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MAKING KIDS TAKE THEIR MEDICINE: THE PRIVACY AND DUE PROCESS RIGHTS OF DE FACTO COMPETENT MINORS

*Jan C. Costello**

A LAW SCHOOL EXAM QUESTION¹

Scene #1: A teenage girl sits and weeps in a mental health professional's office. "I can't stop crying. I'm so depressed. How about some of that Prozac or something?" The kindly mental health professional says, "Sorry, I can't prescribe medication for you without your parent's consent." The teenage girl says, "But they let me get an abortion without parental consent. If I can consent to abortion, why not to medication?"

Scene #2: Adolescent ward of psychiatric hospital. Two teenagers, male and female, are sitting in a day room watching television. A nurse appears with a tray of medications. The teenage boy says, "I don't want to take that stuff." The nurse says, "You don't have the right to refuse; you're a minor." The teenage girl says, "I wanted to have an abortion, but my parents said no. I went to juvenile court, and the judge said I was competent to make my own decision about abortion. I could have it if I wanted or refuse to have it; it was up to me."

The teenage boy asks eagerly, "Do I get to tell a judge that I don't want the meds?"

DISCUSS. (For extra credit, is there any difference if each scene is based in California?)

A STUDENT'S EXAM ANSWER

These scenes present two aspects of the same issue: whether de

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1. Or perhaps a screenplay in progress. For an earlier attempt to discuss a mental disability law issue in screenplay form, see Jan C. Costello, *L.A. Law School*, 29 *LOY. L.A. L. REV.* 1585 (1996) (advising mental health professionals of obligation and ability to disclose confidential communications).

facto competent or "mature" minors have the right to give or withhold consent to psychotropic² medication. The scenes dramatically illustrate an existing confusion in the law: although minors have well-established rights in the context of abortion, it is unclear to what extent such rights are applicable to medication decisions in the context of mental health care.

U.S. Supreme Court Abortion Cases—Privacy Rights and the De Facto Competent Minor

The United States Supreme Court has recognized in abortion cases that minors, like adults, have a constitutionally protected privacy right.³ That right includes the right to protect bodily integrity and to make health care decisions, especially, but not limited to, those involving reproduction.⁴ Of course, a minor's privacy rights are not coextensive with the rights of adults.⁵ Traditionally, at common law and under state statutes a parent or adult legal guardian has exercised this privacy right on behalf of the minor. But at least in the abortion context, a minor's privacy right is so strong that despite such traditional authority,⁶ parental control over the abortion decision

2. "Psychotropic" refers to medication prescribed for treatment of thought or mood disorders and includes antipsychotics, antidepressants, and antimanic agents. See ROBERT J. WALDINGER, *FUNDAMENTALS OF PSYCHIATRY* 397 (1986).

3. See *Roe v. Wade*, 410 U.S. 113, 154 (1973) (holding that the right of privacy includes the right to make decisions about abortion); *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (holding that the right of privacy includes birth control decision). For an excellent discussion of how these early cases formed the basis for substantive due process arguments that courts applied in mental disability cases, see BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* 189-222 (1997), and MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* § 5.07 (1989).

4. See *Roe*, 410 U.S. at 152.

5. In virtually all cases involving children's constitutional rights—from First Amendment to privacy—the Court has made this distinction. In some cases "not co-extensive" may translate into "not even close to" having the weight and scope of the adult's right. See, e.g., *Bethel Sch. Dist. v. Fraser*, 478 U.S. 675, 682 (1986) (discussing regulation of speech in school); *New Jersey v. T.L.O.*, 469 U.S. 325, 341 (1985) (holding that standard for in-school search is less than probable cause); *Ginsberg v. New York*, 390 U.S. 629, 637 (1968) (upholding a New York statute that deems materials obscene for minors but not for adults). In the abortion cases, however, a minor's right most closely approaches the adult's right so that although the state still may regulate the minor to a greater extent than it could an adult, the state must provide an opportunity for the de facto competent minor to exercise her own privacy right.

6. See generally Jan C. Costello, "If I Can Say Yes, Why Can't I Say No?" *Adolescents At Risk and the Right to Give or Withhold Consent to Health Care*, in

cannot be absolute. In *Planned Parenthood v. Danforth*,⁷ the Supreme Court held that a state could not give the parent an absolute veto power over a minor's abortion decision.⁸ Moreover, *Bellotti v. Baird*⁹ laid down the principle that a competent minor must have an opportunity to demonstrate her competence to make the decision herself.¹⁰ If a neutral decision-maker finds that she is competent, the decision is her own.¹¹ If she is not found competent, the neutral decision-maker can decide whether the abortion is in her best interest.¹²

Thus, courts since *Bellotti* have recognized the concept of a de facto competent minor. The Supreme Court has acknowledged that, despite the traditional legal presumption that minors in general are incompetent to make health care decisions, individual minors in fact possess such competence.¹³ And in the context of abortion, such a de facto competent minor must be given an opportunity to demonstrate her competence.¹⁴ Preventing a legally competent minor from making the abortion decision herself would violate her privacy right. Therefore, to save the constitutionality of parental consent and parental notice statutes, the Supreme Court has consistently required a "judicial bypass"—a hearing at which a minor who believes she is competent may prove such competence before a neutral decision-maker.¹⁵

Since minors, unlike adults, are presumed incompetent, the minor has the burden of proving that she is capable of making the abor-

CHILD, PARENT AND STATE: LAW AND POLICY READER 490, 491 (S. Randall Humm et al. eds., 1994) (stating that at common law minors could not make valid contracts with health care providers and could not give valid consent to treatment); Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have A Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1, 17-25 (1996) (discussing that at common law a minor had no right to refuse or consent to medical treatment); Walter Wadlington, *Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 314-18 (1994) (illustrating how courts in the first half of the century refused to acknowledge children's privacy rights).

7. 428 U.S. 52 (1976).

8. *See id.* at 74.

9. 443 U.S. 622 (1979).

10. *See id.* at 643.

11. *See id.*

12. *See id.* at 644.

13. *See id.* at 643-44 & n.23.

14. *See id.* at 643-44.

