Indiana Law Review

Volume 26 1993 Number 3

# ARTICLES

## Disclosing Adolescent Suicidal Impulses to Parents: Protecting the Child or the Confidence?

Joan Neisser*

### Introduction—The Tale of Alana

This Article is about the intersection between law and psychology in the troubling area of adolescent suicide. It focuses on the appropriate role of the suicidal adolescent's parents in the treatment and recovery of the adolescent. Adolescent suicide is a problem of enormous and increasing magnitude in our society today. There are now approximately 6,000 successful suicides and a half-million suicide attempts a year by young people.[1] Every day, mental health professionals[2] in clinics, schools,

---

* Assistant Professor, Seton Hall University School of Law. B.A., 1970, Rutgers University; J.D., 1984, Stanford Law School. I wish to thank Catherine McCauliff and Louis Raveson for their invaluable assistance and support. I also wish to thank Angela Carmella, Maureen Garde, Stephanie Wildman, and Michael Zimmer for their helpful comments. Finally, I would like to thank Edward McHugh, Jodelyn Shack, and Linda Vele for their helpful research assistance.

1. These statistics are for youths ages 15-24. Herbert Pardes, M.D., *Foreword* to Youth Suicide at vii (Michael L. Peck, et al. eds., 1985).

2. I am using the term mental health professional to refer to any professional licensed to provide mental health counseling. There are many other individuals, such as teachers, who come in contact with potentially suicidal adolescents. One commentator has suggested that there should be a general duty imposed on bystanders who have firsthand knowledge of suicidal threats by individuals of any age to report this information to a hotline serviced by mental health professionals. *See* Kate E. Bloch, Note, *The Role of Law in Suicide Prevention: Beyond Civil Commitment—A Bystander Duty to Report Suicide Threats*, 39 Stan. L. Rev. 929 (1987). This Article, however, focuses on situations where a licensed mental health professional learns of an adolescent's suicidal impulses through the adolescent's confidential relationship with the mental health professional.

and private offices have contact with adolescents who are potentially suicidal. In light of the psychological research and clinical experience that calls for parental involvement with the treatment of the suicidal adolescent, the question arises whether mental health professionals should be permitted to notify parents that their child is suicidal over the child's objection.

The story of one suicidal adolescent, Alana,[3] demonstrates the complex family dynamics in which the suicidal adolescent is usually involved. Alana became increasingly depressed during her early teenage years. She had been adopted at the age of two months, and she became increasingly concerned about why her biological parents had given her up. In addition, she became increasingly dissatisfied with her body, as she was only four feet, seven inches tall, and, because of a medical condition, would not grow any taller. She also had developed a kidney problem, which had already required surgery and might require more surgery, and she suffered from severe and chronic allergies. All of these problems left her feeling inadequate and insecure. Her depression made it difficult for her to concentrate on schoolwork, and her grades suffered. Her friendships were not stable. She latched on to a particular boyfriend with great intensity. The relationship did not work out, and its failure exacerbated her depression.

Alana's parents had trouble dealing with their daughter's troubled emotions because of the many feelings that their daughter's emotions generated in them.[4] Alana's mother had been a foster child during much

---

3. Alana's story is presented in DAVID K. CURRAN, ADOLESCENT SUICIDAL BEHAVIOR 88-92 (1987).

4. A parent's resistance to acknowledging that her child is troubled is common. In one study of students in two high schools, when mental health professionals urged treatment for youngsters who were considered suicidal, half the parents refused the referral. Jane E. Brody, *Suicide Myths Cloud Efforts to Save Children*, N.Y. TIMES, June 16, 1992, at C1, C3.

This phenomenon is further illustrated by the retrospective analysis of one adolescent's suicide. Mike took an overdose of sleeping pills after hearing of the suicide of a casual acquaintance. His parents, both of whom were successful lawyers, refused to believe he was suicidal and were reluctant to hospitalize him for psychiatric care. One year later he killed himself. *Id.*

Another striking example of parental resistance can be found in a recent Florida case, Paddock v. Chacko, 522 So. 2d 410 (Fla. Dist. Ct. App. 1988). In *Paddock*, an adult female attempted suicide. After her suicide attempt she went to stay with her parents. A psychiatrist she consulted recommended that she be hospitalized. She agreed but suggested that he speak with her parents first.

