CHAPTER 8: Minors

Due process rights vary according to the legal status of the minor. The law distinguishes between: 1) minors for whom "voluntary" mental health placements are sought and minors who are not voluntary; 2) minors who are involved in the juvenile court system (i.e. minors who are already juvenile court wards and dependents or those currently pending proceedings) and minors who are not involved with the juvenile court; 3) between minors placed in private vs. public facilities; and finally, 4) minors over and under the age of 14.

REPRESENTING A MINOR CLIENT

"Persons with mental illness have the same legal rights and responsibilities guaranteed all other persons by the Federal Constitution and laws and by the Constitution and laws of the state of California, unless specifically limited by Federal or state law or regulations..." (Welfare & Institutions Code (WIC) Section 5325.1).

A minor is a person under the age of 18 and a minor's status as a "person" for mental health purposes is included at WIC Section 5500(b).

Thus, unless there is a specific statute providing differently, all the rights and procedures required by the law for adults also apply for children. Therefore minors retain all the rights set forth in Welfare & Institutions Code (WIC) Section 5325, 5325.1 and these rights "may not be waived by the person's parent, guardian, or conservator." (WIC Section 5325)

Just as with adult clients, when representing a minor, an Advocate should be the voice for the minor's expressed interest. The Advocate must meet confidentially requirements with the minor, ascertain the minor's wishes and vigorously advocate to obtain the results desired by the minor. The minor must be the one to decide the forum of their representation after being carefully advised of the possible options and outcomes by the Advocate.

Advocates should promote the "articulated wishes" of their minor clients, regardless of whether they personally concur or not. The notion of "substituted judgment" should only come into play when it is unmistakably clear that the minor is unable to comprehend or assist in the proceedings in any manner, or perhaps is too young to adequately comprehend the proceedings. However, Advocates

must always ascertain whether there is a logical reason for the minor's decision, even if it is one that perhaps adults would not understand or rely upon.

LEGAL STATUS OF MINORS

INVOLUNTARY COMMITMENT OF A MINOR (72 HOUR HOLDS).

Minors can be held under the same legal procedure for involuntary treatment as adults. (See Chapter 7 Legal Status).

Authorization for Voluntary Treatment and Inability to Get Consent from Parent/Guardian for Treatment

Minors may only be detained for involuntary treatment under WIC Section 5585.50 (a "5150" for minors) if authorization for voluntary treatment is not available. The inability to get consent from the minor's parent/guardian, however, does not preclude treatment of a minor held under the LPS Act.

If the minor is detained, the treating facility must "make every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained." However, inability to contact the parent or legal guardian does not preclude holding and treatment of a minor involuntarily. (WIC Sections 5585.50 and 5585.53)

EVALUATION

The required evaluation for involuntary treatment is more extensive for minors than adults. WIC Section 5585.52 requires that any minor detained under the 72-hour hold provisions, "shall receive a clinical evaluation consisting of multidisciplinary professional analyses of the minor's medical, psychological, developmental, educational, social, financial, and legal conditions as may appear to constitute a problem. This evaluation shall include a psychosocial evaluation of the family or living environment, or both. Persons providing evaluation services shall be properly qualified professionals...in the diagnosis and treatment of minors. Every effort shall be made to involve the minor's parent or legal guardian in the clinical evaluation."

WHAT IS NOT PROOF OF A MENTAL DISORDER

Mental retardation, epilepsy, or any other developmental disability, alcoholism or other drug abuse or repeated antisocial behavior do not, by themselves, constitute a mental disorder. (WIC Section 5585.25)

Further, a minor is not mentally disordered for the purposes of commitment just because s/he exhibits behaviors described in WIC Sections 601, 602 (i.e. is habitually disobedient or truant or because s/he has violated a law defined as a crime).

"GRAVE DISABILITY" IS DIFFERENT FOR MINORS

Because there is always and adult or an agency responsible for providing food, clothing and shelter to minors, the definition of "gravely disabled" is different from the definition which applies to adults. WIC Section 5585.25 defines a "Gravely disabled minor" to mean a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others."

RIGHT TO WRIT OF HABEAS CORPUS HEARING

Minors have the same statutory right to a writ of habeas corpus hearing as adults under the LPS Act.

MINORS CANNOT BE CONFINED WITH ADULTS HELD UNDER THE LPS ACT.