15. *See Planned Parenthood v. Casey*, 505 U.S. 833, 899 (1992); *Hodgson v. Minnesota*, 497 U.S. 417, 448-49 (1990); *Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 439-40 (1983); *Bellotti*, 443 U.S. at 643-44. *But see H.L. v. Matheson*, 450 U.S. 398, 409 (1981) (upholding constitutionality of parental notice statute for incompetent minors).

tion decision. The presumption of incompetence does not itself present a constitutional problem.¹⁶ The state traditionally has a strong "*parens patriae*" interest in looking after the health and welfare of minors, protecting them against bad decisions grounded in immaturity.¹⁷ This interest justifies restrictions on the decisions of a minor who actually is incompetent, as most minors are presumed to be. However, once the minor has proven her competence, the state no longer has a *parens patriae* basis to deny her the power to make her own decision. A judicial bypass that evaluates each minor's individual competence thus satisfies the state's interest in protecting incompetent minors.¹⁸ If a minor is found incompetent, the state's *parens patriae* interest continues and is then exercised through a decision by the judge or hearing officer regarding the minor's best interests. Conversely, if the minor is found competent, the state has no further interest in her decision.

This body of case law chiefly involves constitutional challenges to parental consent or notice statutes. Accordingly, most of these cases involve a minor seeking a judicial determination of competency so that she can consent to an abortion without notice to her parents or despite their disapproval. Occasionally, however, a minor wants to be declared competent so that she may refuse an abortion. The same principle applies to both situations since a competent person has the right both to refuse or consent to an abortion.¹⁹

Applying These Principles to the Medication Decision

These two exam hypotheticals raise an interesting question: why do these principles seem confined to the field of abortion law? Why have they not been applied in the context of mental health law? Suppose a judge found a minor to be competent to consent to an abortion on a Wednesday. The abortion was performed on Thursday. On the following Monday, the minor fell into a deep depression and then sought mental health treatment. Does it make sense that she cannot consent to medication for her depression because as a mi-

16. See *Matheson*, 450 U.S. at 405-07.

17. See *Bellotti*, 443 U.S. at 635.

18. See *id.* at 643.

19. The Supreme Court has recognized the logical corollary of the informed consent doctrine: a patient has the right *not* to consent, that is, to refuse treatment. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 270 (1990); see also *In re Smith*, 295 A.2d 238 (Md. Ct. Spec. App. 1972) (holding that a parent cannot compel a minor to submit to an abortion); WINICK, *supra* note 3, at 1-2.

nor she is presumed incompetent? If she has been found competent to make one important health care decision, what is the basis for the state's *parens patriae* interest in preventing her from consenting to medication? Similarly, if the minor was found competent on Wednesday to refuse an abortion—against her parents' wishes—why can a mental health professional medicate her the very next day against her wishes merely because her parents have given consent?

Perhaps because the abortion case law has developed in such a specialized way, advocates for children with mental disabilities have seldom thought to apply it in a mental health context.²⁰ The older mental health cases that sought due process rights for minors were often brought on basic equal protection grounds. The argument was that because adults have certain rights before being involuntarily hospitalized and treated, a minor should have similar rights. When the courts rejected those arguments, minors were frequently left without many rights at all. Moreover, the older due process cases like *Parham v. J.R.*²¹ and *In re Roger S.*²² focused on the right to a hearing before hospital admission to determine whether a minor satisfied the criteria for commitment. Those cases did not address the issue of a minor's competence to give or withhold consent to medication.²³ Cases addressing an adult's right to refuse treatment at least attempted to separate the question of meeting criteria for commitment from being incompetent to make treatment decisions,²⁴ but the

20. A noteworthy exception is Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 719 (1993) ("If bypass procedures are provided to minors in the abortion context because of the privacy interests and potential harm involved, judicial review and bypass should also be available in the mental health context."). See also *Parham v. J.R.*, 442 U.S. 584, 631 (1979) (Brennan, J., concurring in part and dissenting in part) (arguing that "[t]he right [of a minor] to be free from wrongful incarceration, physical intrusion, and stigmatization has significance for the individual surely as great as the right to an abortion"); Costello, *supra* note 6, at 492.

21. 442 U.S. 584 (1979).

22. 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977).

23. Contributor to this Symposium, James W. Ellis, thinks that the focus of due process for minors admissions proceedings still should be the appropriateness of the proposed treatment, not the minor's competence. See 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). But see N.M. STAT. ANN. § 32A-6-14 (Michie 1995); James W. Ellis & Dorothy Kay Carter, *Treating Children Under the New Mexico Mental Health and Developmental Disabilities Code*, 10 N.M. L. REV. 279, 300-06 (1980) (discussing New Mexico statute that gives certain minors the right to consent to or refuse medication).

24. See *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), *supp.*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*,

decisions in those cases were not automatically extended to minors.²⁵ Indeed, few commentators have even considered the issue of a competent minor's right to give or withhold consent to medication.²⁶

In the hypothetical situation where a minor has already been found competent to make the abortion decision, what justifies denying the minor the same power to decide whether to take medication? Although "competence" has different definitions, for the purposes of this discussion assume a traditional definition of "informed consent." The call of this question is whether a de facto competent minor has a right to demonstrate—or attempt to demonstrate—the ability to satisfy the applicable definition of "competence." Some have suggested that the definition of "competence" should vary with the complexity and seriousness of the decision involved,²⁷ and that assessment of a minor's competence should extend beyond traditional cognitive measures to consider a minor's "judgment."²⁸

One may argue that a minor competent enough to make the abortion decision is likely competent to make a decision concerning

458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983) (holding that an involuntarily committed mental patient's right to privacy conferred the right to refuse psychotropic medication); *Rogers v. Commissioner of the Dep't of Mental Health*, 458 N.E.2d 308, 310 (Mass. 1983) (holding that under state law a committed mental patient is competent to make treatment decisions until adjudicated incompetent by a judge). For an in-depth discussion of *Rennie* and *Rogers*, see PERLIN, *supra* note 3, at §§ 5.10-5.37.

25. See *Riese v. St. Mary's Hosp. & Med. Ctr.*, 209 Cal. App. 3d 1303, 271 Cal. Rptr. 199 (1987) (establishing right of competent persons involuntarily committed under short-term detention provisions of Lanterman-Petris-Short (LPS) Act to refuse treatment), *appeal granted*, 751 P.2d 893, 245 Cal. Rptr. 627 (1988), *appeal dismissed*, 774 P.2d 698, 259 Cal. Rptr. 669 (1989). California subsequently enacted legislation providing for capacity hearings to assess competency of persons asserting their right to refuse treatment under *Riese*. See CAL. WELF. & INST. CODE §§ 5332-5336 (West 1994). Only a minority of counties extend the right to a capacity hearing to minors, even though the language of *Riese* itself made no distinction between adults and minors, and the relevant sections of LPS apply to both minors and adults. See *id.* §§ 5150-5250.

