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Treating Children under the New Mexico Mental Health and Developmental Disabilities Code

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Developing legal rules for the mental health treatment of minors is a problem which has perplexed many courts and legislatures in the last decade. The United States Supreme Court considered the issue of institutional commitment procedures for three years before producing its controversial ruling on one aspect of the issue. Other courts have considered the same issue and have reached different results. In addition to the procedures required for commitment, other important problems include confidentiality rights, consent to treatment, regulation of the provision of treatment, periodic review, educational issues, the role of counsel, and special legal problems involving mentally retarded children. Each of these issues has received some attention from the courts and legislatures of various states, but New Mexico appears to be unique in its attempt to address them all in a comprehensive legislative enactment.

New Mexico's experience may prove useful to other states as they consider changes in their own laws. Although the United States Supreme Court ultimately refused to strike down the commitment statutes of Georgia and Pennsylvania, the controversy which those cases engendered led several states to change their own statutes and some may choose to consider the details of their laws. Still other states may find that issues such as treatment and confidentiality re-
quire clarification and resolution, no matter what their rules of commitment may be.

This article will examine the New Mexico statutes and the policies which they reflect. Its purpose is both to assist New Mexico courts and practitioners in the law's implementation, and to offer the benefit of this state's experience to other states which may be considering some or all of these issues.

THE NEW MEXICO LEGISLATION: BACKGROUND AND PURPOSE

The enactment of the Code

Until 1977, mental health law in New Mexico was based on a version of the National Institute for Mental Health's Draft Act Governing Hospitalization of the Mentally Ill (hereinafter Draft Act). A number of states, including New Mexico, adopted this statute in the early 1950's. The Draft Act had been designed to incorporate the latest in postwar psychiatric developments, and in particular to reduce procedural impediments to hospitalization of mentally ill persons, on the theory that those procedures both stigmatized patients and deterred them from obtaining needed medical treatment. Therefore it encouraged voluntary treatment and gave few real procedural protections to those whose involuntary commitment was proposed. As with most states which adopted the Draft Act, New Mexico allowed the parents of minors to "voluntarily" place their children in mental institutions and, by implication, to make other medical decisions for those children regarding their mental health care.

New Mexico's laws regarding the mentally retarded provided even fewer protections of individual liberties. The law in effect in 1977


9. The parent or legal guardian of any child under sixteen years of age could commit that child for "observation, diagnosis, care, and treatment" if the child was "mentally ill" or had "symptoms of mental illness." 1953 N.M. Laws ch. 182, § 2 (repealed by 1977 N.M. Laws ch. 279, § 24).
was based on statutes enacted in the 1920’s during the eugenics scare. During that period there was a widespread belief that mentally retarded people represented a great danger to society. The conventional wisdom of that era held that the solution to this problem consisted of sterilizing the mentally retarded so they would not “swamp” society with incompetence, and providing for strict lifelong segregation of retarded people from the rest of society. Some of the more draconian aspects of these policies had been moderated by practice and by statutory amendment in intervening decades, but the core of the New Mexico statutes continued to reflect the design enacted in the 1920’s.

By 1977, it had become clear that major portions of New Mexico’s mental health and mental retardation laws were unconstitutional. A large number of court decisions in the 1970’s struck down provisions of other states’ laws which were similar or identical to New Mexico’s. The largest number of these cases declared statutes unconstitutional for providing too few procedural protections to adults facing civil commitment, or held institutional rules and conditions to be constitutionally inadequate. In addition, by 1977 there were several rulings that states could not permit parents to place their children in mental institutions without some kind of hearing.

A consensus developed that New Mexico’s laws would have to be revised. Lawyers for the Department of Hospitals and Institutions first attempted to draft changes in the form of modifications of the existing statutes. Drafting difficulties developed, largely because the changes required by the new constitutional rulings were so drastic that the 1953 structure was ill-suited to accommodate and coordinate them. In the 1977 session, aware of the likelihood of litigation if it did not act, the legislature chose to enact a completely new Mental

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10. See 1925 N.M. Laws ch. 133.
15. See cases cited in note 2 supra.
Health and Developmental Disabilities Code. This Code, which took effect on July 1, 1977, was the product of consultation and compromise between such groups as the Department of Hospitals and Institutions, the New Mexico Psychiatric Association, the New Mexico Council of Community Mental Health Services, the New Mexico Association for Retarded Citizens, and a number of concerned individuals.

Relatively minor problems developed in the implementation of the Code, and other groups, such as the district attorneys, which had not been part of the original negotiations, expressed new concerns and considerations about the operation of the Code. As a result, more negotiations took place and amendments to the Code were enacted in 1978 and 1979. These amendments were intended to cure specific problems; the basic policies and principles which formed the Code in 1977 remain intact.

Values and policy judgments underlying the Code

The Code sought to address two different kinds of mental disabilities: "mental disorders" and "developmental disabilities." Mental disorder is basically synonymous with mental illness and consists of disorders which involve serious disruption of the thinking process. Developmental disability, a term borrowed from federal legislation, encompasses a number of disabilities, of which the most important for the purposes of the Code is mental retardation. Mental retardation is defined by the American Association on Mental Deficiency as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period." Thus mental retardation is a proper term only when the person in question has serious intellectual impairment (often measured in terms of an intelligence quotient) accompanied by major behavioral problems.

17. The Department of Hospitals and Institutions is now part of the Health and Environmental Department.
19. The Code defines "mental disorder" as "the substantial disorder of the person's emotional processes, thought or cognition which grossly impairs judgment, behavior or capacity to recognize reality." N.M. Stat. Ann. § 43-1-3(N) (Repl. 1979).
20. "Developmental disability" is defined by the Code as "a disability of a person which is attributable to mental retardation, cerebral palsy, autism or neurological dysfunction which requires treatment or habilitation similar to that provided to persons with mental retardation." Id. § 43-1-3(H).
The Code treats individuals with mental disorders and developmental disabilities similarly in some respects and differently in others. Some provisions apply equally to both groups, such as personal rights, representation by counsel, and confidentiality. But where the nature of the person’s disability was thought to have direct relevance to his or her legal rights, the groups are treated differently—most notably regarding commitment procedures. On the most important issue, however, the groups receive the same treatment, namely the Code’s recognition that the individuals in question are citizens entitled to full rights of citizenship and to protection of their liberty.

Because the Code is based upon the value of individual liberty, its provisions were designed to avoid unnecessary institutionalization and to reflect a presumption that individuals can and should, wherever possible, make their own decisions regarding treatment or habilitation. The protection of individual liberty is also at the core of the requirement that treatment or habilitation be provided in a manner consistent with the least drastic means principle. This principle acknowledges the potential benefit of community-based services and the potential harms of institutionalization. It also recognizes that treatment goals may be met with greater or lesser intrusion of individual freedom, and mandates that steps be taken to reduce the number and extent of those intrusions as much as possible. For example, when treatment could be provided for a given client either in a large state institution or on an outpatient basis in the client’s home community, the least drastic means principle requires that the state choose the latter option.