The psychiatrist spoke with the patient's mother, who said the psychiatrist should talk with her father. He then spoke with her father, who believed that his daughter did not need hospitalization and that the family could handle the problem by itself. The father tried to help his daughter by rubbing alcohol on her legs and arms and talking with her

of her adolescence. Because of the loss of her own mother, Alana's adoptive mother had been the primary caretaker of her younger brothers and sisters and had to be tough, self-reliant, and independent in order to survive. She was a woman who had gone to extraordinary lengths to steel herself against ever feeling depression, unhappiness, or negative thoughts, and it angered her that Alana threatened to provoke these feelings in her. She appeared incapable of seeing in her daughter any of the feelings she herself had struggled to repress in her youth. Alana's father also kept himself distant from Alana. Although he had experienced depression and could empathize more with Alana's feelings, he had little involvement in her life. He spent most of his time away from home and slept a good deal of the time when he was at home.

During a very lonely summer, when most of her friends were away and she was feeling very estranged from, and misunderstood by, her parents, Alana took an overdose of valium. She took the pills in her bedroom when her parents were present in the house.[5] They heard her vomiting and rushed her to the hospital, where she stayed for two weeks.

Alana's suicide attempt only worsened her relationship with her parents.[6] Although her parents visited her regularly in the hospital, they found it very difficult to speak to her. They could not understand her behavior and could see no reason for her depression. Her mother re-

---

to soothe her anxieties. The next day, before the father went to play golf, his daughter told him that she was upset and had been hallucinating. He left to play golf and the daughter went to a wooded area nearby and cut her wrists and set her blouse on fire.

5. It is common for an adolescent to attempt suicide at home when someone is present in the house. One study of 50 adolescent suicides found that 86% of the adolescents had someone present or nearby when committing the attempt, and 86% also notified a potential helper after the attempt. *See* CURRAN, *supra* note 3, at 43.

On the other hand, studies show that in a substantial number of the attempts made at home, parents are often not the first to be told. In one study, for example, 70% of the attempts were made at home with the parents in the house, but only 20% of the attempters reported the attempt to the parents first, if at all. Many called a friend, who was at some distance, while the parents sat in the next room.

These studies show that most suicidal adolescents do wish to be helped, but they also show the extent of the breakdown of communication in their families. *Id.* at 60. Another study showed that communication was so lacking between suicidal adolescents and their parents that more than half the mothers of the adolescents did not even know that their child had attempted suicide. Marcus Walker, M.D. et al., *Parents' Awareness of Children's Suicide Attempts*, 147 AM. J. PSYCHIATRY 1364 (1990).

6. Typically, parents and family members have great difficulty dealing with the adolescent's suicide attempt. The negative response of the parents and family members has an alienating effect on the attempter. This dynamic is portrayed in the 1980 film ORDINARY PEOPLE (Wildwood Enterprises 1980), in which a family struggles to reintegrate a teenage son into the home following his hospitalization for a suicide attempt. CURRAN, *supra* note 3, at 88. *See also* JERRY A. MOTTO, *Treatment Concerns in Preventing Youth Suicide*, *in* YOUTH SUICIDE, *supra* note 1, at 91, 97-98.

mained determined to hold on to her defenses, smiling throughout the entire session with Alana's therapist during which they discussed Alana's suicide attempt and the possibility of another one. Her father continued to remain concerned, but unavailable.

Alana's parents' failure to deal with her suicidal attempt simply exacerbated her feelings of alienation, and she tried suicide once again.[7] She wrote the following in a note before her second suicide attempt:

> I feel like a balloon with too much air in it. Everything has been bottled up inside of me for so long. All I ever wanted was a family. I guess I never got it. Everything I ever loved I've lost. . . . I love my daddy, but somehow along the way I lost him too. . . . This isn't to say that I don't love my mother. I really do. But somehow I don't think I ever had her. . . . I can't stand feeling worthless. . . . I'm sick of people asking me what's wrong without even caring about the answer. . . . I'm sick of trying to prove I'm okay to everyone else when I don't believe it myself. I'm tired of being lonely. I'm tired of being myself. . . . I'm sick of talking to people who don't hear me.[8]

Even after Alana's therapist showed her parents this note, they could not understand or respond to their daughter's feelings. Weeks later when Alana's mother was speaking to her therapist, she referred to Alana's suicidal attempt as that "thing" that occurred a while back. She could not even say the word suicide.

In addition to revealing her feelings of loneliness and inadequacy, Alana's note revealed her feelings that she was a burden to her parents. "I'm sick of pretending I'm happy so that I won't aggravate people anymore. . . . I never wanted to hurt anybody. I'm sorry for it and for being such a letdown to everybody."[9] Her feelings of being a burden to her parents had been present before the suicide attempts and were

---

7. Persons who have already attempted suicide at least once are far more likely to attempt it again than people who have not attempted suicide. CURRAN, *supra* note 3, at 114. Some studies have shown that half of the children who make one attempt will make at least one other attempt and sometimes as many as two a year until eventually about 10% actually kill themselves. *See* Brody, *supra* note 4.