26. Two commentators have proposed model statutes. See Dennis E. Cichon, *Developing a Mental Health Code for Minors*, 13 T.M. COOLEY L. REV. 529, 568-613 (1996); Redding, *supra* note 20, at 752-54.

27. See Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 992-98 (1991) (analyzing the "different levels" thesis of competency); see also Rosato, *supra* note 6, at 62-73 (developing an operational definition of competency to refuse life-sustaining treatment).

28. See, e.g., Elizabeth S. Scott et al., *Evaluating Adolescent Decision Making in Legal Contexts*, 19 LAW & HUM. BEHAV. 221, 237-38 (1995); Laurence Steinberg & Elizabeth Cauffman, *Maturity of Judgment in Adolescence: Psychosocial Factors in Adolescent Decision Making*, 20 LAW & HUM. BEHAV. 249, 250 (1996).

medications generally. Indeed, a minor competent to consent to abortion, or to refuse it and consent to pregnancy-related care, is by definition competent to make decisions concerning such medications as may be prescribed in connection with abortion or pregnancy and childbirth.

Should the competence standard for refusing mental health care be higher than the standard for refusing abortion?²⁹ Are the abortion decision and the medication decision different in complexity? Are these decisions different in terms of the seriousness of the consequences if the minor makes a "bad" choice?

The argument that minors should not have the right to *consent* to psychotropic medication without parental approval is likely based upon the seriousness of the consequences rather than the complexity of the decision.³⁰ Psychoactive medications can indeed be very powerful. They can also have serious side effects. A patient's response to the medication requires close monitoring in many cases.³¹ Perhaps for these reasons most state legislation does not authorize minors to consent to psychotropic medication under existing medical emancipation statutes.³² Yet these same concerns constitute powerful arguments why *de facto* competent minors who want to refuse the medications should have the right to do so. In cases involving an adult's

29. See Trudi Kirk & Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study*, 2 PSYCHOL. PUB. POL'Y & L. 45, 52 (1996) (criticizing the MacArthur competence definition as too high and as effectively demanding "higher levels of competency for mental health treatment refusal than it does for medical health treatment refusal").

30. There does not seem to be any obvious reason why the risks and benefits of medication are more difficult to grasp than those of abortion, and I have not found a commentator making such an argument.

31. For a detailed description of the most commonly used psychotropic medications, their risks and benefits, and the discussion of medications by courts and commentators, see WINICK, *supra* note 3, at 61-85.

32. Section 6924 of the California Family Code permits a minor age 12 or older to consent to outpatient mental health counseling but explicitly does not authorize the minor to consent to psychotropic medication. See CAL. FAM. CODE § 6924(b)(f) (West 1994). Section 6922 of the California Family Code permits a minor age 15 and older living apart from parent or guardian to consent to general medical and dental care. See CAL. FAM. CODE § 6922(a) (West 1994). General medical and dental care certainly includes prescribing medication; thus, arguably under section 6922 a minor could consent to medication prescribed by a general practitioner rather than a psychiatrist. For a more detailed discussion of the confusion raised by such statutes, see Costello, *supra* note 6, at 492-95, or generally Wadlington, *supra* note 6, at 323-24.

right to refuse treatment,³³ courts have consistently emphasized that involuntary medication represents a substantial intrusion on an individual's privacy right, citing the possibility of adverse side effects including, in some cases, permanent, irreversible damage.³⁴ However, even without such side effects and even when the medications perform exactly as anticipated, courts have recognized that the medications affect the patient's thought content, moods, and even emotions.³⁵ Even when acknowledging the important benefits of appropriate medication, courts have expressed these concerns in both civil and criminal contexts. Further, one cannot assume the benefits of involuntary medication for minors since many commentators have suggested that inappropriate use of these medications in the treatment of children and adolescents poses a significant problem.³⁶

*Comparing the Abortion and Medication Decisions:
Three Criteria*

The obvious counter-argument is that the abortion and medication decisions are not comparable. The abortion decision has three special characteristics: It (1) has critical implications for the minor's future; (2) is time-sensitive and cannot be postponed until the minor reaches legal adulthood;³⁷ and (3) is inextricably linked with an individual's personal values.³⁸ Courts have sometimes used these criteria

33. See, e.g., *Riggins v. Nevada*, 504 U.S. 127 (1992); *Washington v. Harper*, 494 U.S. 210 (1990); see also *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983); *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), modified, 634 F.2d 650 (1st Cir. 1980), vacated and remanded sub nom. *Mills v. Rogers*, 457 U.S. 291 (1982), on remand, 738 F.2d 1 (1st Cir. 1984).

34. See *Rennie v. Klein*, 462 F. Supp. 1131, 1137-38 (D.N.J. 1978); *Rogers*, 478 F. Supp. at 1359-60.

35. See *Riggins*, 504 U.S. at 137-38 (recognizing that prescribed medication may adversely affect decision-making and could possibly have a prejudicial impact on jury demeanor); *Rogers*, 478 F. Supp. at 1366-67 (noting that the ability of medication to affect and change a patient's mood, attitude, and capacity to think triggers First Amendment concerns).

36. See Peter R. Breggin, *Q: Are Behavior Modifying Drugs Overprescribed for America's Schoolchildren?*, INSIGHT, Aug. 14, 1995, at 18; Lawrence H. Diller, *The Run on Ritalin: Attention Deficit Disorder and Stimulant Treatment in the 1990s*, HASTINGS CENTER REP., Mar.-Apr. 1996, at 12; Kathi Grasso, *Children and Psychotropic Drugs: What's An Attorney to Do?*, 16 ABA CHILD L. PRAC. 49 (1997); Glen Pearson, *Lessons Learned: Revisiting Medication for Kids*, 16 ABA CHILD L. PRAC. 49 (1997).