23. N.M. Stat. Ann. § 43-1-6 (Repl. 1979) (personal rights); id. § 43-1-4 (legal representation of clients); id. § 43-1-9(D) (disclosure of information).
25. Habilitation is defined as the process by which professional persons and their staff assist the developmentally disabled client in acquiring and maintaining those skills and behaviors which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment.

N.M. Stat. Ann. § 43-1-3(K) (Repl. 1979). This is the currently accepted terminology of mental retardation professionals. For a concise overview of modern approaches to habilitation of retarded persons, see F. Menolascino, Challenges in Mental Retardation: Progressive Ideology and Services (1977).
In addition to individual liberty, the legislature was also concerned with the treatment and habilitation needs of mentally disabled citizens. The Code provides a statutory right to treatment for those with mental disorders and a right to habilitation for those with developmental disabilities. It further requires that this treatment or habilitation be chosen and provided on an individualized basis, according to the terms of an individualized plan for each client. The objective of this requirement is to improve the quality of care clients receive and to increase the likelihood that their condition and level of skills will improve as well. By mandating individualized care, the legislature committed the state's mental health and developmental disabilities facilities to treatment and habilitation only, and not for use as human warehouses or places of detention.

Perhaps the most perplexing question facing any court or legislature in the area of mental health and retardation law is the proper treatment of clients who are minors. Principles of individual liberty and autonomy obviously have different implications for children. This is true both because children are immature and inexperienced and because their parents claim independent interests and rights. Determining an appropriate balance between protection of the child and deference to parental decision-making and family autonomy is a difficult task. Whether New Mexico has struck the proper balance with regard to every issue is a matter for others to judge. This article explores the reasons behind the particular choices made by the legislature.

ADMISSION TO RESIDENTIAL TREATMENT OR HABILITATION

Overview and legislative purpose

Until quite recently, it was almost universally true that American states allowed the admission of minors to mental institutions upon the application of their parents, with no requirement for further hearing or review. This practice was permitted by New Mexico law until the adoption of the Code in 1977. Concerns about both the

28. Id. § 43-1-9.
30. For comparison, see Legal Issues in State Mental Health Care: Proposals for Change—Mental Health Treatment of Minors, 2 Mental Disability L. Rep. 459-81 (1978) (model statute and commentary).
32. See note 9 supra.
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constitutionality and the practical workings of this system led New Mexico, among other states, to reconsider the desirability of this practice.

The constitutional concerns focused on the procedural due process rights of children whose liberty was deprived by the state in institutionalization. Several courts concluded that confinement in a mental institution was a sufficiently massive deprivation of a child's liberty to warrant independent review of the parent's (and admitting physician's) decision that the child's condition required that he or she be confined. The test established by the United States Supreme Court for determining "how much process is due" calls for balancing three factors: the nature of the individual right involved, the risk of erroneous decision-making without the requested procedural protections and the likelihood that the requested protections will reduce the risk of error, and the interest of the state in avoiding the requested procedures. Applying this test to the facts of juvenile admissions to mental institutions, many courts and observers concluded that the child's right to physical liberty and a normal noninstitutional childhood, combined with concern about the stigma attached to institutionalization for mental illness or mental retardation, constitutes a personal right worthy of careful protection. The imprecision of psychiatric diagnosis and of classification of mental retardation suggests the likelihood of errors in an unreviewed admissions process. Adversarial hearings to determine the necessity for confinement would serve the same purpose of error reduction for children that they serve for adults. The state's interest, both financial and administrative, in avoiding hearings, seemed insufficient to outweigh the personal interests involved.

The United States Supreme Court disagreed with much of this analysis. In opinions by Chief Justice Burger in Parham v. J.R. and Institutionalized Juveniles v. Secretary of Public Welfare, the Court concluded that while states were free to provide judicial hearings to children, the due process clause only required a less formal process of inquiry by the admitting physician. The rationale for

33. See cases cited in note 2 supra.
35. See cases cited in note 2 supra; Ellis, supra note 31; Teitelbaum & Ellis, supra note 29; Note, "Voluntary" Admission of Children to Mental Hospitals: A Conflict of Interest Between Parent and Child, 36 Md. L. Rev. 153 (1976); Note, 48 U. Colo. L. Rev. 235 (1977).
this decision is somewhat obscure. While the Court devotes a con-
siderable amount of discussion to the importance of parental deci-
sion-making, closer scrutiny indicates that this cannot be the basis of the Court's holding. If these were rulings meant to enforce parents' constitutional rights to make decisions concerning their children, the Court would not and could not have allowed states to provide hearings if they wished to do so. The Court clearly left this option open to the states. It would be illogical for the majority to announce a new parental right and then immediately authorize the states to infringe that right. Another indication that parental rights were not central to the holdings of the cases is the fact that the Court had before it in the Georgia case a subclass of children who had no parents, and even for these children, the Court concluded that hearings were not constitutionally required prior to admission. Clearly this denial cannot be premised upon a theory of parental rights.

Since Parham and Institutionalized Juveniles are not cases primarily involving parents' rights, the rationale for the decisions must be sought elsewhere. The Chief Justice and his majority appear persuaded by the argument that the risk of error in the juvenile commitment situation is not unacceptably high, and also that judicial hearings would not significantly reduce the likelihood of mistaken commitments. The majority is not explicit about why it chose to reject the contrary factual conclusions made by the trial courts below, but it was apparently unpersuaded by those conclusions. Thus the majority can be characterized as holding that states are free to provide more formal processes for children, but that in the absence of such state legislation, the Court would not order such hearings because it was not convinced that they were necessary or that they would do much good if they were provided.

The Court's conclusion about the desirability of hearings for children is based on factual and policy considerations which are remarkably similar to those a legislature would confront when determining the desirability of such hearings. Legislatures, which have before them witnesses and a variety of fact-finding devices, are free to disagree with the Chief Justice about the importance of commitment procedures for children. We believe that the Court's "legis-

41. Parham, 99 S. Ct. at 2504-05.
42. Id. at 2507.
43. Id. at 2511-13.
44. Only Mr. Justice Stewart, who concurred in the judgment, appears to have based his conclusion exclusively on parental rights. Id. at 2513-15 (Stewart, J., concurring).
45. Id. at 2509. This is the second prong of the Mathews v. Eldridge balancing test. See note 34 supra.
ture's conclusions embodied in the Code were correct, because we believe that the risk of error is greater than that perceived by the Court and because we believe that hearings can reduce unnecessary institutionalization of children.

The New Mexico Legislature confronted competing demands made in the name of children's best interest: the child's need for treatment and the child's right to be free from unnecessary institutionalization. The legislature apparently concluded that both were legitimate claims, and therefore designed a statutory system which attempts to reconcile and balance them. The Code also reflects a judgment that parents have legitimate concerns and rights regarding the treatment or habilitation of their child, and that while parents should not be given unreviewable discretion in these matters, their rights should be protected and their concerns honored whenever that is consistent with the interests of their child in both treatment and liberty.

