

# LEGAL RIGHTS OF MINOR PATIENTS

## I. Introduction.

### A. My background in mental health.

### B. A brief Overview of the History of Mental Health Care.

Mental health care began as entertainment. It moved on to become indifferent at best and vicious at worst for those without means throughout the 18<sup>th</sup>, 19<sup>th</sup> and 20<sup>th</sup> Centuries, up through the 1960s. Commitment laws were lax in the extreme. Anyone, rich or poor, could be easily committed by a relative who wanted to gain control of the committee's property.

In *A Streetcar Named Desire*, Stanley Kowalksi has his sister-in-law, Blanche DuBois committed without her knowledge so he can get control of the plantation she owns. At the end of the play, Blanche is lead away by officials of the Louisiana state mental health facility, people she does not know. Nor does she know where they are taking or her why. But, she goes willingly because, as she says, her mother taught her "to trust in the kindness of strangers."

As Tennessee Williams knew, when he wrote the play in 1945, Blanche would be treated so harshly that she would be destroyed. As someone who was involved in litigating over conditions in Southern mental health facilities in the 1970's, I know they provided no care, bad food, an unhealthy environment and a high likelihood that patients would be physically or sexually abused or both

In the 1960's and 70's, the development of anti-psychotic drugs, litigation and lobbying and the governmental desire to move people out of state facilities combined to create legal protections for patients in California and even in Southern facilities. These protections governed committed and conditions within facilities. Blanche DuBois could not be summarily committed today in this state. Nonetheless, many legal problems remain and some of these touch on the commitment and treatment of minors.

### C. Legal Rights of Minor Patients Are Complex<sup>1</sup>.

The legal rights of minor patients raise complex issues because these rights

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<sup>1</sup>Some of the information contained in this outline is taken from the California Physician's Legal Handbook (2005), written by the staff of the California Medical Association: Catherine I. Hanson, Astrid G. Meghrigian, Susan L. Penney, Gregory M. Abrams, Has P. Lee and Steven M. Fleisher. Any mistakes in this material are my own.

depend on several factors: the age of the minor; the status of the minor; whether, apart from age, the minor is competent; and the type of health care services being provided.

The rights are also complex because there are several sources of these rights, including the privacy provisions of Article 1 of the California Constitution, statutes, regulations and court decisions. Despite all of this, not all the issues have been resolved. In some instances, we will not know the answers until the issues have reached the California Legislature or the Court of Appeal.

Further, while there is a considerable amount of law defining the legal rights of minors in many situations, there is very little law specifically concerning the rights of minors in facilities. Only a few of the patients rights' set out in the Welfare & Institutions Code §§5325-5337 and 77099-77111 or the regulations governing facilities<sup>2</sup> specifically refer to minors. Otherwise the rules seem to be applicable to all patients with some significant exceptions. There are other exceptions not set out in the patient rights rules.

Accordingly, we can assume that minors are entitled to all patient rights with the exceptions noted in this outline, all of which are significant. The principal exceptions involve admission, convulsive therapy, psychosurgery, the use of anti-psychotic drugs and release of information.

## **II. The definition of a minor.**

### **A. Basic definition.**

A minor is anyone who is seventeen years of age or younger. This definition is based solely on chronological years and does not take into account any other factor such as intelligence or mental competence.

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<sup>2</sup> There are patient rights regulations governing every type of licensed facility, including but not limited to acute psychiatric units in general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities and out-patient clinics.

## **B. Exceptions.**

The following categories of minors are authorized by law to consent to all types of medical treatment, assuming they are mentally competent. In a mental health facility these minors must be treated as adults:

1. Married or divorced minors. Family Code §§7002 and 7050(e)(1).
2. Minors on active duty with the U.S. Armed Forces. Family Code I7002 and 7050(e)(1).
3. Minors emancipated by a court order. Family Code §7120.
4. Self-sufficient minors. These are minors 15 years or older who are living away from home and managing his or her own financial affairs. Family Code §6922.