37. See *Bellotti*, 443 U.S. at 642; *Lungren*, 16 Cal. 4th at 336, 940 P.2d at 815, 66 Cal. Rptr. 2d at 228.

38. See *Planned Parenthood v. Casey*, 505 U.S. 833, 850-51 (1991); *Lungren*, 16 Cal. 4th at 333, 940 P.2d at 813, 66 Cal. Rptr. 2d at 226.

beyond the abortion context to uphold a mature minor's right to decide even in cases where refusal of treatment will result in death.³⁹

Does the decision to give or withhold consent to psychotropic medication satisfy these criteria? First, will taking or refusing psychotropic medication have critical implications for the minor's future? Courts have consistently acknowledged that the stigma associated with being "mentally ill" or a "mental patient" can have serious negative consequences in the future.⁴⁰ In the first hypothetical, if the minor consents to taking Prozac and then subsequently tells, for example, her friends, a college admissions officer, a future employer, or even the state bar examiners, she may well experience such stigma.⁴¹

39. See *In re E.G.*, 549 N.E.2d 322, 378 (1990) (upholding the right of a seventeen-year-old Jehovah's Witness to refuse life-sustaining treatment). The Illinois Supreme Court based its ruling on the common law mature-minor doctrine and found that because E.G. was competent to appreciate the consequences of her decision, she was entitled to exercise her right to refuse treatment. See *id.* But see *O.G. v. Baum*, 790 S.W.2d 839, 842 (Tex. Ct. App. 1990) (holding that sixteen-year-old Jehovah's Witness had no right to refuse treatment since the jurisdiction had not adopted a mature-minor rule; the court did not reach a finding on the minor's competence). See generally Rosato, *supra* note 6, at 40-49 (discussing recent cases in which the court upheld the minor's decision to refuse life-sustaining treatment); see also Jessica A. Penkower, Comment, *The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment—Fatal Misuse of the Mature Minor Doctrine*, 45 DEPAUL L. REV. 1165 (1996) (analyzing the development of a minor's right to refuse treatment).

For some international perspectives on mature minors' decision making in a variety of medical contexts, see Alistair Bissett-Johnson and Pamela Ferguson, *Consent to Medical Treatment by Older Children in English & Scottish Law*, 12 J. CONTEMP. HEALTH L. & POL'Y 449 (1996); Morag McDowell, *Medical Treatment and Children: Assessing the Scope of a Child's Capacity to Consent or to Refuse to Consent in New Zealand*, 5 J.L. & MED. 81 (1997); Adrian Sutton, *Authority, Autonomy, Responsibility and Authorisation: With Specific Reference to Adolescent Mental Health Practice*, 23 J. MED. ETHICS 26 (1997).

40. See *Vitek v. Jones*, 445 U.S. 480, 494 (1980) ("[T]he stigmatizing consequences of a [prisoner's] transfer to a mental hospital for involuntary psychiatric treatment . . . constitute the kind of deprivations of liberty that requires procedural protections."); *Addington v. Texas*, 441 U.S. 418, 425-26 (1979) ("Whether we label this phenomena 'stigma' or choose to call it something else . . . we recognize that it can occur and that it can have a very significant impact on the individual."); *Conservatorship of Roulet v. Roulet*, 23 Cal. 3d 219, 228-29, 590 P.2d 1, 7, 152 Cal. Rptr. 424, 431 (1979) (noting that stigma of mental illness can be as "socially debilitating as that of a criminal conviction"); *In re Roger S.*, 19 Cal. 3d 921, 929, 569 P.2d 1286, 1291, 141 Cal. Rptr. 298, 303 (1977) (stating that a minor has an "interest in not being improperly or unfairly stigmatized as mentally ill or disordered").

41. And as Professor Susan Stefan's article shows, protection under the Americans with Disabilities Act may not be an available or adequate remedy in such instances. See Susan Stefan, "You'd Have to be Crazy to Work Here:" *Worker Stress, the Abusive Workplace, and Title I of the ADA*, 31 LOY. L.A. L.

Perhaps the stigma associated with taking psychotropic medications has greatly lessened because of the popularity of antidepressants like Prozac.⁴² But greater stigma can be associated with an antipsychotic medication like Thorazine, which carries a popular connotation that she must be "really crazy."

There is thus a danger of stigma if the minor decides to take the psychoactive medication. However, a minor who refuses medication may also suffer from stigma if his or her mental illness goes untreated. Chief Justice Burger in *Parham* opined that the untreated symptoms of mental illness are also likely to stigmatize a minor.⁴³ In *Addington* he further stated that one who is suffering from untreated mental illness is not really free.⁴⁴ In both due process cases, the Court considered the benefits of appropriate involuntary treatment in balancing the interests at stake.⁴⁵ Yet the Court's reasoning only reinforces the point that the decision to accept or refuse medication holds serious future consequences for a minor, thus satisfying the first criterion.

The second criterion is easily satisfied: The medication decision is time-sensitive and cannot be postponed until adulthood. If the depressed minor in the first hypothetical is given the right to take medication without parental consent, she may perhaps postpone her decision. She is an outpatient and no third party is urging her to make an immediate decision. But in the second hypothetical the hospitalized minor faces an immediate decision because the staff member has forced it upon him. However, in either case if the minor's mental condition causes her or him great distress, that can be an important internal source of pressure to decide immediately. If the minor's mental condition deteriorates rapidly without medication, as a practical matter the minor cannot postpone the decision until adulthood. Thus, depending upon the seriousness of the minor's mental condition, the decision to take or refuse medication may be postponed for a short period of time—but certainly not until the minor reaches adulthood.

REV. 795 (1998).

42. See PETER D. KRAMER, LISTENING TO PROZAC (1993).

43. See *Parham v. J.R.*, 442 U.S. 584, 601 (1979) ("[W]hat is truly 'stigmatizing' is the symptomatology of a mental or emotional illness The pattern of untreated, abnormal behavior—even if non-dangerous—arouses at least as much negative reaction as treatment that becomes public knowledge.").

44. See *Addington*, 441 U.S. at 429 ("One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma.").

45. See *Parham*, 442 U.S. at 600-06; *Addington*, 441 U.S. at 426-27.

The third criterion is the most important: Is the decision inextricably linked with the individual's personal values? This wonderful language really goes to the heart of the right to refuse or consent to treatment. No decision more closely involves an assessment of an individual's own values than the one to accept mental health treatment.

Identifying oneself as suffering from mental illness requires a judgment about whether one's own thoughts and feelings are acceptable or cause intolerable distress⁴⁶—whether one is “normal” or “abnormal,” “well” or “sick.”⁴⁷ This judgment may be difficult enough even when the individual is deciding whether to seek relatively less intrusive forms of mental health treatment, such as outpatient talk therapy. However, taking medication necessarily implies acceptance of the premise underlying its prescription—that the individual has a mental illness or condition that is pathological and whose symptoms the medication will alleviate. Indeed, mental health professionals praise individuals who comply with medication directions as showing insight into their condition. Conversely, individuals who refuse medication because they deny their own mental illness are said to lack insight.⁴⁸

Like adults, minors will vary in their readiness to accept a label of pathology and in the symbolic importance they assign to taking medication. Similarly, there will be great variation in response to and tolerance of the changes in thought or mood brought about by psychotropic medication.⁴⁹ In some cases a minor may willingly ac-

46. The DSM-IV defines mental disorder as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or with a significantly increased risks of suffering death, pain, disability, or an important loss of freedom.” AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* xxi (4th ed. 1994). Under this definition, a person can be mentally ill even if not “in distress” if the mental disorder is causing problems in life, but the individual does not recognize mental illness as the cause.