To accommodate these competing demands and interests, the legislature devised a unique and somewhat complex system of juvenile admissions. The primary mechanism for such admissions is a judicial hearing before the district court. The Code also provides for voluntary admissions of juveniles under a limited set of circumstances because the legislature recognized that some older minors should be able to participate in their own mental health treatment decisions to a greater extent than the hearing mechanism allows, and such minors and their families may have legitimate reasons for wishing to avoid court proceedings.

The judicial hearing process

The court proceedings prescribed by the Code for juvenile admissions resemble adult commitments in many respects. There are, however, provisions which reflect the legislature's conclusion that important differences between adults and children should be recognized. One such difference involves the substantive criteria for commitment.

For an adult to be committed as mentally ill, he must be shown to be suffering from a mental disorder and to present a likelihood of serious harm to himself or others, and it must be shown that his commitment would be consistent with the least drastic means principle.\(^46\) In the case of a child, the court need not conclude that the child

\(^46\) These criteria must always be met, both for short term (not to exceed 30 days) commitment for evaluation and treatment, N.M. Stat. Ann. § 43-1-11(C) (Repl. 1979), and for extended commitment. Id. § 43-1-12(C).
is dangerous to himself or to others. In addition to the requirements of a mental disorder and the least drastic means principle, the court need find only that the child “needs and is likely to benefit from the treatment or habilitation services proposed” and “that the proposed commitment is consistent with the treatment needs of the minor.” This less rigorous standard makes it possible to place a child in a residential facility when a similarly situated adult could not be committed.

The different substantive standard for children recognizes that the state may exercise a greater interest in the welfare of children than it may constitutionally exercise with adults. The United States Supreme Court has long held that states have more expansive power to protect the well-being of children than they have in cases involving adults. The issue of commitment standards seems an appropriate place to exercise that greater interest. The due process clause of the fourteenth amendment protects adults from involuntary confinement when the state's only justification is that the state knows the individual's needs better than the individual does. States are justified in concluding that this same protection does not extend to children whose judgment is more suspect than that of adults. The state may legitimately conclude that a child's objection should not be sufficient to prevent treatment when it is clearly shown that the child needs and would benefit from treatment.

There is also a secondary and more practical justification for treating children differently from adults in this regard. Adults who "need" treatment but are not dangerous are not committable, but they may seek treatment on a voluntary basis. Nondangerous children who need treatment may not be able to admit themselves voluntarily because of their lack of capacity. If courts did not have the power to order treatment for such children, a class of children would be created that needed treatment, but could not receive it on any basis—voluntary or involuntary. This result is avoided by the Code's separate standard of commitment for children.

47. Id. § 43-1-16.1(G).
48. While the Code requires a showing of dangerousness for the involuntary commitment of an adult for mental illness, the adult standard for developmental disabilities is somewhat less rigorous. Compare §§ 43-1-11(C) and -12(C) with § 43-1-13(E).
52. See text accompanying note 81 infra.
The Code's procedures for the commitment of children thought to need treatment or habilitation are designed to protect those children from unnecessary confinement. In this respect they resemble the protections afforded adults. They include notice to the child and his parents, representation by counsel, a hearing before a neutral fact finder, provisions to insure that the hearing officer has sufficient evidence to reach a reasoned decision, and the right to appeal.

A. The petition.

The Code provides that any person who believes that a child needs residential treatment or habilitation may petition the court for his commitment. The legislature envisioned that the petitioner would be the child's parents or guardians in almost all cases. However, other persons are authorized to file such a petition. This allows the court to consider a child's need for treatment even when the child's parents are unable or unwilling to propose his commitment. It would be unreasonable and probably unconstitutional to read this provision as granting to the court the power to remove a child from his home when the parents wish the child to remain in the home and have not been found to be neglectful. Such a reading would allow evasion of the substantive and procedural protections afforded parents by the Children's Code, and the legislature clearly did not intend such a result. The better reading of the provision is that it allows petitions to be filed by interested persons other than parents, but that a court may remove a child from a family who wishes to keep him in the family home only upon a finding of neglect as provided in the Children's Code.

Whether the petition is filed by the parents or by another person, it must contain certain specific items of information. As with petitions for the commitment of an adult, it must include a detailed description of the symptoms or behaviors of the minor which support the petition's allegations, and a list of prospective witnesses along with a summary of their anticipated testimony. These

54. The Supreme Court addressed the question of state power in a recent unanimous opinion saying:

We have little doubt that the Due Process Clause would be offended "if a State were to attempt to force the breakup of a natural family, over the objections of the parents and their children, without some showing of unfitness and for the sole reason that to do so was thought to be in the children's best interest."

56. Id.
requirements allow the child and his lawyer adequately to prepare a response to the petition. A petition which contains only "boiler-plate" allegations does little to assist the child and clearly would be inappropriate under this provision. The "notice" function of the petition is implemented by the requirement that copies must be served upon the child, and upon his parents if they were not the petitioners.\footnote{57}

B. Representation by counsel.

The commitment system established by the Code places great reliance on the performance of the child's lawyer. While the Code does not treat children as if all of them are incapable of participating in their own treatment decisions, it does recognize that all of them will need assistance in sorting out their available options and in making their case. Because of the heavy emphasis on the role of counsel, the legislature enacted explicit provisions about what the child's lawyer is to do.

Once counsel is retained or appointed,\footnote{58} he must meet with the child and clearly explain the procedural and substantive rights afforded by the Code.\footnote{59} This counseling function is extremely important. Children who are thought (at least by the petitioner) to be mentally ill or developmentally disabled may well be confused about what is happening to them. While others, such as parents or physicians, will probably have explained to the child what treatment or habilitation is proposed, there remains a need for counsel to place these proposals and events in the context of the child's legal rights, and to explain to the child that there may be alternatives to what is proposed.\footnote{60} For some children, an issue of trust may also be involved. Some minors may not feel comfortable discussing their options with the parents and physicians who are proposing institutionalization. Because counsel's only job is to advise and represent the child, he may be in a unique position to help the child sort out what the child really desires to do.\footnote{61}

\footnote{57. Id.}
\footnote{58. Upon receiving a petition for involuntary commitment, the court must ascertain whether or not the child has retained an attorney to act as his or her counsel in the commitment proceedings. If not, the court must appoint counsel to represent the child at all stages of the proceeding. \textit{Id.} § 43-1-16.1(C). Pursuant to N.M. Stat. Ann. § 43-1-4 (Repl. 1979), the court is under the same obligation to appoint counsel, if none has been retained, when it is notified of a minor's voluntary admission. \textit{Id.} § 43-1-16(F).}
\footnote{59. N.M. Stat. Ann. § 43-1-16(F) (Repl. 1979) details the procedural and substantive rights which must be explained by counsel in reviewing a minor's voluntary admission.}
\footnote{60. See Ellis, \textit{supra} note 31, at 881-90.}
\footnote{61. \textit{Id.} at 888-90.}
The Code also calls for counsel to determine whether the child wishes to waive his right to a commitment hearing. Waiver is possible only if the child fully understands his rights and options under the law and freely chooses to enter residential treatment without a hearing. While the Code does not place a minimum age on the right to waive a hearing, it is clear that the child's age and maturity, as well as the nature and severity of his disorder or disability, will be important factors to consider in determining whether his purported waiver is valid. If the attorney concludes after discussing the matter with the child that the child has sufficient capacity and information and has voluntarily chosen to waive his right to a hearing, he shall submit a verified written statement to the court explaining the child's wishes. If the court is satisfied that the child has validly waived the right to a hearing, it may order the child placed in treatment or habilitation.