Whether or not a minor is self sufficient may not always be clear. Self-sufficient minors can be required to document their status and identify a parent or guardian. Many members of one group of self-sufficient minors may not want to do this. These are people who have left their homes around the country to come to Los Angeles. Often they support themselves through prostitution or drug-dealing. They do not have documents and do not want contact with their parents. The California Medical Association recommends that the physician be careful about this. If the minor is self-sufficient, providing the minor's patient information to the parent would be an invasion of the minor's privacy.

## **III. Medical treatment to which a minor can consent.**

### **A. Overlapping categories and discretion.**

As you can see the categories set out below can overlap. So the manner in which the service is classified can affect the rights of the minor. Again, whether the minor can consent would depend on whether the minor is otherwise mentally competent. Insofar as I can determine, a minor does not lose these rights when committed. In some cases, parental participation in treatment is left to the discretion of the treating physician.

Commitment does not change the minor's right to the services set out in Sections B through F as well as I.

### **B. Pregnancy, Contraception and Abortion.**

A minor of any age can consent to care for the prevention or treatment of pregnancy, including contraception and abortion. Family Code §6925. The California Legislature enacted a bill that required parental or court approval before a minor could obtain an abortion but that law was declared unconstitutional by the California Supreme Court. *American Academy of Pediatrics v. Lungren* (1997) 16 Cal.4th 307, 66 Cal.Rptr.2d 210. The right of a minor to consent to pregnancy related services includes genetic counseling and testing services which, under the law, must be offered to all pregnant women. Health & Safety Code §125000.

As this outline is being drafted, there is an initiative pending (Prop 73) that would again require a minor to obtain parental or court consent before obtaining an abortion. If this initiative passes, we can not be certain our current Supreme Court will strike it down.

A minor cannot consent to sterilization. Family Code § 6925. In very extraordinary cases, a parent or guardian can seek a court order to have the minor sterilized. *In re Valerie N.*(1985) 40 Cal.3d 143. Courts are very reluctant to issue such an order.

### **C. Contagious Diseases**

A minor, twelve and older, can consent to the care and treatment of any contagious disease of the type that must be reported to the County Public Health Officer. Family Code §6926. These would include such infectious, contagious or communicable diseases as tuberculosis, meningitis, measles, mumps, various types of flu and the like.

#### **D. Sexually Transmitted Diseases<sup>3</sup>.**

A minor twelve or older can consent to the care of a sexually transmitted disease. Family Code §6926.

#### **E. Rape.**

A minor twelve years of age or older can consent to the care and treatment of a rape. Family Code §6927. This would include access to what is called Plan B or the morning after pill. This medication is available in California without a prescription.

#### **F. Sexual Assault.**

Sexual assault is a broader term than rape but does include rape. A minor of any age can consent to care and treatment for sexual assault, but the physician must attempt to contact the parent or guardian unless the physician has some reason to think a parent or guardian committed the assault. Family Code §6928. The physician must also make an appropriate child abuse report.

#### **G. Outpatient Mental Health Treatment.**

A minor twelve years of age or older who is mature enough to participate intelligently in the treatment can consent to mental health treatment or counseling on an outpatient basis or to residential shelter services under certain circumstances. The minor must either be an alleged victim of incest or child abuse or there must be a serious risk of mental or physical harm to the minor without such treatment. The treating physician must, however, contact and involve the parents unless the physician believes such contact would be inappropriate. Family Code §6924.

#### **H. Outpatient Drug or Alcohol Treatment.**

A minor twelve years of age or older can consent to the diagnosis or treatment of drug or alcohol related problems on an outpatient basis. Again, the physician must notify the parents and give them an opportunity to participate in the treatment unless the physician believes this is inappropriate.

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<sup>3</sup>Section C, D and E are discussed in some detail because they do refer to acts which take place in facilities.

## **I. Testing for HIV and Treatment for HIV and AIDS.**

## **IV. Disclosure of medical information.**

### **A. Medical Information.**

The disclosure of medical information, other than mental health information, is governed by the federal Health Insurance Portability and Accountability Act and the California Confidentiality of Medical Information Act (CIMA). Civil Code §§56 *et seq.* Both sets of laws permit the disclosure of medical information to all members of the health care team, to all third party payors, certain government agencies, accrediting bodies and to designated research groups. Otherwise, except as noted, disclosure can be made to the person who consented to the care and treatment.