47. This of course reflects the powerful “borderline” metaphor used by Professor Perlin. See Michael L. Perlin, “Where the Winds Hit Heavy on the Borderline:” *Mental Disability Law, Theory and Practice*, “Us” and “Them”, 31 *LOY. L.A. L. REV.* 775 (1998).

48. This may be perfectly true both as to refusers generally and to an individual patient. The point is that accepting medication is regarded—by the treating mental health professionals and parents as well as by the minor—as a sign that the minor has accepted the premise that he or she is “sick” and in need of treatment.

49. Reasons for refusing medication often include the denial of mental illness.

knowledge mental illness and accept medication while his or her parents reject mental health treatment as inconsistent with their personal values or religious beliefs. On the other hand, it is far from uncommon for parents to seek treatment of a minor, in part, because of concern about behavior, sexual orientation, or opinions contrary to the parents' moral or religious beliefs.⁵⁰ In such cases the connection between personal values and a minor's decision to accept or refuse treatment is particularly strong. Thus, the decision to accept or refuse medication is inextricably linked with the minor's personal values, satisfying the third criterion.

Accordingly, because the medication decision and the abortion decision share the same special criteria, the argument that they are not comparable fails.

*Extra Credit: How Is The Discussion Affected If The Two
Hypotheticals Take Place In California?*

The California Constitution grants greater privacy and due process rights to minors than are available to them under the federal Constitution.

But even persons who identify themselves as mentally ill may refuse a particular medication—or all medications of a certain type—because when medicated, “I just don't feel like myself.” Unavoidable side effects of some medications can impair intellectual acuity, physical coordination, or libido. See WINICK, *supra* note 3, at 72-76. This is not unique to psychoactive medications—nor is the problem of refusal or noncompliance.

50. The inappropriate use of the private mental health care system to confine “out of control” children has been well documented for almost two decades. See, e.g., MIKE A. MALES, *SCAPEGOAT GENERATION* 242-53 (1996) (critiquing unnecessary hospitalization as “treatment of ‘Kid-With-Insurance-Disorder’”); IRA M. SCHWARTZ, (IN)JUSTICE FOR JUVENILES: RETHINKING THE BEST INTERESTS OF THE CHILD 131, 131-48 (1989) (characterizing unnecessary hospitalization as “being abused at better prices”); Jan C. Costello & Nancy L. Worthington, *Incarcerating Status Offenders: Attempts to Circumvent the Juvenile Justice and Delinquency Prevention Act*, 16 HARV. C.R.-C.L. L. REV. 41, 61-72 (1981) (identifying inappropriate use of the mental health system to circumvent restrictions on juvenile court power to confine status offenders); Carol A.B. Warren & Patricia Guttridge, *Adolescent Psychiatric Hospitalization and Social Control*, in MENTAL HEALTH AND CRIMINAL JUSTICE 119, 119-22 (Linda A. Teplin ed., 1984) (discussing inappropriate hospitalization of adolescents as a means of social control); Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773, 831-34 (1988) (linking dramatic increase in hospitalization to inappropriate admissions of “troublesome youth”).

On the especially controversial use of such placements by parents hoping to “cure” their lesbian or gay child, see Beth E. Molnar, *Juveniles and Psychiatric Institutionalization: Toward Better Due Process and Treatment Review in the United States*, 2 HEALTH & HUM. RTS. 99, 102-05 (1995).

In two cases, *American Academy of Pediatrics v. Lungren*⁵¹ and *In re Roger S.*,⁵² the California Supreme Court found unconstitutional two statutory schemes—one regulating a minor's consent to abortion⁵³ and the other regarding admission of a minor to a state mental hospital.⁵⁴ Both are comparable to those *upheld* by the United States Supreme Court under the federal Constitution.⁵⁵ In *Lungren* the court found unduly burdensome, and hence unconstitutional, a statute that required consent of both the minor⁵⁶ and one parent before the minor could receive an abortion, even though the statute provided a judicial bypass. In *Roger S.* the court found that a fourteen-year-old minor was entitled to an adversarial administrative hearing, including the assistance of counsel, before he could be committed to a state mental hospital even with parental consent.⁵⁷ Of the two precedents, *Lungren* ironically is most immediately relevant to the issue of a *de facto*⁵⁸ competent minor's privacy and due process right to refuse medication for two reasons: the powerful way in which the majority characterizes the privacy right of minors, and the parallels which Justice Mosk, dissenting, draws between the case before the court and the issues presented in *Roger S.*

The California Supreme Court found that the explicit guarantee of a privacy right in the California Constitution confers greater protection than does the United States Constitution.⁵⁹ Since minors as

51. 16 Cal. 4th 307, 940 P.2d 797, 66 Cal. Rptr. 2d 210 (1997).

52. 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977).

53. Cf. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (upholding Pennsylvania statute that required parental consent while providing a judicial bypass procedure); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (holding that a Minnesota statute containing a two-parent notification requirement was constitutional so long as it contains a judicial bypass).

54. Compare *Parham v. J.R.*, 442 U.S. 584 (1979) (upholding as constitutional a Georgia law permitting commitment of minors to state mental hospital on application by parent and admission interview at hospital), with *Roger S.*, 19 Cal. 3d at 937, 569 P.2d at 1295-96, 141 Cal. Rptr. at 307-08 (holding that statute violated minor's due process rights by not providing for a pre-admission hearing).

55. The *Lungren* majority opinion noted that the provisions of the challenged statute, Assembly Bill 2274, "clearly were drafted to comply with the requirements set forth in the applicable federal decisions." *Lungren*, 16 Cal. 4th at 325, 940 P.2d at 807-08, 66 Cal. Rptr. 2d at 220-21.

56. This effectively gives the minor a veto power which the parent does not possess under the statute.

57. See *Roger S.*, 19 Cal. 3d at 931, 569 P.2d at 1292, 141 Cal. Rptr. at 304.

58. The Court uses the terms "mature" and "immature" minors. For the purposes of this discussion, "mature" and "de facto competent" minors are the same.

