

## Resource Document on Consent for Voluntary Hospitalization of Minors

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Prepared by the Council on Psychiatry and Law

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### I. Background

In 2020, a Position Statement on the Voluntary and Involuntary Hospitalization (of Adults) was adopted by the APA (1). Because minors (children under 18 years of age) raise separate issues, a workgroup was created to study the issue of minors' hospitalization. There was general consensus that for involuntary hospitalization, done when a parent or, in some states, the minor, does not consent, the procedures should be similar to adults, and a Position Statement on the Involuntary Hospitalization of Minors has been proposed. In practically all states, if a physician determines, based on professional judgment, that hospitalization of a minor is medically indicated and a parent or guardian consents to the hospitalization, then the minor is admitted. Because the parent (or guardian) is the consenting party, these admissions are typically characterized as "voluntary" admissions, even though the minor may be objecting. State statutes differ as to whether a minor above a designated age (e.g., 14 or 16) should be permitted to consent to psychiatric hospitalization without parental consent. Similarly, in some states, parental consent for psychiatric admission is not sufficient if the youth is older than the designated age; in such cases, judicial findings that statutory criteria for civil commitment have been met are typically required to hospitalize the youth over his or her objection.

This resource document seeks to lay out the major issues involved in formulating the rules governing the psychiatric hospitalization of minors so that psychiatrists can be better informed when rendering their judgment in particular cases. Admission for substance use treatment raises somewhat different concerns that are not addressed in this document.

#### ***History of relevant APA positions***

In 1982, the APA published a guideline on the psychiatric hospitalization of minors that proposed age 16 as the age at which a minor could independently consent to hospitalization or, in the absence of consent, could be involuntarily hospitalized only under emergency procedures or under the authority of a judicial order (2). The recommended emergency procedures for children under 18 included involuntary hospitalization if a physician "determines that the child, as a result of a mental disorder, appears to be in

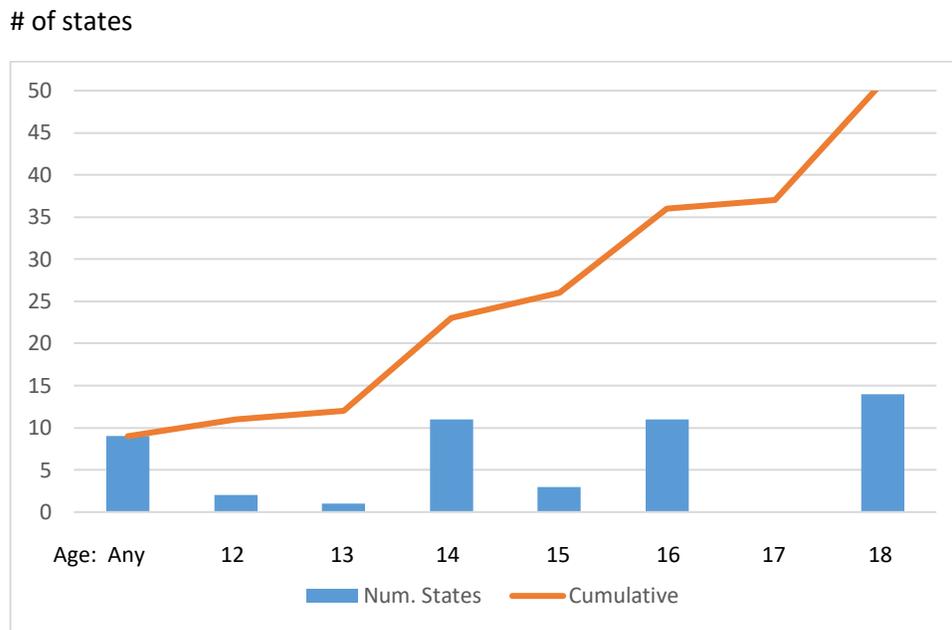
need of immediate hospitalization...” (2). The publication of that guideline was accompanied by another document authored by Alan Stone and Richard Bonnie laying out four alternatives that included setting 14 rather than 16 as the age at which the adolescent’s consent is sufficient for voluntary hospitalization (3).

In 2016 the APA adopted a Position Statement on the Hospitalization of Children and Adolescents (4). That Position Statement does not address issues of voluntary admission and civil commitment.

**Current state laws**

Currently, about two-thirds of states allow some minors to independently consent to mental health hospitalization. Figure 1 shows the cumulative count of states that allow some minors to consent to psychiatric hospitalization. Some states, including many of the nine that set no minimum age, include criteria in addition to age, such as being able to make a competent decision.

**Figure 1. Counts and cumulative number of states allowing minors to consent to mental health admission**



Any age: AK, AR, IA, LA, ME, NE, NH, NV, NC. Some states impose additional conditions, such as capacity to make an informed decision.