No minors under 16 years may be held with adults receiving psychiatric treatment under the provisions of LPS. The Department of Health Care Services is authorized by statute to issue waivers of this prohibition for counties who can show the requirement is a hardship due to inadequate or unavailable alternative resources. Before issuing such a waiver, the Department must "require the county to establish specific treatment protocols and administrative procedures for identifying and providing appropriate treatment to minors admitted with adults." (WIC Sections 5585.55 and 5751.7)

However, "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." (WIC Section 5751.7)

TREATMENT PLAN

If, in the opinion of the professional person conducting the evaluation, the minor will require additional mental health treatment, a treatment plan shall be written

and shall identify the least restrictive placement alternative in which the minor can receive the necessary treatment. (WIC Section 5585.53)

AFTERCARE PLAN REQUIRED FOR ALL INVOLUNTARY MINORS

"A mentally ill minor, upon being considered for release from involuntary treatment, shall have an aftercare plan developed. The plan shall include education or training needs, provided these are necessary for the minor's well-being." (WIC Section 5585.57)

In addition, the facility must meet the aftercare plan requirements applicable to all patients: The minor, the minor's conservator, guardian or legally authorized representative must be given a written aftercare plan specifying the nature of the illness and follow up required, medications, including side effects and dosage schedules, the expected course of recovery, recommendations regarding treatment that are relevant to the minor's care, referrals to providers of medical and mental health services, and other relevant information. (WIC Section 5622).

LEAST RESTRICTIVE PLACEMENT

When considering "least restrictive placement" in the mental health context for minors, inpatient confinement often is not appropriate. For minors many of the underlying issues often relate to a disruption in parenting, family life, or nurturing. These needs cannot be filled by an institution. Combined with the stigma that attaches to hospitalization and may follow a child through subsequent placements and school, the least restrictive environment appropriate for minors is almost always a family-based community setting with necessary supports, not a psychiatric facility or residential treatment center.

14 DAY CERTIFICATION

If the treating facility determines that intensive treatment related to the mental disorder is required, a minor of any age may be certified. The minor gets exactly the same information, rights and representation as adults are given, including an explanation of the purpose for the certification and the opportunity to file a writ. The facility has the burden of proof to show that the minor is still a danger to self or others or gravely disabled (as defined for minors) and is not willing or able to accept voluntary treatment on the advice of counsel/Advocate. If a minor is placed on a 14-day hold pursuant to WIC Section 5250, the minor shall have a certification review hearing and be represented by the Patients' Rights Advocate or an attorney.

SECOND 14 DAY CERTIFICATION FOR SUICIDAL MINORS

Just as with adults, if the hospital seeks to hold the minor an additional 14 days because they believe there is an "imminent threat" that the minor will take their own life, then WIC Section 5260 procedures must be followed.

ADDITIONAL 180 DAY HOLD AS A DANGER TO OTHERS

Just as with adults, if the facility seeks to hold the minor as "dangerous to others," then the criteria in WIC Section 5300 must be shown.

CONSERVATORSHIP

The process is the same for minors as for adults, but Advocates must keep in mind the definition of "grave disability" and "mental disorder" for minors found in WIC Section 5585.25. Additionally, "bizarre or eccentric behavior, even if it interferes with a person's normal intercourse with society, does not rise to a level warranting conservatorship except where such behavior renders the individual helpless to fend for themselves, or destroys their ability to meet those basic needs for survival." (Conservatorship of Smith, 187 Cal. App. 3d 903, 232 Cal. Rptr. 277 (1986))

MINORS UNDER THE JURISDICTION OF THE JUVENILE COURT

This category includes wards of the court for being "habitually disobedient or truant" or for violating a law defined as a crime (WIC Sections 601, 602), and dependents of the court because their parents/guardians have been accused of abuse, neglect, or abandonment. (WIC Section 300).

The juvenile court does not have the authority to commit minors. LPS processes may only be used when inpatient mental health treatment is provided on an involuntary basis.

INVOLUNTARY COMMITMENT OF A WARD OR DEPENDENT (WIC SECTION 5585.20).

Minor's Commitment Criteria (72-Hour Hold). Minors in the following three categories: wards; dependents; or dependent petition pending, can be held for a 72-hour evaluation pursuant only to WIC Section 5585.20. The admission criteria are similar to those for adults-- they must be, as a result of a mental disorder, 1) danger to themselves, 2) danger to others, or 3) gravely disabled. WIC Section 5585.20 specifically requires that any evaluations be done according to the provisions set forth there. This can be a significant protection if the court wants to

send a child whose dependency petition is pending for a mental health "evaluation" under WIC Section 357 or Section 635.1, a similar provision for minors whose ward petition is pending.

When the court is in doubt as to whether a ward or dependent has a mental disorder, the court or person in charge can order the minor be taken to an LPS-designated facility for an evaluation. (WIC Section 6550 et seq.; Penal Code Sections 4011.6, 4011.8)

In the 1975 case In re Michael E., 15 Cal. 3d 183, 538 P.2d 231, 123 Cal. Rptr. 103 (1975) the California Supreme Court determined that a ward of the court could not be signed in as a "voluntary" patient to the state hospital by either the juvenile court, or by a probation officer acting under its direction. The court held that the minor was entitled to LPS due process protections prior to such a commitment.