59. See *Lungren*, 16 Cal. 4th at 325-26; 940 P.2d at 808, 66 Cal. Rptr. 2d at 221.

well as adults are "persons" entitled to constitutional protection, "there can be no question but that minors, as well as adults, possess a constitutional right of privacy under the California Constitution."⁶⁰ The court made a threshold determination that the challenged statute implicated a protected privacy interest of minors,⁶¹ even though "the only effect of the statute . . . is to condition the minor's exercise of his or her constitutional privacy right upon parental consent."⁶² The court underscored the principle that the privacy right includes the right to consent to *or to refuse to consent to* medical treatment.⁶³ "[I]f a group or an individual . . . were to compel a pregnant minor to undergo an abortion against her will, there would be no question but that [this] . . . would constitute a direct intrusion upon a constitutionally protected autonomy privacy interest of the minor."⁶⁴ Although acknowledging that parents traditionally make most health care decisions for their children—exercising the privacy right on the child's behalf⁶⁵—the court reasoned that at least regarding the abortion decision, a parental consent "statute denies a pregnant minor . . . control over her own destiny" and represents a "most significant intrusion on the minor's protected privacy interest."⁶⁶

The *Lungren* court next considered whether the state's asserted interests justified such a significant intrusion and concluded that they did not.⁶⁷ Applying a "compelling state interest" test,⁶⁸ the court found the statute unconstitutional. Acknowledging that protecting the health and welfare of minors and enhancing the parent-child relationship were indeed compelling state interests, the court found that the parental consent requirement was not "necessary" to promote such interests.⁶⁹ The majority cited at length to the trial court's findings that most minors were capable of informed consent.⁷⁰ In view of the numerous statutes authorizing a minor to obtain other

60. *Id.* at 334, 940 P.2d at 814, 66 Cal. Rptr. 2d at 227.

61. *See id.* at 331-39, 940 P.2d at 812-18, 66 Cal. Rptr. 2d at 225-31.

62. *Id.* at 335, 940 P.2d at 815, 66 Cal. Rptr. 2d at 228.

63. *See id.* at 333, 940 P.2d at 814, 66 Cal. Rptr. 2d at 227.

64. *Id.* at 335, 940 P.2d at 814, 66 Cal. Rptr. 2d at 227.

65. *See id.* at 336, 940 P.2d at 815, 66 Cal. Rptr. 2d at 228.

66. *Id.* at 339, 940 P.2d at 817-18, 66 Cal. Rptr. 2d at 230-31.

67. *See id.* at 340, 940 P.2d at 818, 66 Cal. Rptr. 2d at 231.

68. *See id.* at 342, 940 P.2d at 819, 66 Cal. Rptr. 2d at 232 ("We conclude that, under the California constitutional privacy clause, a statute that impinges upon the fundamental autonomy privacy right of either a minor or an adult must be evaluated under the demanding 'compelling interest' test.").

69. *See id.* at 352, 940 P.2d at 826, 66 Cal. Rptr. 2d at 239.

70. *See id.*

types of medical care without parental consent, particularly pregnancy-related care,⁷¹ the majority concluded that a parental consent requirement was unnecessary to protect the health of a pregnant minor.⁷² Those “immature” minors who were incapable of informed consent by definition could not receive an abortion without the consent of their parents because both state law and medical ethics would preclude a physician from performing the procedure.⁷³ As to the “mature” or de facto competent minors, however, the parental consent requirement imposed an undue burden.⁷⁴

Remarkably, the court concluded that judicial bypass *did not* save the statute’s constitutionality.⁷⁵ To the contrary, the court viewed the judicial bypass not as a helpful procedure that enabled a “mature” minor to demonstrate her competence, but rather as an undue burden on a minor’s power to make the abortion decision.⁷⁶ Requiring de facto competent minors to use the judicial bypass “would not serve—but rather would impede—the state’s interest in protecting the health of minors and enhancing the parent-child relationship.”⁷⁷

Thus in the abortion context, the *Lungren* court regarded it as an unconstitutional burden to require a minor to prove that she is competent to give or withhold informed consent. But in a mental health care context, would the same court have even conceded that a “mature” minor has a right to give or withhold consent to medication, much less a due process right to a hearing to demonstrate com-

71. *See id.*

[The power to consent to] medical care, without parental consent, for all conditions relating to pregnancy . . . [permits] a minor who, for example, develops life-threatening medical complications during her pregnancy to make medical decisions relating both to her own health and to her fetus’s survival, without parental consent, in circumstances that may pose much greater risks than generally are presented in undergoing an abortion.

Id.

72. *See id.* at 355-56, 940 P.2d at 828-29, 66 Cal. Rptr. 2d at 241-42.

73. *See id.* at 355, 940 P.2d at 828, 66 Cal. Rptr. 2d at 241.

74. *See id.* at 354-59, 940 P.2d at 827-31, 66 Cal. Rptr. 2d at 240-44.

75. *See id.* at 356, 940 P.2d at 829, 66 Cal. Rptr. 2d at 242.

76. *See id.* The Court found:

[R]esort to this judicial procedure inevitably will delay the minor’s access to a medically safe abortion, thereby increasing the medical risks posed by the abortion procedure, and will inflict emotional and psychological stress upon a minor without providing any greater protection of the interests of either a mature or immature minor than what is provided by the minor’s own health care provider.

Id.

77. *Id.* at 356, 940 P.2d at 829, 66 Cal. Rptr. 2d at 242.

petency? For all its powerful language about a minor's privacy rights in the abortion context, the court hastened to distinguish more mundane health care decisions by stating: "No one reasonably could suggest that a serious state constitutional privacy question would be presented . . . whenever a parent, over a child's objection, requires the child to go to the dentist or to take his or her medicine."⁷⁸ But what if state action supported the parent's authority, and the medication was administered not by a loving parent in the home, but by an employee of a state mental hospital—or of a private mental hospital, where a juvenile court, for instance, has placed the minor?⁷⁹ Are not the privacy and due process issues very similar to those in the abortion context? Would it not raise a state constitutional privacy question? At a minimum, would not a "mature" minor have a right to exercise his or her own due process rights in such a case?

Justice Mosk, dissenting in *Lungren*, did not answer these questions but drew important parallels between the abortion and mental health contexts.⁸⁰ He cited as closely analogous to the abortion cases the precedent of *In re Roger S.*,⁸¹ which may be called California's better version of *Parham*. It raised the question of what process is due a fourteen-year-old minor whose parents wanted to place him in a state mental institution. Citing significantly to the early abortion cases,⁸² the California Supreme Court found that a minor has a liberty interest protected under both the federal and the state constitutions.⁸³ Confinement to a mental hospital, which subjects the minor to involuntary treatment and imposes the stigma of mental illness, is a serious curtailment of that liberty interest, such that the minor is entitled to due process protection.⁸⁴

But unlike the United States Supreme Court in *Parham*, which found that a traditional clinical admissions interview satisfied due

78. *Id.* at 336, 940 P.2d at 815, 66 Cal. Rptr. 2d at 228.