The rules for mental health information are somewhat different from the rules for other types of medical information and are set out below.

### **B. Information Which May Not Be Disclosed by the Provider to Anyone, except as permitted by CIMA or HIPAA.**

This means that this information cannot be disclosed to the minor's family.

1. Information about medical treatment provided to a minor who is legally considered an adult..

2. Treatment for pregnancy, contraception and abortion (Subsection III.B, above) unless the pregnancy is the result of rape or constitutes child abuse, in which case the information must be disclosed to the County.

3. Information about minor's HIV status. This information must be provided to the County Department of Public Health using a coded identifier that does not reveal the patient's name.

### **C. Information Which Must Be Disclosed to Public Officials.**

1. All information concerning infectious diseases, including sexually transmitted diseases must be reported by the physician to the County Department of Public Health using patient identifiers. This includes diagnoses of AIDS but does not include diagnoses of HIV.

2. All incidents of child abuse, including sexual abuse, must be reported by any licensed persons as well as school teachers to either the local law enforcement agency or the local child protective agency. Failure to report could result in disciplinary action and fines.

Although the statutes are not clear about this, generally, consensual sex among teenagers is not considered child abuse unless one of the parties is a close relative such as a sibling.

### **D. Information Which Must Be Disclosed to Others.**

Very specific threats of violence by the patient must be disclosed to the potential victim and the police. What constitutes a specific threat is usually one that is specific as to the potential victim, the timing, the local and the weapon.

## **V. When Consent from Someone Other Than the Minor Is Required: Who Can Consent.**

The key word here is custody. Unless the courts, a government agency or death have intervened, the parents of the minor have custody of any minor children and can consent for them wherever parental consent is necessary.

As noted above, information can be disclosed to the person who can consent to the admission.

### **A. Parents.**

Only one parent needs to consent to the admission of a minor. If, however, the

is any clear dispute between the parents as to whether, for example, to have a child admitted to a state facility, and the dispute cannot be resolved by counseling or some other informal means, the dispute can only be resolved by the courts. I would not recommend that a facility admit a minor if one parent is opposed to the admission. That could result in a suit against the facility.

There can be questions as to whether someone is a parent. These questions can only be handled on a case-by-case basis and may require the advice of an attorney.

### **B. Adoptive Parents.**

Adoptive parents have the same rights as biological or contractual parents.

### **C. Minors Born to Unmarried Parents.**

While there is usually no question as to who the mother is, there can be a question about paternity. Under California law, if a man acknowledges the child as his, he is legally the father.

### **D. Parents Who Have Been Divorced.**

Where parents have been divorced, the Family Court's custody order determines who has custody. If there is joint custody and the parents disagree, one or the other parent must obtain a modification of the order in order to admit a child to a facility.

### **E. Legal Guardians.**

Children are most frequently under a guardianship when the parents are deceased. The guardian has custody and the same authority to consent as a parent.

### **F. Dependent children.**

Dependent children are children who have been removed from the custody of their parents by court order and placed in the custody of a county agency. These children probably form the largest group of minors in state facilities. See Welfare and Institutions Code Section 369.5 for the procedure to get court authorization for the

administration of psychotropic medications. The corresponding Judicial Council Form, JV-220, can be found at <http://www.courtinfo.ca.gov/forms/documents/jv220.pdf>

### **G. Caregivers.**

This category includes baby-sitters, employees in day care facilities and similar people who bring in a minor to a doctor or hospital because of a medical emergency. Often they have an authorization from a parent to consent to treatment. As caregivers rarely, if ever, try to admit their charges to mental health facilities, this category can be ignored.

### **H. Step-Parents.**

The authority of a step-parent who has not adopted the stepchild is a complex issue that is still being determined by the courts.

### **I. Foster parents.**

Foster parents, who have been so designated by the County, have the same authority as biological parents.

### **J. Minors Whose Parents are Unavailable.**

This is also not an easy issue. The minor may be self-sufficient. If not, the child may have to be referred to Dependency Court.