In another case, In re Michael D., 70 Cal. App. 3d 522, 140 Cal. Rptr. 1 (1977), the Court of Appeal followed In re Michael E. ruling that the court could not circumvent the minor's right to LPS protections by appointing a guardian. Although the facts in each of these cases involved commitment to a state hospital, both courts focused upon the lack of authority of the juvenile court to substitute consent for treatment for minors under its jurisdiction. Thus, the principles underlying these cases clearly apply to commitment in private facilities as well.

VOLUNTARY COMMITMENT OF MINORS UNDER THE JURISDICTION OF THE JUVENILE COURT

Welfare & Institutions Code Section 6552 is the provision for minor wards or dependents (WIC Sections 300, 600) who want either inpatient or outpatient mental health services. The public defender of the county must make the application on behalf of the minors. In some counties, the local rules of court allow for the Patients' Rights Advocate to complete the application with the minor if the minor's attorney is unavailable.

1) Standard of Review

The minor's request for voluntary treatment, either inpatient or outpatient, will be granted if the court "is satisfied… that the minor suffers from a mental disorder which may reasonably be expected to be cured or ameliorated by a course of treatment offered by the hospital, facility or program in which the minor wishes to be placed; and that there is no other available hospital, program, facility which might better serve the minor's medical needs and best interest." (WIC Section 6552).

Additionally, the court should ensure that efforts have been made to explain the probable nature and duration of treatment and that the minor actually wants treatment. The Advocate can offer technical assistance and placement suggestions to the public defender.

2) Revocation of Consent

A minor may revoke the application for voluntary treatment at any time. The process for revocation of minor's application is as follows:

- The minor notifies the facility or attorney/Advocate that s/he no longer agrees to accept treatment at the facility voluntarily.
- The facility or attorney/Advocate must immediately notify the court.
- The court must calendar a special hearing and notify all counsel and parties.
- After the hearing, the minor must be released to the court unless the minor is placed on an LPS hold.

MINORS IN CARE AND CONTROL OF THEIR PARENTS

"VOLUNTARILY PER PARENT" TREATMENT IN PRIVATE FACILITIES

The "voluntary" admission of a minor means the parent or legal guardian wants the minor to be admitted to the hospital. It does not necessarily mean the minor wants or agrees to the hospitalization.

LPS requires specific "voluntary" admission procedures for minors admitted to private facilities by their parents. These admission procedures apply to minors who meet the following criteria:

1) The minor is not emancipated and is between 14 and 17 years old;
2) The minor is not also be committed under LPS provisions WIC Section 5585.50;
3) The minor is not voluntary under WIC Section 6552;
4) The minor is not a ward or dependent of the court;
5) The minor has a mental disorder.

(WIC Section 6002.10)

It should be noted that although these admission procedures do not apply to minors detained on a 72-hour hold under LPS provisions of WIC 5585.50, LPS cannot be used to circumvent these minors' due process rights. In discussing minors initially brought in under LPS and later signed in by their parents, the California Hospital Association acknowledges, "These procedures [including the Independent Clinical Review] would apply…at the time of a change to voluntary status of a minor who was initially admitted on such a 72-hour hold if the other criteria are met." (MENTAL HEALTH LAW: A handbook of laws governing mental health treatment, 8th Edition (2014) California Hospital Association, pages 3.3 – 3.6)

Resistance to treatment may not be used as evidence that the minor has a mental disorder. Nor can behaviors described in WIC Sections 601, 602, i.e. habitually disobedient or truant or having violated criminal laws, be the sole basis for admittance. Nor can alcoholism, other drug abuse, or repeated antisocial behavior (WIC Sections 5585.25 and 6002.10).

The "voluntary" admission procedures that apply to minors meet the criteria above are as follows:

Prior to accepting written authorization for treatment, the private facility must provide the parent/guardian must be given orally and in writing, a full explanation of the treatment philosophy followed, including the use of seclusion and restraint, medication and how involved the parent/guardian can expect to be in the treatment process. It should be noted that seclusion and restraint laws apply equally to children and adults; therefore, parents/guardians cannot waive any of those precautions.

The professional person in charge of the admission must affirm in writing that meets the admission criteria above.

The private facility must inform the minor in writing about his/her right to an Independent Clinical Review (ICR) and give him/her a copy of the Department of Health Care Services rights of minors' booklet. (WIC Section 6002.15)

The private facility must notify the Patients' Rights Advocate within one day that the minor has been admitted. (WIC Section 6002.15(c)(2))

RIGHT TO AN INDEPENDENT CLINICAL REVIEW

A post-admission Independent Clinical Review (ICR) is conducted by a psychiatrist selected by the facility who may or may not have staff privileges at the hospital which is treating the minor. The ICR is conducted at the facility. Prior

to the ICR, the psychiatrist-reviewer must interview the minor, review clinical information, including past treatment and future treatment plans, and consult with the treating physician to review alternative options.