C. The hearing.

Absent a waiver, a hearing is to be held within ten days of the appointment of counsel. The hearing may be before a judge of the district court or before a special commissioner appointed by the court. At this hearing the child is entitled to the same basic protections which are afforded to adults: representation by counsel; the right to present evidence, including the testimony of a mental health or developmental disabilities professional of the child's own choosing; the right to confront and cross-examine petitioner's witnesses; and the right to have a complete record made of the proceedings. The right to obtain the testimony of an expert witness of the child's own choosing is especially important. Without this right, petitioner's witness may be the only expert before the court. This would

62. N.M. Stat. Ann. § 43-1-16.1(D) (Repl. 1979) provides that if the attorney determines that a child understands his rights and wishes to waive the court hearing on the involuntary commitment issue, then the attorney must submit a verified written statement to the court which explains the attorney's understanding of the child's intent.
64. See generally Am. Ass'n on Mental Deficiency, Consent Handbook (H.R. Turnbull ed. 1977).
66. N.M. Stat. Ann. § 43-1-16.1(E) (Repl. 1979) shortens this time period to seven days if the child has already been admitted to a residential facility. This covers two sets of circumstances. First, the child may have been voluntarily admitted under section 43-1-16 and his involuntary commitment is now sought (e.g., when he has sought his own release). Secondly, the child may have been admitted on an emergency basis as provided for in section 43-1-16.1(K) of the Code.
create considerable unfairness because many of the questions at issue in the hearing will be medical and technical in nature and the court will need to rely upon expert witnesses to sort out the facts and reach a just conclusion. The child’s right to his own expert is therefore a logical and necessary outgrowth of the right to effective representation by counsel. It should help the court prevent the proceedings from becoming the equivalent of an ex parte hearing.\(^69\)

After hearing the evidence and argument, the court may order the child committed if it finds, by clear and convincing evidence,\(^70\)

1. that as a result of mental disorder or developmental disability the minor needs and is likely to benefit from the treatment or habilitation services proposed; and
2. that the proposed commitment is consistent with the treatment needs of the minor and with the least drastic means principle.\(^71\)

As noted above, this standard is less rigid and more oriented toward treatment needs than the standard applied to mentally ill adults.\(^72\) It is not, however, merely a rewording of a “best interest of the child” standard. The court must specifically find that the treatment or habilitation proposed (and not merely confinement) will meet the child’s individual needs in a way that no less drastic form of treatment or habilitation can achieve. Therefore, for example, a mere finding that the child is developmentally disabled and needs habilitation services will not be sufficient to support an order to place that child in the Los Lunas Hospital and Training School. To order such a placement, the court would also have to find that the proposed habilitation plan for the child at Los Lunas is appropriately tailored to that child’s individual needs and that the same or better result could not be obtained in another setting, such as a group home or a day program or specialized assistance to the child’s parents.\(^73\)

As the preceding example suggests, the court’s task in these cases

\(^69\) The rights to counsel and to be heard in civil commitment proceedings are hollow without resort to an examination by and testimony from a mental health professional of one’s own choosing. Without the assistance of one’s own examiner, the individual and his lawyer can usually be expected to be ill-prepared to rebut the adverse testimony of [the state’s] expert witnesses. Legal Issues in State Mental Health Care: Proposals for Change—Civil Commitment, 2 Mental Disability L. Rep. 73, 104 (1977).


\(^72\) In order to be involuntarily committed, an adult must always be shown to present a likelihood of serious harm to himself or others. See note 44 and accompanying text supra.

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is most demanding. It must evaluate the petitioner's evaluation of the child's needs and must also judge the acceptability of alternatives which might be less restrictive of the child's liberty. Once again, expert testimony and skillful presentation by counsel for both sides are extremely important because the Code places the ultimate decision in the hands of a legally trained judge or commissioner rather than in the hands of medical professionals. This placement of decision-making authority is necessary and appropriate because the ultimate question in each case is legal rather than technical: shall the child be deprived of liberty in the manner proposed? The technical and medical evidence is to aid a nonmedical inquiry, which is whether that evidence is sufficient to sustain a decision to place a child in an institution.

One final issue regarding the court's authority and responsibility deserves mention: what should be done with children who do not need the proposed commitment but who cannot return to their family home? This group will include children who do have a mental disorder or developmental disability, but whose treatment or habilitation needs do not require that the child enter an institution. The Code clearly provides that the petition for commitment cannot be granted in such cases, but the legislature also recognized that many such children cannot, as a practical matter, return home. This may be because disagreements between parents and child are too severe or because the child's behavior or condition is too disruptive of the family's life. But whatever the reason, without a specific legislative provision on this point, the court would face a choice between unacceptable alternatives: placing the child in an institution whose services he does not need, or sending him back to a home where he is not wanted and where emotional and/or physical damage to the child or his family could result. The Code's response to this dilemma allows the court to order alternative living arrangements for the child (such as foster care) without having to find the parents to be neglectful under the Children's Code. This solution allows an appropriate placement for the child without forcing him into a home in which he is unwelcome and without unnecessarily stigmatizing parents.

D. Periodic review.

The legislature's decision to abolish indeterminate commitments of adults also extends to children. The Code provides that any

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75. Id. § 43-1-12(C) (Repl. 1979) (six month to one year limits for mentally ill adults); id. § 43-1-13(E) (six month limit for developmentally disabled adults).
order committing a child to residential treatment or habilitation shall expire on a date set by the court at the time of the commitment. The outer time limits for those expiration dates are sixty days for the first commitment period, and six months for subsequent periods.\(^7\)

The court is always free to set a shorter time period for a given commitment when it does not believe that the child's condition and treatment or habilitation needs warrant a period as long as the statutory limits. Setting a shorter time limit would be appropriate even when the court thinks the child's treatment or habilitation will require a longer time period, if the court also concludes that the child's progress under his individualized plan should be reviewed earlier than the outer limit prescribed by the Code. A shorter time limit may be particularly desirable for subsequent commitment orders where the allowable time limit for periodic review is six months.