## **VI. The Minor in a Mental Health Facility.**

**A. Except as Noted Below, the Minor Has the Same Patients' Rights in a Facility as an Adult. A parent or guardian may not waive the minor's rights. Welfare & Institutions Code § 5325.**

### **B. Admission to a State Facility.**

1. A minor may be admitted to a state or county mental health facility by a parent, guardian or other person having custody of the minor as set out in Section V.

Technically, because the parent has consented to the admission, this is considered a “voluntary” admission.

2. A minor 14 years or older has a Due Process/Right of Privacy right to request a hearing to determine whether the he/she is gravely disabled or dangerous to himself/herself or others as a result of mental illness or disorder and whether the admission sought is likely to benefit him. The California Supreme Court has recognized that “[t]he serious consequences attendant upon involuntary commitment of a minor as a mentally ill or disordered person, and the significant potential for error in diagnosis convinces us that...a minor who is mature enough to participate intelligently in the decision to independently assert his right to due process in the commitment decision must be permitted to do so. *In re Roger S., a Minor* (1977) 19 Cal. 3d 921, 930; 141 Cal. Rptr. 298;.

The hearing is an administrative one and usually takes place after the minor is admitted. The hearing officer is usually a psychiatrist but cannot be the physician who admitted the patient or who is providing the patient’s care. At the hearing, the minor is entitled to be present, not to be medicated, if the minor so requests and to present evidence. The minor may be represented by an advocate. The evidentiary test is substantial evidence and not preponderance of the evidence.

If the hearing officer finds that the minor is not mentally ill or disordered, the minor must be released. If the hearing finds the minor is mentally ill or disordered but is not gravely disabled or dangerous to himself or others and that treatment in the state hospital is not reasonably likely to be of benefit to the minor, the minor is entitled to release.

My own impression has been that psychiatrists serving as hearing officers are generally favorable to the admission of minors. Among psychiatrists, an interest in reciprocity prevails. A hearing officer is likely to support admission with the expectation that the admitting psychiatrist will support admission when the admitting psychiatrist is the hearing officer in another case in which the hearing officer in the first case is the admitting psychiatrist.

3. The Supreme Court in *In re Roger S.* explicitly did not address the

applicability of the ruling to minors 13 years of age and younger.

4. *In re Roger S.* is by its own terms only applicable to minors admitted to state facilities. It was assumed, however, when the decision came down that it was also applicable to private facilities. In Los Angeles County, the Department of Mental Health, with good reason, has been hostile to private facilities treating minors and as closed all or almost all of such facilities. I do not know if private facilities treating minors exist elsewhere in the state.

**C. Psychosurgery may not be performed on a minor.**

Welfare & Institutions Code §5326.6.(d).

**D. Limitations on Convulsive Therapy.**

Welfare & Institutions Code §5326.8 provides:

Under no circumstances shall convulsive treatment be performed on a minor under 12 years of age. Persons 16 and 17 years of age shall personally have and exercise the rights under this article.

Persons 12 years of age and over, and under 16, may be administered convulsive treatment only if all the other provisions of this law are complied with and in addition:

(a) It is an emergency situation and convulsive treatment is deemed a lifesaving treatment.

(b) This fact and the need for and appropriateness of the treatment are unanimously certified to by a review board of three board-eligible or board-certified child psychiatrists appointed by the local mental health director.

(c) It is otherwise performed in full compliance with regulations promulgated by the Director of Mental Health under Section 5326.95.

(d) It is thoroughly documented and reported immediately to the Director of Mental Health.

### **E. Release of Information.**

The release of mental health information is governed by the LPS<sup>4</sup>. A therapist may release information about the minor to a person the parent, guardian, etc., designates in writing as someone to whom information may be disclosed. Welfare & Institutions Code §5328 (d). In addition, information may be released to members of the health care team, third party payors, various government agencies, the courts and defined research projects. Otherwise, written consent for the release of information is required.

If a request for information is made by the spouse, parent, child, or sibling of the patient and the patient is unable to authorize the release of such information, the requester shall be given notification of the patient's presence in the facility, except to the extent prohibited by federal law.