12 yrs: CA, GA

13 yrs: WA

14 yrs: AL, CT, ID, IN, KS, MI, NJ, NM, PA, VT, WI

15 yrs: CO, HI, OR

16 yrs: IL, KY, MD, MA, MN, MT, NY, OK, SC, TN, TX

18 (adults only): AZ, DE, DC, FL, MS, MO, ND, OH, RI, SD, UT, VA, WV, WY

In almost all states, if the minor objects and the parent consents and a physician agrees that admission is warranted, the minor may be admitted. A small number of states provide for judicial review if the minor objects to admission by a parent. See Table 1.

**Table 1. Models for Admission to Psychiatric Hospitalization**

| Position of the Minor | Position of the Parent | Position of the Physician   | Process Required  |
|-----------------------|------------------------|---|---|
| Objects               | Consents               | Agrees hospitalization Needed   | No hearing necessary in almost all states                                     |
| Consents              | Objects                | Agrees hospitalization needed   | No hearing necessary in states that allow minor to consent to hospitalization |
| Objects               | Objects                | Determines hospitalization needed under state civil commitment criteria | Hearing required (“Involuntary hospitalization”)                              |

## II. General issues pertaining to health care decisions by minors

### ***Adolescent autonomy and decision-making***

Research on adolescent decision-making on medical issues tends to show that adolescents without developmental delays who are 14 years old and up tend to have similar capacities to make medical decisions as adults when given time to reflect (5-8). More recent research on adolescent decision-making under stress, cited in briefs and cases on the culpability of juvenile defendants (e.g., *Miller v. Alabama* (9)), shows that adolescents tend to overweigh short-term consequences over long-term consequences when compared to adults and make worse decisions than adults under stress or peer pressure, or when deciding impulsively (10-12). These tendencies may affect decisions by adolescents in a mental health crisis being considered for hospitalization.

### ***Adolescent assent/consent for physical health care***

The American Academy of Pediatrics Committee on Bioethics outlined their guidelines for informed consent in medical decision-making in the pediatric population in a 2016 policy statement (13). Under prevailing law and practice, the authors note, parents or other surrogates essentially provide “informed permission” for diagnosis and treatment with the assent of the child whenever appropriate. The policy statement does not explicitly address consent or refusal by a minor for inpatient mental health care, although it notes that state laws increasingly allow adolescents to consent to mental health and substance use prevention and treatment services. The statement includes the following recommendations for specific clinical situations:

1. If the likely benefits of treatment in conditions with a good prognosis outweigh the burdens, parents should choose a treatment plan over the objections or dissent of the minor, as in choosing an appendectomy for acute appendicitis.
2. A minor should be able to consent to health care without the need for parental consent in specific diagnostic/care categories, including health care needs related to sexual activity (treatment of sexually transmitted infections, provision of contraceptive services, prenatal care, and abortion services). This exception is not related to an acceptance of the adolescents' abilities in medical decision-making, but rather a public health decision as adolescents may not seek care for issues that reflect sexual activity if required to involve their parents for consent.
3. The mature minor doctrine recognizes that a subset of adolescents have adequate maturity and capacity to understand and appreciate an intervention's benefits, risks, likelihood of success, and alternatives and can reason and can choose voluntarily. The age, overall maturity, cognitive abilities, and social situation of the minor are considered in a judicial determination, finding that an otherwise legally incompetent minor is sufficiently mature to make a legally binding decision and provide his or her own consent for medical care. *Cardwell v. Bechtol* (14) is considered the seminal case addressing the mature minor doctrine.
4. Emancipated minor statutes address the legal status of the minor, not the adolescent's decision-making ability. Adolescents who are living separately from their parents and are self-supporting, married, or on active duty with the armed forces are generally considered legally emancipated and competent to make their own decisions and provide consent for medical care.

### ***Consent to medical care by mature minors***

The American Law Institute (ALI) is a private, independent, nonprofit organization with a mission to clarify, modernize, or otherwise improve the law to promote the better administration of justice. In 2019, the American Law Institute approved Section 19.01 of the *Restatement of the Law* relating to *Children and the Law*, which, if adopted by state courts, would authorize mature minors to consent to routine, beneficial medical treatment (15). Routine, beneficial treatments are defined as those with clear medical benefits and with limited risks and consequences. A "mature minor" is described as a minor capable of giving informed consent to the proposed treatment, and the commentary refers to the substantial body of research showing that a typical mid-adolescent can understand information and make a rational decision about treatment similar to a typical adult. The *Restatement* explains that a mature minor's consent to treatment is "legally sufficient for a medical condition that poses risks or costs to public health." The *Restatement* highlights outpatient mental health services as a treatment that falls under the mature minor rule because of the public health concerns, noting that it is routine, beneficial, and the cost of nontreatment "extends beyond the health costs incurred by the individual patient."