To keep a child in confinement beyond the expiration date of his commitment order requires a new hearing similar to the one which the child originally either received or waived. The burden of persuasion thus remains with the petitioner (which will often be the residential facility in cases of subsequent commitments), which reinforces the Code's presumption in favor of liberty and in favor of children remaining in or returning to their own homes. However, the Code's placement of the burden with the petitioner in recommitment proceedings may or may not accurately describe what actually happens in such hearings. Despite the Code's presumption against institutionalization, counsel and courts may come to view periodic review hearings as a form of habeas corpus proceeding in which the burden is on the client to prove that he no longer needs confinement.\(^7\) While this tendency is natural and understandable (especially in cases in which the child's family is not eager for the child to return home), it is a dangerous corruption of the Code's intent and may produce unnecessarily long institutionalization which can be damaging to the child. Once again, the practical burden of combating this possibility rests with the child's counsel.

E. Appeals.

Appeals from the court's decision on a petition for commitment lie in the court of appeals.\(^7\) Given the relatively short duration of the commitment periods involved, it is not surprising that few appeals

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\(^7\) Id. § 43-1-16.1(1).
\(^7\) The provision of periodic review hearings, however, does not limit the child's constitutional right to petition the court for a writ of habeas corpus. Id. § 43-1-16.1(J).
\(^7\) Id. § 43-1-24.
are actually taken. One unfortunate consequence of this fact is that trial courts receive little guidance from the appellate courts regarding the Code's interpretation and implementation. Because the Code is a relatively new and complex statute, this may be a serious problem. The court of appeals has acknowledged the problem by ruling that appeals from commitment orders may not be rendered moot by the mere expiration of the commitment period, because these cases fall within the category of cases "periodically arising but evading review." 9 The court's view of these cases seems amply justified.

The voluntary admission process

One of the major criticisms of recent statutes, including New Mexico's, which give minors procedural rights prior to institutionalization, is that they fail to allow older juveniles to admit themselves voluntarily for treatment. The New Mexico Legislature addressed this problem in a 1979 amendment which attempted to allow some minors to enter residential facilities by voluntary admission while protecting the substantive and procedural rights of all minors.

This has proved to be a difficult problem. One way to recognize the ability of some minors to make decisions about residential treatment would be to allow any minor to apply for voluntary admission. The problem with this approach is that it would create the possibility that some children would be coerced by their parents or by their physician to "volunteer" in order to avoid the difficulties which the parents might anticipate from a commitment hearing. Children thought to be mentally ill or mentally retarded certainly do not, as a group, have the resources to resist such pressures. Therefore a legislative scheme which allowed unchecked voluntary admission of minors would create incentives for coercion and fraud and would probably produce the institutionalization of a considerable number of children who would not have been institutionalized had they been given the advice of counsel and the option of a hearing. The legislature was unwilling to accept such risks.

Instead, the legislature adopted an approach which allows some teenagers to obtain voluntary admission within a system of safeguards established to assure true voluntariness and the adequacy of their consent to admission. Such voluntary admission is available only to minors who are twelve years of age or older and who seek residential treatment for a mental illness. 80 These limitations indicate

the legislature's judgment that there is not a significant number of children under the age of twelve who have the maturity to reach an informed judgment about their need for residential treatment. Similarly, these limitations reflect the conclusion that there is not a significant number of children who need residential habilitation for mental retardation or other developmental disability who possess factual capacity to grant such consent. Therefore the mechanism was made available only to older minors seeking treatment for mental illness.

The legislature also concluded that the voluntary admission procedure should only be available when the eligible minor and his parent agree that the proposed treatment is desirable. Requiring concurrent consent provides a further protection against unwise decisions by minors to enter residential treatment. However, it also creates the possibility that a minor who is mature enough to consent to residential treatment but whose parents oppose it might be unable to admit himself on a voluntary basis. The value of the parental check was thought sufficient to justify a requirement that these minors obtain treatment through the hearing mechanism of section 16.1.

Eligible minors can become voluntary patients through the following process. When a minor and his parent have agreed that admission is desirable, they will both sign a "minor’s voluntary consent to admission document." This document must include a clear statement of the minor’s rights concerning both admission and discharge. The statute is quite explicit in its requirements concerning the consent process, reflecting a concern that all parties have full knowledge of what it is they are consenting to. The consent document is filed in the child’s hospital record, and the facility then has the responsibility to notify the district court of the child’s decision and admission. Within seven days of admission, the child must consult with counsel, who has the responsibility of informing him of his rights and of ascertaining whether the child’s voluntary consent appears to be legally valid. If the attorney concludes that the consent is valid,

81. A showing of capacity for consent on the part of a mentally retarded child may often be the equivalent of a showing that the child does not require residential habilitation.
83. Id. § 43-1-16.1 (involuntary residential treatment of minors).
84. Id. § 43-1-16(C).
85. Id.
86. This notification must be accomplished "on the next business day of the court following the minor's admission . . . ." Id. § 43-1-16(E).
87. Id. § 43-1-16(F).
88. Id. § 43-1-16(G).
TREATING CHILDREN

he certifies this fact to the court.\textsuperscript{89} The child may then remain a voluntary patient for up to sixty days.\textsuperscript{90} During a voluntary admission the child is free to seek his own discharge and is not under a court order committing him to the facility.\textsuperscript{91} If the child wishes to remain in the facility past the sixty days, the consent procedure outlined above must be repeated.\textsuperscript{92}

The Code places particular emphasis on protecting the child's confidentiality throughout this process. The documents filed with the court contain only minimal identifying information\textsuperscript{93} and the court file is to be kept confidential.\textsuperscript{94} In addition, the minor may obtain from the court all copies of court records regarding his admission once he attains majority.\textsuperscript{95} These provisions reflect the legislature's concern that the child should not be stigmatized by his decision to seek residential treatment, and its attempt to accomplish this purpose by assuring that safeguards of the child's voluntariness will not create a set of records which could later be used to harm his reputation.\textsuperscript{96}

Taken together, the 1979 amendments concerning voluntary admissions represent a unique attempt to mitigate perceived difficulties with a statutory system which grants children the right to commitment hearings.\textsuperscript{97} These provisions balance recognition of the child's right to participate in decisions about his treatment with concern that the child's right should be fully protected.

In conclusion, it should be noted that in both the voluntary admission provisions and those governing judicial hearings for involuntary commitment of children, great weight is placed upon the skill and diligence of the child's attorney. The main burden of explaining the child's rights rests with his lawyer, as does the responsibility of determining whether the child wishes to become a voluntary patient or to waive a commitment hearing. In addition, the child's only chance to have his wishes fully considered depends upon counsel's

\textsuperscript{89} Id. \\
\textsuperscript{90} Id. § 43-1-16(K). \\
\textsuperscript{91} Id. § 43-1-16(J). \\
\textsuperscript{92} Id. § 43-1-16(K). \\
\textsuperscript{93} Neither the attorney's statements or certifications to the court nor the court file itself may identify the minor by name. The file kept by the court "shall keep the minor's identity anonymous." Id. § 43-1-16(G). \\
\textsuperscript{94} Id. \\
\textsuperscript{95} Id. § 43-1-16(H). \\
\textsuperscript{96} The common practice in several states of "sealing" various kinds of records concerning children may provide inadequate protection, since often the only "seal" is a label of "confidential" on the otherwise available folder. \\
\textsuperscript{97} The design of this voluntary admission system was suggested by counsel for Vista Sandia Hospital in 1979.
efforts to represent those views faithfully.98 The successful operation of the entire system largely depends upon the efforts and dedication of the lawyers who represent these children.