"Independent clinical reviewer" means a psychiatrist who is a neutral party to the review, with experience in treating adolescents. He/she shall have no financial relationship with the family or the treating physician. The county mental health director must approve the list of independent reviewers at least annually. (WIC Section 6002.25).

The ICR is not automatic, but is available to minors who request it. The request for an ICR must be made within the first ten days of admission and the review shall take place within five days of the request. The facility does have the obligation to inform the minor of the right to the ICR in writing. No party in the proceeding has the right to counsel, but the Patients' Rights Advocate is required to provide assistance to the minor at the review. (WIC Sections 6002.20(b) and 6002.30).

STANDARD OF REVIEW AT THE ICR

The standard of review at the ICR is as follows:

- Whether the minor continues to have a mental disorder.
- Whether further inpatient treatment is reasonably likely to be beneficial to the minor's mental disorder, or
- Whether the placement in the facility represents the least restrictive, most appropriate available setting, within the constraints of reasonably available services, resources, and financial support, in which to treat the minor. (WIC Section 6002.30 (c)).

If the psychiatrist conducting the clinical review determines that further inpatient treatment in the facility is not reasonably likely to be beneficial to the minor's mental disorder or does not represent the least restrictive, most appropriate available setting in which to treat the minor, the minor shall be released from the facility to a custodial parent or guardian on the same day the determination was made. (WIC Section 6002.35 (d)).

The decision of the reviewing psychiatrist to release the minor is binding and not appealable. The minor shall be released to a custodial parent or guardian on the same day the determination was made. (WIC Sections 6002.35 (b) and (d)).

REVIEW PROCEDURES

1) If the minor requests the ICR then the Advocate must be notified no later than one working day after the request. Only the minor can waive the right to this hearing. Once a request is made, the minor can change his or her mind at any time. (WIC Section 6002.20).
2) The minor has the right to be assisted by the Advocate and to question those recommending inpatient treatment. However, if the minor does not want to attend then the Advocate can represent the minor in his or her absence. (WIC Section 6002.30 (e)).
3) The review should be in an informal but private setting. The review can be limited to the minor, the parent/guardian, the Advocate, a representative of the facility, and the psychiatrist conducting the review. (WIC Sections 6002.30 (f), (g) and (h)).
4) An interpreter must be provided if any participant requires one (WIC Section 6002.30 (j)).
5) The reviewing psychiatrist is responsible for keeping a record of the hearing (WIC Section 6002.35 (a)).

RIGHT TO WRIT OF HABEAS CORPUS HEARING

The statutes governing minors in this category do not specifically give minors the right to a habeas corpus writ hearing. However, the right is made clear by the historical language. The statutes "do not preclude the right to review of inpatient treatment through the exercise of other legal remedies available to minors, including, but not limited to, a writ of habeas corpus." Many Superior Court Local Rules specifically provide minors with this right. (Note: The judicial council LPS-writ form has an "Other" box where the form asks which LPS Act code Section the person is being held under. Minors in this category should use this "Other" box and write WIC Section 6002).

"VOLUNTARY" PER PARENT TREATMENT OF MINORS IN PUBLIC FACILITIES ("ROGER S.").

1) Background: Minors right to pre-commitment ("Roger S.") hearing

Minors voluntarily admitted by parents or a guardian to public psychiatric facilities, like minors admitted to private psychiatric facilities, are not entitled to the protections of the LPS Act. Minors 14 years and older are, however, entitled by statute to the pre-commitment hearing described below.

In re Roger S., 19 Cal. 3d 921 (1977), the California Supreme Court held that though a minor's personal liberty interest is less comprehensive than that of an adult, a minor does possess due process rights which cannot be waived by a parent or guardian before being committed to a state hospital. The minor is not entitled to full LPS protections, but is entitled to a pre-admission hearing on the issue of whether inpatient hospitalization is appropriate. The court did not require that the hearing be judicial but did establish the right to counsel, the right to present evidence, and the right to cross-examine.

Although the facts of Roger S. involved commitment to a state hospital, the rationale applies to any state controlled facility. Roger S. is therefore applicable to minors being admitted by parents to county-operated facilities.