### **III. Admission to a psychiatric hospital with parental consent**

Parents are responsible for caring for their children and have significant liberty interests in how they raise them. In most cases where a psychiatrist recommends admission and an adolescent does not want to be admitted to a psychiatric hospital, a parent's consent is legally sufficient and, except in a few states, judicial review is not required. When judicial review is required, the criteria for admission tend to focus on medical appropriateness rather than dangerousness. In the 1979 Supreme Court case *Parham*

*v. J.R. and J.L.* (16), the Court allowed parents to voluntarily admit their child for mental health treatment with the admitting physician's concurrence. In the Supreme Court's view, an independent judgment by the admitting physician regarding the need for hospitalization provides adequate protection for the child's constitutional liberty interest.

While an adolescent's objection should be respectfully considered, the still-developing psychosocial maturity of adolescents, together with the stressful circumstances leading to the clinical crisis, suggest that an adolescent's objection to hospitalization should not overrule parental consent.

#### ***Situations in which consent by a parent or guardian is problematic***

1. If parents disagree, such as in a contested custody situation in which both parents have medical decision-making authority, a non-emergency admission typically requires some form of judicial review.

2. States differ as to whether a state guardian for a youth in state custody should have all the same authority for admission as a parent, or whether different procedures should apply.

3. In some instances, parents may seek hospitalization for reasons other than the child's best interests (such as when the child is difficult to manage and the parents want a respite, or when the parents want to punish the child). It is critical that the psychiatrist assess the patient and the totality of the situation to render a clinical decision about the appropriateness of psychiatric hospitalization.

#### ***Situations in which parental refusal to consent to admission constitutes medical neglect***

Generally, in those situations in which refusal to admit constitutes medical neglect, the state can take custody and authorize admission under a "need for appropriate treatment" standard without resorting to civil commitment, although from an emergency department doctor's perspective, instituting emergency admission/civil commitment procedures when allowable by statute is frequently easier than instituting emergency state guardianship. The ease in obtaining emergency state guardianship varies widely among the states. Issues of medical neglect in psychiatric care can have other effects on the youth and parental authority over time. Nonetheless, where a child's psychiatric care is being neglected, it should not be deemed any less critical than when a child's medical care is being neglected. A parent insisting on removing their child from an emergency department when the clinical assessment indicates that psychiatric hospitalization is needed may ultimately require security and child welfare both on site to help manage both the parents and the youth. Psychiatrists working in emergency departments should be familiar with state and institutional protocols to manage these complicated situations to protect the rights and needs of the child patient, while minimizing negative impacts on parent-child relationships.

### **IV. Admission to a psychiatric hospital with a minor patient's consent**

#### ***Practical considerations***

Although there is little published data, it appears to be fairly rare that a minor requests admission for psychiatric hospitalization without the parents' being aware or consenting to admission. Furthermore, even in states that allow some adolescents to consent to admission, many private

hospitals will not accept such patients unless they are clear on the financial issues involved and relevant insurance, which often requires parental involvement to ascertain. Finally, some states distinguish between the ability of an adolescent to consent to admission and the ability of the adolescent to consent to treatment once hospitalized, and hospitals in those states may be reluctant to admit a minor who cannot consent to treatment.

### ***Setting an age for adolescents to consent on their own to psychiatric hospitalization***

As discussed above and in Figure 1, states vary widely in their criteria for adolescents being able to consent to psychiatric hospitalization. A number of factors discussed above need to be weighed in determining appropriate public policy, including:

1. The ability of the adolescent to make reasonable health care decisions
2. Supporting developing adolescent autonomy
3. The right of parents to make decisions regarding their children
4. Practical considerations related to billing for inpatient services
5. The frequency that an adolescent would seek admission without involving parents
6. Setting the criteria for a minor's consent based on the ability of the minor to make a competent decision, rather than specifying a particular age

The first two factors support a lower age of consent, such as 14, while factors 3 and 4 tend to support a higher age, such as 16 or 18. Factor 5, the low frequency with which adolescents independently seek admission, suggests that adolescents are generally not reluctant to discuss psychiatric admission with their parents (unlike, for example, treatment for sexually transmitted diseases). Factor 6 gives the most weight to the adolescent's competence to consent, as opposed to the parents' wishes, and suggests a functional, rather than a clear age, criterion. One central issue that remains unclear is the extent to which supporting an adolescent's ability to consent, and thus giving less weight to parental decision-making, undercuts the integrity of the family unit.

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