CONSENT TO TREATMENT AND HABILITATION

While many courts and legislatures have addressed the issue of commitment procedures for minors, far fewer have considered the problem of consent to other forms of treatment and habilitation.99 An ever increasing number of courts have ruled that adults have a constitutional right to refuse psychiatric treatment,100 but little attention has been paid to the effect this right might have on the treatment of minors. New Mexico's Code, while recognizing the right of adults to refuse intrusive and hazardous forms of psychiatric treatment,101 also establishes a different set of consent procedures for juvenile patients.102 Once again, New Mexico's legislative approach is unique, and its provisions may suggest new directions for other states to consider as they begin to confront this problem.

Conceptual issues in consent by and for minors

It is well settled that for an adult's consent to be valid, it must be voluntary and the patient must be informed and capable of making the decision involved.103 While much of the appellate litigation involving surgery has focused on the level of information the patient possessed at the time he purportedly consented, it is clear that all three elements—competence, information, and voluntariness—must

102. Id. § 43-1-17.
be present for consent to serve as a defense in a tort action against the physician. 104

The general rule regarding consent for the treatment of minors has been that, absent such extraordinary circumstances as emancipation or emergency, the child’s parents have the authority to consent to his medical treatment. 105 But in recent years, courts and commentators have suggested limitations on such parental powers. 106 Some of the same concerns which have led several states to abandon the authorization of parental commitment of minors also suggest limits on the desirability of giving parents absolute control over the decision regarding what kind of treatment or habilitation services their child will receive. The first concern is a desire to protect children from unnecessary treatment which may be hazardous and intrusive, but to which his parents may mistakenly consent. A second concern involves the opposite problem: allowing a child to receive needed mental health care even if his parents oppose its provision, where the parental objections appear to be based on concerns other than the child’s interest. 107 Finally, there is the consideration that some older minors have enough maturity and insight to participate in decisions regarding their own treatment.

These concerns have not led New Mexico to abandon the general rule of parental consent. A rule which allowed all children to make all their own treatment decisions would present even more problems. Each of the three elements of adequate consent entails serious practical difficulties when the consent-giver is a child. Minors, as a group, have far less information upon which to base medical decisions than adults. Children may also be particularly susceptible to suggestion and even coercion from treatment-providers or others, and thus the voluntariness of their consent may be questionable. Most important, however, is children’s lower degree of capacity to make complex decisions which have important long-term consequences. 108 The issue of their capacity involves not only their level of intellectual functioning, but also implicates their level of maturity and the quality of their judgment. The combination of these factors should make both legislators and treatment-providers skeptical about any wholesale grant of consent power to minors.

105. See Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941).
106. See note 99 supra.
Still, it is also true that minors are not a homogeneous group—they differ widely in their levels of ability, maturity, and judgment. The traditional rule that minors can have no legal role in decisions regarding their health care seems as arbitrary and unrealistic as the rule which would allow all of them the same power to consent that adults possess. The New Mexico Code's consent provisions attempt to strike a middle ground between these two extremes.

The Code's approach is to vary the minor's participation in his treatment decisions according to the nature of the proposed treatment and the age and maturity of the child. The governing principles are that the child's role should increase with the child's age and experience, and decrease when the proposed treatment involves serious hazards and intrusiveness. The older the child and the safer the treatment, the greater the legislature's willingness to authorize the child's participation. For younger children and more serious forms of treatment, the role of the child is reduced or eliminated, and the decisions are left for others to make on the child's behalf. This calculus is designed to accomplish two goals: to enhance the minor's participation in treatment decisions to the extent practical, and to protect children from unwise decisions which could have adverse consequences for their health and future.

To accomplish this balance, the legislature categorized common forms of treatment according to their intrusiveness, irreversibility, and hazardousness. At the "less serious" end of this spectrum, the Code places "talking" therapies which do not involve physical touching of the patient. At the opposite end of the spectrum are the more hazardous and intrusive forms of treatment: psychosurgery and electroconvulsive therapy. Between these extremes are psychotropic medications and behavior modification programs which involve the use of aversive stimuli. The following sections will discuss the consent procedures for each of these groups.

A. Verbal therapy.

This category of treatment includes the traditional forms of "talking" therapies such as individual psychotherapy and group therapy that basically involve no physical touching. The Code explicitly excludes any form of treatment which involves aversive stimuli or substantial deprivations (such as a behavior modification program which uses electric shocks or deprivation of food as negative reinforcers).
The legislature concluded that this group of treatments posed relatively little risk for children. Verbal therapies are considered to be far less intrusive than physical forms of treatment. The Code therefore allows any minor to receive such treatment upon his own consent, whether or not he has the agreement of his parents. This provision has several important ramifications.

The first situation to note is the kind which led the legislature to conclude that a blanket requirement of parental consent was inappropriate for verbal therapy. Some parents may be unable to objectively weigh their child's need for mental health care. The clearest illustrations of this problem are children who wish to receive professional therapy or guidance to deal with emotional problems stemming from incest or other physical abuse by their parents. In such cases, requiring parental consent to mental health treatment would quite likely prevent treatment from being provided. Analogies can be drawn to other laws allowing teenagers to receive treatment for venereal disease and drug abuse, as well as abortions and contraceptives without parental consent. In each case, requiring parental consent or notification might prevent, rather than just delay, treatment which the minor may desperately need. The balance between parental prerogative and the minor's medical needs is struck in the child's favor when such extraordinary circumstances may be present.

Of course, not every case in which a child seeks mental health treatment without his parents' consent will involve incest or child abuse. It may be that the child simply wishes to discuss troubling emotional problems which he does not feel he can discuss with his parents. These cases present a closer balance between parental concerns and the child's health needs. Both the difficulty of legislative line-drawing between different kinds of psychological problems and the belief that relatively little harm can come from such treatment led the legislature to make a broad exception to the rule of parental consent.

112. This is not to say there are no risks involved in verbal therapies. Concerns about privacy and undue dependence on the therapist are valid, and must be balanced against anticipated benefits of the proposed treatment.


114. See cases cited in note 109 supra.

It is also important to note that the provision which exempts verbal therapy from the requirement of parental consent does not grant all minors legal capacity to consent to such treatment. Granting minors the "right" to consent does not transform all children into individuals with sufficient maturity and capacity to give legally valid consent to therapy. Many juveniles, especially younger children, will certainly lack such capacity. The statute only provides that if a minor has the factual capacity to understand what is being proposed and to give or withhold consent, he need not obtain his parents' concurrence before obtaining treatment.

The Code does not address the situation in which a minor lacks the factual ability to make his own decisions regarding verbal therapy. Presumably the parents of such a minor retain their common law right to grant or withhold consent on his behalf. A more difficult question is whether such a child can somehow receive treatment without parental consent. Since the Mental Health and Developmental Disabilities Code is silent on the subject, courts would have to look to other provisions of law for an answer. The courts' power to provide for neglected children under the Children's Code might provide a starting point, but this solution would only be available in relatively drastic circumstances. In other cases, relief from the rule of parental consent may not be available.