2) Standard of Review at Roger S. hearing

Most Superior Court Local Rules require that all of the following criteria be met, by a "preponderance of evidence," in order to hospitalize a minor under the Roger S. case:

a) The minor has a mental disorder;

b) The minor requires twenty-four hour treatment in a locked facility;

c) The hospital represents the least restrictive and most appropriate setting to fulfill the objectives of treatment;

d) Hospitalization is reasonably expected to ameliorate the mental condition, and

e) The facility is in the minor's home community, and if not, that the benefits of treatment out way the detriment of removal from that home community.

If any of the above criteria is not met, then the minor should not be committed.

The purpose of these pre-commitment hearings is to assure that admission is justified before the minor has been significantly deprived of their liberty interests. The Roger S. court wrote, "Clearly, post-admission procedures would be inadequate to avoid the trauma of removal of the child from the home and unnecessary placement in a mental hospital." However, in reality most of these hearings are post admission because a minor is usually brought in under the 72 hour hold criteria and then "transferred" to voluntary status when signed in by a parent.

3) Hearing procedures

Roger S. hearing procedures are as follows:

a) The minor must be given notice and information about the hearing.

b) The hearing must be before a judge or an administrative officer of the court;

c) The minor has a right to counsel. (One appellate district court has interpreted "counsel" to mean an attorney. In re Antoine C., 186 Cal. App. 3d 424, 230 Cal Rptr.738 (1986). However, in at least one county, non-attorney Advocates are successfully conducting these hearings. Further, in some counties non-attorney advocates provide the minor with the advisement of their right to hearing and discuss with him/her whether they want to proceed to hearing or waive it).

d) The minor has the right to appear and present evidence on his/her own behalf.

e) The minor must have the opportunity to confront and cross-exam witnesses brought against them.

Only the minor can waive these rights after being given notice of them.

4) Pre-commitment Hearings for Minors under 14 years

The law is silent regarding the rights of children under 14 to a pre-commitment hearing. This lack of protection in premised on the idea that children of that age are not intelligent or mature enough to assert their own rights. Therefore, should the facts of any particular situation refute that presumption, then the right to a pre-commitment hearing should be asserted.

MINORS AND MEDICATION

RIGHT TO REFUSE PSYCHOTROPIC MEDICATIONS

The Riese decision, (finding that people held involuntarily are presumed to have the capacity to consent or refuse to consent unless specifically found not to have the capacity), makes no distinction between adults and minors--it gives the presumption to all persons. Advocates should assert that all involuntarily confined minors (and even all voluntary minors over the age of 14) are entitled to undergo medication only by informed consent or by judicial order, as has been endorsed by the court for adult patients.

A hand full of counties have convinced the Superior Court that minors held under the LPS are entitled to capacity hearings. Although in most cases, parents hold sole authority to consent to psychotropic medication for their minor children, these counties acknowledge the distinction between authority to consent and right to refuse. Consequently, they recognize that minors with capacity have the right to refuse these powerful medications under the Riese decision.

MEDICATION FOR MINORS UNDER THE JURISDICTION OF THE JUVENILE COURT

For wards and dependents of the juvenile court who have been removed from the physical custody of their parents, only a juvenile court judicial officer has the authority to make orders regarding the administration of psychotropic medications. Court authorization for the administration of psychotropic medication shall be based on a request from a physician. The physician's statement supporting the request must include the following:

1) The diagnosis of the minor's condition that the physician asserts can be treated through the administration of the medication;
2) The specific medication recommended, with the recommended maximum daily dosage and length of time this course of treatment will continue;
3) The anticipated benefits to the minor of the use of the medication;
4) A description of possible side effects of the medication;
5) A list of any other medications, prescription or otherwise, that the minor is currently taking, and a description of any effect these medications may produce in combination with the psychotropic medication;
6) A description of any other therapeutic services related to the minor's mental health status; and
7) A statement that the minor has been informed in an age-appropriate manner of the recommended course of treatment, the basis for it, and its possible results. The minor's response must be included.

Notice of the physician's request must be provided to the parents/legal guardians, their attorneys of record, the minor's attorney, the minor's Child Abuse Prevention and Treatment Act guardian ad litem, the minor's current caregiver, the minor's Court Appointed Special Advocate, if any, and where the minor has been determined to be an Indian child, the Indian child's tribe.

Within seven court days from receipt by the court of a completed request, the juvenile court judicial officer shall either approve or deny in writing a request for authorization of psychotropic medication to the minor, or shall, upon a request by the parent, the legal guardian, or the minor's attorney, or upon its own motion, set the matter for hearing.

It should be noted that the code Sections authorizing the juvenile court to make orders authorizing psychotropic medication for both wards and dependents specify, "Nothing in this Section is intended to supersede local court rules regarding minor's right to participate in mental health decisions." This allows those counties that apply the Riese decision to minors to continue to conduct capacity hearings for wards/dependents who refuse psychotropic medication authorized by the juvenile court.

(WIC Sections 369.5 and 739.5; California Rules of Court 5.640.)