### **F. Protection from Adults.**

A facility may not admit a minor unless the facility can provide protection from adult patients, appropriate treatment and educational services when applicable. Welfare & Institutions Code §77111(a). More specifically, Welfare and Institutions Code section 5157.7 states that “minors shall not be admitted into psychiatric treatment with adults if the health facility has no specific separate housing arrangements, treatment staff, and treatment programs designed to serve children or adolescents”. There is a procedure for counties receiving waivers, but the statute concludes with:

However, notwithstanding any other provision of law, no minor may be admitted for psychiatric treatment into the same treatment ward as any adult receiving treatment who is in the custody of any jailor for a violent crime, is a known registered sex offender, or has a known history of, or exhibits inappropriate, sexual, or other violent behavior which would present a threat to the physical safety of minors.

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<sup>4</sup> There are state and federal rules governing information about substance abuse patients which will not be covered here.

### **G. *Riese* Hearings.**

The law concerning whether a minor can consent or refuse to take anti-psychotic medication and is entitled to a *Riese* hearing is not clear as to minors who are “voluntarily admitted. A minor who has been involuntarily admitted is entitled to a *Riese* hearing. Welfare & Institutions Code §5332(a).

This Code section is supported by two courts which, in enacting rules implementing the requirements of *Riese v. St. Mary's Hospital* and §5332, have interpreted the case and code section as being applicable to patients, both adults and minors, who are being treated in public or private hospitals, and are being detained pursuant to Welfare & Institutions Code section 5150 (72-hour hold), 5250 (14-day hold) or 5350 et seq. (temporary conservatorship). San Diego County Superior Court Rule 4.302. And see Tulare County Superior Court Rule 1062.5.

Further, Family Code §6924 could be interpreted as not allowing minors to consent to medication.

On the other hand, there is nothing in *Riese v. St. Mary's* that restricts the ruling to adults. Further, even though a minor is admitted by a parent, guardian, etc., the minor is really an involuntary admittee if the minor indicates that he/she does not consent to the admission. The involuntary nature of the admission is reinforced if the minor requests a *Roger S.* hearing and a determination is made that the minor should not be released.

### **H. Informed Consent.**

If the minor's consent is required, it must be competent, voluntary and informed. Competency is generally determined by the attending physician and is based on whether or not the patient is capable of understanding, as a lay person, the information which the physician must provide in order to obtain consent.

This information is set out in Welfare & Institutions Code §5326.2.

To constitute voluntary informed consent, the following

information shall be given to the patient in a clear and explicit manner:

- (a) The reason for treatment, that is, the nature and seriousness of the patient's illness, disorder or defect.
- (b) The nature of the procedures to be used in the proposed treatment, including its probable frequency and duration.
- (c) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.
- (d) The nature, degree, duration, and the probability of the side effects and significant risks, commonly known by the medical profession, of such treatment, including its adjuvants, especially noting the degree and duration of memory loss (including its irreversibility) and how and to what extent they may be controlled, if at all.
- (e) That there exists a division of opinion as to the efficacy of the proposed treatment, why and how it works and it's commonly known risks and side effects.
- (f) The reasonable alternative treatments, and why the physician is recommending this particular treatment.
- (g) That the patient has the right to accept or refuse the proposed treatment, and that if he or she consents, has the right to revoke his or her consent for any reason, at any time prior to or between treatments.

## **VII. Conclusion.**

In my opinion, the rights of minors in mental health facilities are severely impaired by treating an admission by a person having custody of the minor as a voluntary admission. All admissions of minors should be treated legally as involuntary admissions and minors, at least minors 12 years of age and older, should be treated as adults, once admitted. This would mean replacing *Roger S.* hearings with the type of hearings to which adults committed under 5150 are entitled. In addition, this would mean giving minors an unequivocal right to a *Riese* hearing.

There is no rational basis for not doing this. Minors 12 and older are much more sophisticated than they were when the LPS was first enacted. They are capable of understanding the risks and benefits of medication. They are capable, too, of understanding their right to challenge a commitment. In the area of reproductive

rights, the courts have recognized the ability of minors to make their own decisions. That recognition should extend to the area of mental health.