The verbal therapy provisions attempt to strike a balance between highly valued competing interests. The legislature sketched its choices in relatively broad terms. A more detailed approach to this problem may not be possible in the form of legislation, and the details of implementation may require case-by-case evaluation by the courts.

B. Psychosurgery and convulsive therapy.

These forms of treatment are quite drastic, especially when the patient is a child. Psychosurgery encompasses surgical procedures in

116. [T]here is little evidence that minors of age 15 and above as a group are any less competent to provide consent than are adults. In the age range of 11-14 years, existing research suggests caution regarding any assumptions about these minors' abilities to consider intelligently the complexities of treatment alternatives, risks, and benefits, or to provide consent that is voluntary. Most research suggests that minors below age 11 generally do not have the intellectual abilities or are too prone to deferent response to satisfy a psychological interpretation of the legal standard for competent consent.

Grisso & Vierling, supra note 108, at 423.


which the brain operation is designed to affect thoughts and behavior.\textsuperscript{119} It is a most intrusive procedure, and carries with it irreversible consequences.\textsuperscript{120} Convulsive therapy, which is most frequently performed by passing an electric current through the patient's brain but may involve the administration of drugs such as insulin, represents a somewhat lower degree of intrusiveness and irreversibility,\textsuperscript{121} but it is believed by most psychiatrists to be an inappropriate form of treatment for children.\textsuperscript{122}

While the legislature did not outlaw these forms of treatment in cases involving children, it did note the increasing regulation of these treatments by courts and legislatures of other states,\textsuperscript{123} and chose to make such treatment available only upon court order.\textsuperscript{124} A child may receive psychosurgery or convulsive therapy only when a court is convinced that the proposed treatment "is necessary to prevent serious harm to the minor."\textsuperscript{125} It seems likely that very few such cases will arise and that their adjudication will not greatly burden the courts. Nevertheless, the protection of children from the potential harm of ill-advised use of these forms of treatment warrants substantial procedural safeguards.

C. Psychotropic medications and aversive conditioning.

These forms of treatment and habilitation are neither as harmless as verbal therapy nor as hazardous and unusual as psychosurgery and convulsive therapy. Therefore the legislature enacted a different type of consent procedure for them.\textsuperscript{126}

Medications for the treatment of mental illness have worked a genuine revolution in mental health care in the last 25 years. They

\textsuperscript{121} For a comprehensive review of the literature on electroconvulsive therapy (ECT), see Note, Regulation of Electroconvulsive Therapy, 75 Mich. L. Rev. 363 (1976).
\textsuperscript{122} A poll by the American Psychiatric Association of 2,973 psychiatrists revealed that only 16% thought ECT should be administered to children aged 16 or under. Am. Psychiatric Ass'n, Electroconvulsive Therapy 4 (Task Force Rep. 14, 1978).
\textsuperscript{123} See notes 120, 121 supra; see also Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976).
\textsuperscript{124} N.M. Stat. Ann. § 43-1-17(B) (Repl. 1979).
\textsuperscript{125} Id.
\textsuperscript{126} N.M. Stat. Ann. § 43-1-17(C). This discussion will focus on psychotropic medications. The legislature concluded that the balance of interests regarding aversive conditioning was roughly comparable. See Friedman, Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons, 17 Ariz. L. Rev. 39 (1975).
have enabled some patients to receive verbal therapy who would not have been able to profit from it had not the medicines been available. They have also made it possible for many patients to receive treatment on an out-patient basis who would have been institutionalized in earlier times. Recognition of the value of these drugs is nearly universal.\textsuperscript{127}

Psychotropic medications also present serious problems. Foremost among these are the physical side effects which may accompany their use. These undesirable effects are both numerous and serious. Perhaps the most troubling is tradive dyskinesia, an irreversible form of brain damage which can produce uncontrollable facial contortions and other serious symptoms.\textsuperscript{128} These side effects, coupled with the extremely widespread use of such drugs, have led courts and legal commentators to call for careful limitations on their use.\textsuperscript{129} There is additional reason for concern when the patient receiving the medications is a minor, because the long-term effects of the drugs are somewhat less clear for children than for adults.\textsuperscript{130}

The extraordinary promise of psychotropic medications when properly prescribed, coupled with their serious side effects, produce a legislative dilemma regarding consent. Considerable risks would be involved in giving minors the right to consent to such potent forms of treatment. Errors of judgment could have serious consequences, and minors need protection from such errors. On the other hand, placing limitations on drugs comparable to those provided for psychosurgery would make it impractical to treat the large number of children who currently benefit from these medications. The courts would soon be filled with petitions for medication treatment, and either the treatment would not be provided or else the petitions

\textsuperscript{127}See generally Group for the Advancement of Psychiatry, Pharmacotherapy and Psychotherapy: Paradoxes, Problems and Progress (1975). However, it is also recognized that psychotropic medications alter behavior by ameliorating symptoms, but do not constitute a "cure." Symptoms frequently return when the medications are discontinued. See 5 American Handbook of Psychiatry 441-513 (2d ed. S. Arieti ed. 1975); 2 Comprehensive Textbook of Psychiatry 1921-27 (2d ed. A. Freedman, H. Kaplan & B. Sadock eds. 1975); Byck, \textit{Drugs and the Treatment of Psychiatric Disorders}, in The Pharmacological Basis of Therapeutics 152 (5th ed. L. Goodman & A. Gilman eds. 1975).


\textsuperscript{130}See Pediatric Psychopharmacology: \textit{The Use of Behavior Modifying Drugs in Children} (J. Werry ed. 1978).
would be routinely approved without thoughtful consideration of the child's needs. Neither roadblocks nor rubberstamp procedures are appropriate for drug therapy.

The Code provides that for children under the age of fourteen, the parents have the authority to give or withhold consent. For these younger children, any direct participation in the treatment decision will take place informally at the initiative of the parents or the doctor, because the Code specifies no role for the child. For minors who are fourteen and older, a system of concurrent consent has been devised. If the older minor is factually able to grant consent, his agreement will be sufficient unless his parents object. If the parents do object, or if the minor lacks the capacity to grant consent, or if the minor refuses to consent to proposed treatment, a mechanism for substitute consent by a third party is provided. This proxy consent mechanism involves the appointment of a treatment guardian, as provided for adults elsewhere in the Code.

As was the case with the provisions previously discussed, the consent section for minors attempts to strike a balance between the risks posed by the treatment involved and the consensual abilities of the minors for whom the treatment is proposed. In cases involving younger children, the power to give or withhold consent is granted to the parents on the grounds that children under fourteen will not be able to comprehend fully the consequences of such a complex and serious decision. A significant number of older teenagers should be able to participate meaningfully in decisions regarding their treatment, and they are granted a say in such decisions. Even for these older minors there is a perceived need to protect them from the consequences of an unwise decision—thus the provisions for parental objection and third party decision-making.