OTHER IMPORTANT CONSIDERATIONS

MINORS HAVE THE SAME PATIENTS' RIGHTS AS ADULTS.

Minors in any of the above categories must be advised of their rights and of their right to contact a Patients' Rights Advocate (WIC Section 5325 (h)).

The rights under WIC Section 5325(a)-(e) may only be denied for good cause. Parents/guardians may not waive them for any reason. In addition, minors have all the non-deniable rights enumerated at WIC Section 5325.1. It should be noted that the right to see and receive the services of the Patients' Rights Advocate (5325(h)) is also undeniable right, as it specifically excluded from the list of "5325" rights which may be denied for good cause. (See WIC Section 5326)

RESTRAINT AND SECLUSION OF MINORS IN PUBLIC AND PRIVATE INPATIENT FACILITIES

The same protections and procedures that apply to adults also apply to minors.

CONSENT TO CONVULSIVE (ECT) TREATMENT.

The laws related to Electro-convulsive treatment apply differently to minors depending on their age and voluntary status. Electro-convulsive treatment may not be performed under any circumstances on a minor under the age of twelve. Minors age twelve up to sixteen may be provided with ECT only in a life-

threatening emergency. Minors who are 16 or 17 years old have the same rights and protections as adults related to the administration of ECT.

(WIC Section 5326.7 et seq., and 9 California Code of Regulations (CCR) Section 845 et seq.).

MINORS' RIGHT TO CONSENT TREATMENT

As a general rule parents have the right to control and consent to medical and mental health care of their children they reach 18 years of age. For minors under the jurisdiction of the juvenile court, the court may order medical treatment. For minors under the jurisdiction of the juvenile court and removed from the physical custody of their parents, only the court may order psychotropic medication for the minor. (Family Code Sections 6920-6929; WIC Sections 362, 369.5, 727 and 739.5).

There are, however, statutory exceptions to the general rule requiring parental consent.

OUTPATIENT MENTAL HEALTH TREATMENT/COUNSELING OR RESIDENTIAL SHELTER SERVICES

Family Code Section 6924(b) allow a minor age 12 or over to consent to outpatient mental health treatment or to residential shelter services without the concurrence of parent or guardian if-

1) The professional in charge believes the minor is mature enough to participate intelligently, and
2) The minor would present a danger of serious physical or mental harm to self or others without the treatment or residential services, or the minor is an alleged victim of incest or child abuse.

"Residential shelter services" means residential and other support services to minors on a temporary or emergency basis in a facility that services only minors by a governmental agency, a person or agency having a contract with a governmental agency to provide these services, an agency that receives funding from community funds, or a licensed community care facility or crisis resolution center.

"Mental health treatment or counseling services" means outpatient treatment or counseling by a governmental agency, a government contractor, an agency that receives funding from community united funds, a runaway house or a crisis resolution center.

The provider has the discretion to include the parent/guardian in treatment. However, in some instances, payment for services to the minor by the parent/guardian and/or participation of the parent/guardian in treatment may affect the confidentiality of the minor/physician relationship.

MINOR'S CONSENT TO OTHER KINDS OF MEDICAL CARE

A minor may consent to the following types of medical care:

a) Prevention or treatment of pregnancy, with the exception of sterilization unless the minor seeks authorization from the court;

b) Treatment for sexually transmitted or infectious diseases that must be reported;

c) Diagnosis and treatment related to an alleged rape (minors 12 years and older);

d) Diagnosis and treatment for alleged sexual assault; and

e) Treatment related to drug or alcohol abuse with the exception of methadone treatment (minors 12 years and older).

(Family Code Sections 6925- 6929).

MEDI-CAL FOR YOUTH

Minors can get their own Medi-Cal card and use it to pay for the services minors can consent to independently. This can also include after-care treatment. This is commonly referred to as "minor consent Medi-Cal." Eligible minors who wish to receive confidential care for the services listed above may do so under the Medi-Cal Minor Consent Program.

LEGALLY EMANCIPATED AND SELF-SUFFICIENT MINORS

Legally emancipated minors requiring involuntary treatment shall be considered adults.). Emancipated minors include: those under 18 who are on active military duty; those who have been married, even if they later divorced; or "Court Declared Emancipated": minors, 14 or older, who live apart from parents/guardians with their consent and are managing their own financial affairs and their income is not derived from criminal activities. As with other adults, emancipated minors have the right to consent to or refuse medical and mental health treatment. (WIC Section 5585.59; Family Code Section 7000 et seq.)

"Self-sufficient Minors" may consent to medical treatment if 15 or older, living apart from parents with or without consent, and managing his/her own financial affairs, regardless of the source of those funds. (Family Code Section 6922).