79. Under California law, a juvenile or dependency court can refer minors for temporary mental health observation and evaluation; however, under the Lanterman-Petris-Short Act commitment proceedings must accompany any extended hospital confinement. See *In re Michael E.*, 15 Cal. 3d 183, 538 P.2d 231, 123 Cal. Rptr. 103 (1975).

80. See *Lungren*, 16 Cal. 4th at 392-98, 940 P.2d at 853-57, 66 Cal. Rptr. 2d at 266-70 (Mosk, J., dissenting).

81. 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977).

82. See *Lungren*, 16 Cal. 4th at 393 n.7, 940 P.2d at 854 n.7, 66 Cal. Rptr. 2d at 267 n.7 (Mosk, J., dissenting).

83. See *Roger S.*, 19 Cal. 3d at 927, 569 P.2d at 1289, 141 Cal. Rptr. at 301.

84. See *id.* at 937, 569 P.2d at 1296, 141 Cal. Rptr. at 308.

process,⁸⁵ the California Supreme Court in *Roger S.* required more. While recognizing that a minor's rights are not coextensive with an adult's,⁸⁶ the court stated that due process certainly entitles a minor to an administrative hearing, assistance of counsel, and the opportunity to present witnesses and cross-examine the case against him or her.⁸⁷ Further, the hearing must occur before admission so that the minor has better access to community services and witnesses closer to home.⁸⁸

The court, in giving Roger S. these protections, stated that at age fourteen he was capable of exercising his own due process rights.⁸⁹ Accordingly, his parents could not waive those rights on his behalf. The distinction is important because even an extremely young child has a liberty right which the state cannot abridge or deny without due process. But traditionally, the parents exercised such due process rights against the state on the child's behalf. *Roger S.* stands for the important proposition that minors who can capably exercise their own rights must be permitted to do so—parents cannot waive those rights for them.⁹⁰

Indeed, Justice Mosk stated in *Lungren*:

From *In re Roger S.*, we may derive the following principles. First, an unemancipated minor's constitutional rights are not equal to, but are more limited than, those of an adult, both as against his or her parents and as against the state. Second, *an unemancipated minor has a right to procedures that will protect him or her from arbitrary and drastic curtailment of constitutional rights by his or her parents, or, presumably, the state, no manner [sic] how well motivated.* Third, *a mature unemancipated minor, as opposed to one who is immature, has an increased right to exercise her constitutional rights, but even a mature unemancipated minor is not entitled to all of the same procedural protections as an*

85. See *Parham v. J.R.*, 442 U.S. 584, 607 (1979).

86. See *Roger S.*, 19 Cal. 3d at 928, 569 P.2d at 1290, 141 Cal. Rptr. at 302.

87. See *id.* at 937-38, 569 P.2d at 1296, 141 Cal. Rptr. at 308.

88. See *id.* at 937, 569 P.2d at 1296, 141 Cal. Rptr. at 308.

89. See *id.* at 931, 569 P.2d at 1292, 141 Cal. Rptr. at 304.

90. As the *Lungren* court noted, it is well established in the juvenile justice context that a parent cannot waive a minor's Fourth, Fifth or Sixth Amendment rights. See *Lungren*, 16 Cal. 4th at 336-37, 940 P.2d at 815-16, 66 Cal. Rptr. 2d at 228-29 (1997) (citing *In re Scott K.*, 24 Cal. 3d 395, 595 P.2d 105, 155 Cal. Rptr. 671 (1979) (holding that parent may not waive a minor's right to be free from unreasonable search and seizure)).

adult in the same situation.⁹¹

Justice Mosk then observed the similarities between abortion cases and *Roger S.*: both involve a significant deprivation of liberty and a minor's due process right to protection against "arbitrary and drastic curtailment of constitutional rights by his or her parents, or the state."⁹² In *Roger S.* a hearing to determine whether the minor met the criteria for commitment provided that protection.⁹³ In the abortion context, what would satisfy a mature minor's due process rights under the state constitution? The answer is a judicial bypass—a hearing to determine the minor's competence to make the abortion decision. In Justice Mosk's view, the two situations contain striking similarities and therefore should share similar results. The state should recognize a minor's privacy and liberty right and provide a fair procedure: in the abortion context, a judicial bypass, and in the mental health context, a pre-admission administrative hearing.

Justice Mosk could not understand the majority's view that the judicial bypass was burdensome and terrible when in *Roger S.* the right to a hearing was a great thing. Justice Mosk argued that the judicial bypass, rather than restricting a minor's right, "facilitates the ability of a mature unemancipated minor to obtain an abortion, regardless of parental consent, if she so chooses."⁹⁴ He acknowledged that minors who are competent to make the abortion decision have the right to decide themselves. But he believed the state can require the minor "to convince competent medical authorities that she has the requisite understanding and maturity to give an informed consent for any medical treatment."⁹⁵ "[S]omeone must in every case make the determination whether an individual unemancipated minor is capable of giving informed consent."⁹⁶

Of course, Justice Mosk did not argue for a minor's right to a hearing to demonstrate his or her competency to refuse medication. That issue was not before him. Rather, he used *Roger S.* and the

91. *Lungren*, 16 Cal. 4th at 394, 940 P.2d at 854, 66 Cal. Rptr. 2d at 267 (Mosk, J., dissenting) (emphasis added).

92. *Id.* (Mosk, J., dissenting).

93. *See Roger S.*, 19 Cal. 3d at 937-39, 569 P.2d at 1295-97, 141 Cal. Rptr. at 307-09.

94. *Lungren*, 16 Cal. 4th at 398, 940 P.2d at 857, 66 Cal. Rptr. 2d at 270 (Mosk, J., dissenting).

95. *Id.* at 399, 940 P.2d at 858, 66 Cal. Rptr. 2d at 271 (Mosk, J., dissenting) (quoting *Ballard v. Anderson*, 4 Cal. 3d 873, 883, 484 P.2d 1345, 1352, 95 Cal. Rptr. 1, 8 (1971)).

