court has upheld the notion that minors do, in fact, possess constitutional rights. The Court, however, has *not* found those rights to be co-extensive with the rights of adults. The Court has relied on the traditional notion that minors do not possess the maturity and ability to make certain critical decisions. Therefore, those decisions must be made for them by a parent or guardian or an entity such as the state acting in the role of parent.

These holdings have reinforced a system that views the hospitalization of minors for chemical dependency and/or mental health treatment as voluntary hospitalization, even though the minor who is

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58. *Belter*, *supra* note 55, at 21; *Grisso*, *supra* note 51, at 24.

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confined has not consented. This fiction of voluntariness allows for the placement and confinement of youth in institutions without the benefit of the kind of judicial review that would be required in an involuntary commitment situation. The absence of appropriate court review of these "voluntary" admissions essentially means that there are no checks and balances within the system.

The trend toward increasing hospitalization of minors for mental health and chemical dependency treatment is alarming. Mounting research indicates that the traditional justification of the incompetency of minors to make critical decision is in error. Similarly, the implication that parent-child conflict may be a substantial factor in hospitalization of minors should be carefully examined. In light of these concerns, legislators, policy makers, health care professionals, and public interest groups should recognize that minors, particularly older adolescents, should be accorded the same legal status as adults in this decision-making process and should be given sufficient due process protection against inappropriate hospitalization.