   C. Psychotropic medications and behavior modification programs involving aversive stimuli or substantial deprivations may be administered to minors under the age of fourteen only with the consent of the minor's parent or guardian. Such treatment may be administered to minors fourteen years of age and older with the consent of the minor unless his parent or guardian objects. If the consent of the minor is not obtained, or his parent or guardian objects, and the treatment provider or another interested person believes that the administration of the drug or program is necessary to protect the minor from serious harm, any interested party may petition the court for appointment of a treatment guardian under the same procedures as provided in Section 43-1-15 NMSA 1978.

132. Id.
133. Id.
134. Id. § 43-1-15. For a general discussion of limited purpose guardianship, see Note, Limited Guardianship for the Mentally Retarded, 8 N.M.L. Rev. 231 (1978).
These consent provisions reflect a judgment that older minors are more capable of making or participating in treatment decisions, and should therefore be treated differently from younger children. The choice of a cutoff age here, as was true with a similar cutoff involving the ability to enter residential treatment voluntarily,\textsuperscript{135} is a somewhat arbitrary exercise. But this kind of rough categorical measure of minors' abilities\textsuperscript{136} grants decisional rights to most minors who are able to exercise them without burdening the treatment and judicial systems with the need for a case-by-case inquiry into the abilities of each child. In this respect, these provisions resemble other legal judgments which arbitrarily affect the rights of young people, such as minimum age requirements for voting, driving, and other activities. Their inherent inaccuracy with regard to the abilities of specific children are justified by their utility in reducing both administrative and judicial burdens.

D. Consent provisions generally.

The balances and compromises struck by the Code regarding minors' consent are rough and imperfect. New Mexico has gone further than other states in its attempt to tailor consent rules to the nature of the proposed treatment and to the ability of the child. The Code may provide a model for other states which wish to modify the rule of parental consent in order to recognize the rights and abilities of juveniles.

CONFIDENTIALITY OF RECORDS

Despite the efforts of voluntary associations and mental health professions, a stigma still attaches to those who have been labeled mentally ill or mentally retarded.\textsuperscript{137} This stigma can affect an individual's life in many ways, limiting his access to educational and employment opportunities. Thus adults who receive treatment for mental illness or habilitation for mental retardation have a legitimate interest in assurance that information about their condition or past condition will not be made public. Without such assurance, some potential clients may not seek needed treatment or habilitation because of fear that the stigma will outweigh any bene-

\textsuperscript{135} N.M. Stat. Ann. § 43-1-16 (Repl. 1979); see text accompanying note 80 supra.
\textsuperscript{136} See note 116 supra; see also Wisconsin v. Yoder, 406 U.S. 205, 245 n.3 (1972) (Douglas, J., dissenting in part).
fits they might gain. These considerations led the legislature to provide rather strict protections of clients' confidentiality.\textsuperscript{138}

The same concerns also affect children and their parents, and therefore the Code provides protections of the child's privacy which are tailored to the special needs of children and of family situations.\textsuperscript{139}

In general, children receive the same protection of privacy and confidentiality which the Code provides for adults. The legislature established as a general principle that no information about a client which might reveal the client's identity may be transmitted unless the proposed recipient has a need to obtain that information, or unless the client has consented to the release.\textsuperscript{140} Thus the presumption is that the client will control access to his own records. This control is accompanied in most circumstances by access of the client to his own records.\textsuperscript{141} The only exception to the principle of client control are those specified in the statute.\textsuperscript{142}

The most important of these exceptions for adults are (1) cases in which treatment professionals working to serve the client need to share information with each other, and (2) cases in which serious bodily harm to the client or others might occur unless information is revealed.\textsuperscript{143} Both exceptions also apply when the client is a minor, and there would appear to be nothing in the nature of minority which would make these provisions inappropriate for children.

But the legislature concluded that there were two other exceptions to the rule of client control which were appropriate only in cases involving children. This conclusion is based on the assumption that because of their immaturity, children require special provisions to protect both their treatment and privacy rights.

The first exception allows the provider of services to release information to the child's parents when that release "is essential for the treatment of the minor . . . ."\textsuperscript{144} This provision makes clear that

\begin{footnotes}
\textsuperscript{141} Id. § 43-1-19(D).
\textsuperscript{142} Id. § 43-1-19(B).
\textsuperscript{143} For perspective on service provider liability in this area, see Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 551, P.2d 334, 131 Cal. Rptr. 14 (1976); Wexler, \textit{Patients, Therapists, and Third Parties: The Victimological Virtues of Tarasoff}, 2 Int'l J.L. & Psych. 1 (1979).
\end{footnotes}
the child's confidentiality extends even to general releases of privileged information to his parents. This is particularly important because a bond of confidentiality may be necessary to establish the degree of trust needed for successful therapy, and because the child will often wish to discuss aspects of his family relationships confidentially. An inflexible rule that information could not be shared with the parents, however, appeared to be excessively harsh, and a 1978 amendment allows the therapist to share information with the parents under limited conditions. The requirement that the release to the parents be essential for the purposes of treatment is quite general, and therefore grants the therapist a great deal of latitude to use professional judgment in deciding what, if anything, to tell the parents. The grant of discretion to the service-provider recognizes that this is an area of extreme sensitivity, and any blanket rule which attempted to regulate the professional's judgment with any specificity could potentially cause serious harm to the child, his treatment, and his family. The success or failure of this provision will depend on the care and judgment which professionals exercise in its implementation.

The other difference between adults and minors regarding confidentiality involves the client's decision to authorize the release of information. Whether the client is an adult or a minor, his consent to release information must meet general consent requirements: capacity, information, and voluntariness. When a client is not capable of making his own decision regarding the release of information, the Code provides for substitute consent. But because the legislature concluded that younger children, as a class, lack sufficient maturity to make their own decisions regarding important matters, it provides that parents of children under fourteen have the authority to give or withhold consent for the release of information. Once again the legislature has attempted to balance the child's approximate abilities against the potential harm from an erroneous decision by protecting those children whose decisions are most likely to be unwise.

As with consent, New Mexico's provisions regarding disclosure are unique, attempting to recognize and accommodate both the privacy interest and the treatment needs of the client, even when the client is a minor.

145. See note 104 supra.
147. See text accompanying note 108 supra.
CONCLUSION

The Code extends other rights to children which have not been discussed in this article, such as the right to individualized treatment or habilitation149 and the right to education.150 But the provisions discussed in this article suggest a new approach to children's mental health and retardation services. They represent a unique legislative attempt to balance competing rights and competing interests. The child's liberty and treatment interests receive the greatest attention and protection, but the special vulnerability and immaturity of children have also been taken into account. For judges and treatment-providers, implementing the Code requires that challenging and demanding decisions be made regarding individual children. For other states considering new legislation, the Code suggests a new approach to children's needs which they may profitably adapt to their own situation.

149. Id. § 43-1-9.
150. Id. § 43-1-18.