96. *Id.* at 401, 940 P.2d at 859, 66 Cal. Rptr. 2d at 272 (Mosk, J., dissenting).

analogy between involuntary hospitalization and abortion to argue that the California statute was adequate. Unfortunately, Justice Mosk alone made that connection. If the medication issue were before him today, would Justice Mosk carry the analogy to its logical conclusion?

Probably not. Like the majority, Justice Mosk was wary of the implications of recognizing a mature minor's rights to make other health care decisions. The "unemancipated minor's disability of nonage . . . [is based] on a fundamental social tenet that children require protection against their own immaturity and vulnerability in making decisions that may have serious consequences for their health and well-being."⁹⁷ Although the state has chosen "to remove [that] disability . . . in the so-called medical emancipation statutes . . . [i]t is not, however, constitutionally required to do so."⁹⁸ "Certainly, a parent can compel an obdurate six-year-old—or sixteen-year-old—to submit to a tetanus vaccination."⁹⁹

Is receiving a tetanus shot the same as receiving antipsychotic medication? Is parental authority to "compel" a minor limited to threats of grounding the obdurate teenager, or can the parent use the power of the state to hospitalize the teenager against his or her wishes? Both the *Lungren* majority and Justice Mosk, in dissent, seem worried that if these due process rights are extended beyond the abortion context, obdurate children at home will be screaming, "I'll go get a court order. Don't give me that cough medicine." Yet it is easy to distinguish between, on the one hand, a mother administering a spoonful of cod liver oil to a child in his own bedroom and, on the other, the staff of a locked mental hospital ward physically restraining and injecting the minor with antipsychotic medication.

So, if a state agent involuntarily medicates a minor, with or without parental consent,¹⁰⁰ does that constitute "state action," thereby

97. *Id.* at 395, 940 P.2d at 855, 66 Cal. Rptr. 2d at 268 (Mosk, J., dissenting).

98. *Id.* at 396, 940 P.2d at 856, 66 Cal. Rptr. 2d at 269 (Mosk, J., dissenting).

99. *Id.* (Mosk, J., dissenting).

100. The "state action" aspect of involuntary medication of a minor by a state agent cannot be avoided by having the parent "consent." In both *Parham* and *Roger S.*, the United States and California Supreme Courts acknowledged that confinement in a state mental hospital, even with parental consent, triggered the Due Process clause. See *Parham v. J.R.*, 442 U.S. 584, 599-601 (1979); *In re Roger S.*, 19 Cal. 3d 921, 929, 569 P.2d 1286, 1290, 141 Cal. Rptr. 298, 302 (1977). Additionally, the constitutional guarantee of privacy in California protects against wrongful action by both the state and private entities. Indeed, *Lungren* found that "when the only effect of [state law] is to condition the minor's exercise of his or her constitutional privacy right upon parental consent" the privacy and

implicating the minor's privacy rights under the Federal and California Constitutions? Unquestionably, yes. Does that minor have a due process right, under both constitutions, to demonstrate the competence to make the medication decision? Given the language from the abortion cases, I do not see how the answer could be anything other than yes.

True, the abortion cases typically include dicta to the effect that even a competent minor does not have the right to make *every* health care decision.¹⁰¹ However, because the medication decision satisfies the three criteria established in the abortion cases, it is not sufficient for the state as *parens patriae* or a minor's parent to exercise the privacy right on the minor's behalf in all instances. A de facto competent minor who wishes to exercise the right is entitled to do so. Therefore, despite Justice Mosk's assurances to the contrary,¹⁰² the California legislature may well be constitutionally required to recognize a de facto competent minor's right to make psychotropic medication decisions. It could do so either by a "medical emancipation" statute authorizing minors to give informed consent to psychotropic medications or by providing a judicial bypass procedure for individual minors to establish their competence.¹⁰³

Therapeutic Jurisprudence Issues

No discussion of the issues raised by the two hypotheticals would be complete without at least a mention of therapeutic jurisprudence. What are the therapeutic benefits and risks of giving a minor the

due process rights under the California constitution are triggered. *Lungren*, 16 Cal. 4th at 335, 940 P.2d at 815, 66 Cal. Rptr. 2d at 228. Justice Mosk's statement of the principles derived from *Roger S.* includes a guarantee of a minor's right to procedures that sufficiently protect against "arbitrary and drastic curtailment of constitutional rights by his or her parents, or, presumably, the state, no [matter] how well motivated." *Id.* at 394, 940 P.2d at 854, 66 Cal. Rptr. 2d at 267 (Mosk, J., dissenting).

101. See, e.g., *Bellotti v. Baird*, 443 U.S. 622, 634-37 (1979); *Lungren*, 16 Cal. 4th at 336, 940 P.2d at 815, 66 Cal. Rptr. 2d at 228. Nor does a parent have a right to make any and all health care decisions *other* than the abortion decision for a minor. A state may restrict or prohibit the use of certain health care procedures on minors, even with parental consent. See CAL. WELF. & INST. CODE § 5325(g) (West 1988) (providing no psychosurgery for minor); CAL. PROB. CODE § 2356(d) (West Supp. 1998) (providing no sterilization for minor).

102. See *Lungren*, 16 Cal. 4th at 396, 940 P.2d at 856, 66 Cal. Rptr. 2d at 269 (Mosk, J., dissenting).

103. Despite the holding in *Lungren* that such a judicial bypass unnecessarily burdened a minor's privacy rights in the abortion context, it would likely pass constitutional muster in the mental health context so long as *Roger S.* remains good law.

right to demonstrate competence and, if found competent, to accept or refuse medication? Do these risks and benefits differ from those identified for adults? Is it possible to implement such a right so as to assist a minor's mastery of the developmental tasks characteristic of adolescence, such as separation of identity from parents? What are the implications for family dynamics—can a de facto competent minor's rights be recognized without undermining family strength and unity?

When assessing the individual minor's competency, are there procedural alternatives to a traditional "adversarial" hearing which are more therapeutic? Perhaps either a mediation model or giving the mature minor the power to obtain a clinical "second opinion" to assist in the decision better serves both the minor's and parents' interests? TIME. I REALLY ENJOYED THE CLASS!

PROFESSOR'S GRADE AND COMMENT: B+

Clear statement of issues, good identification of relevant case law and generally accurate—although in places oversimplified—exposition of federal and state constitutional doctrine on privacy and due process. Your application of the three criteria is fairly persuasive. However, you evaded the issue of a different definition of competency for minors, relying instead on shifting the burden of proof to the minor. And I would like to see you explore the interesting therapeutic jurisprudence issues you raised. Perhaps you'd like to do an independent study on the topic? I'd be happy to supervise.