ACCESS TO RECORDS

BY THE MINOR

1) Medical Care Records

A minor is entitled to inspect "patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent." See "Minor's consent to other kinds of medical care" above for a list. Significantly, the parent or guardian is not entitled to inspect these records without the express authorization of the minor. This is to encourage minors to seek medical and mental health care without fear of their parents/guardians finding out. (Health and Safety Code (HSC) Sections 123110 (a), 123115 (a)(1))

It is important to keep this protection in mind because children often talk about these issues in the course of mental health treatment and therefore it can and should, absent the minor's permission, be excised from any records the parent/guardian requests.

2) Mental Health Records

A minor patient can request their own mental health records, but access to these records can be denied under regulations pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), if the a "licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person…" (45 Code of Federal Regulations (CFR) Section 164.524(a)(3)) This applies to outpatient mental health care the minor has the right to consent to independently under California Family Code Section 6924 with the exception of "psychotherapy notes."

The commentary in the Federal Register that accompanies the HIPPA regulations makes clear that this is meant to be a narrow exception: "If a licensed health care professional determines that… permitting inspection or copying of some of the individual's protected health information is reasonably likely to result in the individual committing suicide, murder, or

other physical violence, then the health care professional may deny the individual access to that information. Under this reason for denial, covered entities may not deny access on the basis of the sensitivity of the health information or the potential for causing emotional or psychological harm." (65 Federal Register 82555).

If inspection is refused then the health care provider has to document the request and the specific reasons for the refusal. However, the provider must tell the minor that the provider is required to permit inspection by a licensed physician or psychologist if the minor patient requests that in writing. (HSC Section 123115 (b)(3))

BY THE PARENT OR GUARDIAN

A minor's personal representative has the right to review the minor's medical records, except as provided below. For minors, "personal representatives" are parents or guardians. (HSC Section 123105(e)(1)).

Medical care records: See "Medical care records" above concerning excising from the mental health records information about medical treatment received pursuant to the minor's independent consent.

Mental health care records: The parent/guardian of a minor may request the minor's records. However, inspection is not automatic. If "the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the providers professional relationship with the minor patient or the minor's physical safety or psychological wellbeing, then the parent may be denied access by the health care provider." (Health & Safety Code, Section 123115 (a)(2)). This restriction of access is specifically allowed under the federal HIPAA privacy regulations. (45 CFR Section 164.502(g)(3)(ii)(B)).

BY THE ADVOCATE

A minor in any category is guaranteed, under WIC Section 5325, the right to receive the services of a Patients' Rights Advocate. The general rule is that "a recipient of mental health services is presumed competent for the purpose of entering into an agreement with" Advocates for services "unless found by the court to be incompetent to enter into" such an agreement.

Therefore, any client, i.e. any person, including a minor who is receiving mental health services, can authorize an Advocate to inspect their records. The facility may remove information given in confidence by the minor's family.

DISCLOSURE OF MINORS RECORDS TO OTHERS

"If the recipient of services is a minor, ward, or conservatee," then his/her parent, guardian, guardian ad litem or conservator can designate persons to receive the records. However, nothing in the statute compels "a physician, psychologist, social worker, nurse, attorney or other professional person to reveal information which has been given to him or her in confidence by members of the patient's family." (WIC Section 5328(d)).

Here again, where records are a result of treatment that the minor can consent to independently they can only be disclosed to others with the permission of the minor.

FACILITIES FOR MINORS

GROUP HOMES

Group homes are 24 hour residential facilities which provide care and supervision to seven or more children and/or adolescents in a structured environment which is non-secured. They are "community care facilities" and are licensed by the Department of Social Services (DSS).

(22 CCR Section 84000 et seq.)

1) Personal Rights of Residents

The rights of minors in group homes are governed by Title 22 CCR Section 84072. Some of these rights are the same as those enumerated in WIC Sections 5325 and 5325.1. County Patients' Rights Advocates are responsible for receiving and investigating complaints from or concerning recipients of mental health services residing in licensed health facilities or community care facilities regarding abuse, unreasonable denial or punitive withholding of rights. (WIC Section 5520).

While patients' rights advocates do have access to clients in community care facilities, the licensing agency, DSS-Community Care Licensing (CCL), has ultimate responsibility for monitoring and investigating residents' complaints. Advocates should therefore develop a working relationship with CCL personnel.

2) Discipline and Use of Seclusion and/or Restraints

A facility cannot initiate forms of discipline which violate the minor's personal rights referred to above. Acceptable forms of discipline which a facility may

utilize are listed in Title 22 CCR Section 84072.1. A facility must maintain and implement written policies and procedures governing this practice.

The use of locked seclusion and/or restraint are not allowed by the regulations. Advocates should obtain a copy of the facility's policies and procedures, as well as, any waivers which the facility has obtained from DSS-CCL when investigating a complaint regarding the appropriateness of a particular use of discipline and /or restraint.

COMMUNITY TREATMENT FACILITY

Community Treatment Facilities (CTF) are secured residential facilities and are programs for seriously emotionally disturbed minors and wards or dependents of the juvenile court. CTF's are licensed by the Department of Social Services and certified by the Department of Health Care Services. The facility shall be defined as "secure" if residents are not permitted to leave the premises of their own volition. DHCS shall limit the total number of beds to no more than 400 beds, statewide. The number of secure and non-secure beds that a facility maintains can only be modified with the approval of both DHCS and DSS.

(WIC Section 4094 et seq.; Title 9 CCR 1900 et seq.)

1) Criteria for Admission

Only minors certified by an appropriate mental health professional as "seriously emotionally disturbed", as defined in WIC Section 5600.3(a)(2), for whom less restrictive mental health interventions have been tried, as documented in the case plan, or who are placed in an acute psychiatric hospital or state hospital, or out of state facility can be placed in a CTF. (WIC Section 4094.5(a)).

The minor shall be determined, by a county interagency placement committee, to be in need of the level of care provided by a CTF. (WIC Section 4094.5(c)(1)).

The minor must be considered, clinically, to require a period of containment to participate in and benefit from mental health treatment. The proposed treatment program at the CTF must be reasonably expected to improve the minor's mental disorder. (See also Title 9 CCR Sections 1923(b), (c) & (d) which specify the admission criteria in greater detail).

Minors who are admitted to a CTF must be either (a) under the jurisdiction of the juvenile court and have made a voluntary application for mental health

services pursuant to WIC Section 6552, or (b) admitted with the informed consent of a parent, guardian, conservator or other person having custody of the minor.

2) Due Process Rights

Any minor admitted to a CTF shall have the same rights afforded to minors admitted to a state hospital or county acute psychiatric hospital pursuant to the "Roger S." procedures. ("Voluntary Per Parent" Treatment of Minors in Public Facilities above). Minors who are wards or dependents of the court shall be afforded due process pursuant to WIC Section 6552 and may not be admitted involuntarily except in accordance with the LPS Act. (Note: Minors under the juvenile court's jurisdiction cannot be admitted to a CTF by court order or by consent of the minor's parent or guardian, probation officer or social worker).

The specific pre-admission due process procedures are listed in the regulations at Title 9 CCR Section 1923(b). All minors have a right to a writ of habeas corpus within two judicial days of filing a petition in the superior court in the county in which the facility is located pursuant to WIC Section 4094.6. (See Title 9 CCR Section 1926 for specific requirements related to such a request by a minor).

3) Patients' Rights

Minors admitted to a CTF have the contained in WIC Sections 5325, 5325.1, 5325.2 and 5325.6. In addition to the rights above, every minor in a CTF has the right to participate in daily outdoor activities. (Title 9 CCR Section 1931).

Every minor admitted to the facility must be personally informed of their rights in writing or by other means if unable to read or understand the information provided; such notification must be noted in the minor's facility record within 24 hours of admission. A list of right of rights must be posted in all wards and common living areas. (Title 9 CCR Section 1932).

Any denial of rights must comply with "good cause" criteria and documentation of the denial, including specific information must be noted in the minor's facility record immediately following the denial. The right must be restored as soon as good cause for the denial no longer exists. (Title 9 CCR, Sections 1934- 1937).

When a complaint regarding a denial of rights is received by a county Patients' Rights Advocate, action must be taken, within two working days, to investigate and resolve the complaint. (Title 9 CCR Section 1933 (b)).

4) Medication Consent

The CTF must obtain written informed consent for psychotropic medications from each minor, as well as the legal guardian, conservator or judge, pursuant to Title 9 CCR Section 851. The prescribing physician must examine each minor prior to prescribing any medication and the treating physician must conduct a written medication review at least every 30 days. The facility's medication protocols shall not allow for blanket consent for psychotropic medication to be prescribed for, or administered to, minors in the facility. (Title 9 CCR Section 1928 (a)(3)(A)).

5) Seclusion & Restraint

The regulations governing the use of seclusion and restraint are almost identical to those governing acute psychiatric facilities. Seclusion and/or restraint orders must be limited to two (2) hours for minors 9 to 17, one (1) hour for minors under 9, and four (4) hours for anyone 18 to 21. (Title 9 CCR Section 1929 (d)(2)(D)).

Seclusion is defined as any isolation of a minor in any room or part of the facility in which the minor is prevented from leaving for any period of time, thus limiting their movement, activities and contact with the other minors. (Title 9 CCR Section 1929(d)(5)(A), also see Section 1901 (v) and (dd))