8. CURRAN, *supra* note 3, at 90-91.

9. Studies reveal that many suicidal adolescents feel they are a burden to their families and their families would be better off without them. In many cases the perception is covertly or overtly reinforced by the parents. CURRAN, *supra* note 3, at 30; *see also* CYNTHIA R. PFEFFER, THE SUICIDAL CHILD 146 (1986) (discussing the phenomenon of the "expendable child" as part of a complex set of family interactions contributing to the child's suicidal behavior).

reinforced after the first suicide attempt by relatives who were angry with her for frightening and upsetting her parents.[10]

In her work with her therapist, Alana eventually learned to accept her parents' limitations and to feel less alienated from them. As her anger and alienation from her parents lessened, she became a more enjoyable daughter for them. Because she was no longer threatening to her parents, they could feel more comfortable with and closer to her. Her work with them helped her healing process.

Like Alana, most suicidal adolescents have a significant psychological disturbance,[11] and that disturbance is generally rooted in deeply imbedded family pathology.[12] Their suicide attempt is generally not a wish to die but a cry for help.[13] Because the pain that causes adolescents to become suicidal is so intertwined with the adolescent's family dynamics, involvement of the family in the adolescent's treatment is almost always indicated.[14] In the best of circumstances, the family itself will change. As Alana's story demonstrates, however, even if that does not happen, at least the adolescent, with the help of a skilled therapist, can come to grips with the family's dynamics and heal.

Alana's parents became involved in her treatment because she attempted suicide in their home and they saw she was ill and took her

---

10. Alana's story in some ways follows the common life sequence of suicidal adolescents charted by psychiatrists: "first, numerous behavior problems and dissensions within the family; second, onset of adolescence with yearning for autonomy and personal authority leading to strict discipline and personal restrictions on the child by the parents; third, alienation from the family with the development of an intense relationship with a single peer too intense to last; and finally, a suicide phase when all social and family attachments are gone." NORMAN L. FARBEROW, *Youth and Suicide: A Summary*, *in* YOUTH SUICIDE, *supra* note 1, at 191, 195.

Alana did not have behavior problems and open dissensions within her family, thereby not causing her parents to take steps to restrict her autonomy. However, she did feel increasing alienation from her family and tried to resolve her feelings of alienation by developing a consuming relationship with a boyfriend, which, because of the intensity she attached to it, did not last. As a result, she felt that all her social and family attachments were gone and she attempted suicide.

11. *See* Brody, *supra* note 4.

12. *See* NORMAN L. FARBEROW, *Youth Suicide: A Summary*, *in* YOUTH SUICIDE, *supra* note 1, at 191-200.

13. Studies on suicide have found that there are three major characteristics of suicide attempts: ambivalence, the temporary nature of the wish to die, and the attempt as a cry for help. *See* Bloch, *supra* note 2, at 938-39.

In addition, there is a good deal of research and clinical experience to support the view that most adolescent attempts, more so than the suicidal attempts of older persons, are not compelled by a strong wish to end one's life, but rather to ameliorate it. CURRAN, *supra* note 3, at 46-47.

14. Mental health professionals agree that it is critical to include the family in the treatment plan unless the families are far away or intractably estranged from the young person. MOTTO, *supra* note 6, at 91, 97-98.

to the hospital. Had Alana gone directly to a mental health professional and shared her suicidal impulses but asked that they not be disclosed to her parents, the mental health professional would have faced a serious conflict. The professional would have had to choose between maintaining Alana's confidence, thereby depriving Alana of the treatment benefits of parental involvement, or breaching the confidence and risking liability.[15]

The mental health professional's duty to maintain a patient's confidences is based upon two policies: protecting the patient's privacy and maximizing the benefits of the psychotherapist-patient relationship. These are strong interests that are not easily overcome. Nonetheless, courts and legislatures have recognized circumstances in which other considerations are still more compelling. This Article proposes that the need to involve a parent in a suicidal adolescent's treatment is such a compelling circumstance.

Part I examines the justifications for the patient's right to confidentiality and the circumstances in which legislatures and courts have deemed it appropriate to limit that right. The policies supporting a parental notification exception to the suicidal adolescent's right to confidentiality are then explored.

Part II explores the proper parameters of this exception and proposes that parental notification should be permitted[16] unless the mental health professional has reason to believe that parental notification would not be in the minor's best interest. In order to adequately protect the minor's right to confidentiality, Part II further proposes that, if a mental health professional wishes to contact a parent over an adolescent's objection, the professional should be required to obtain the concurrence of two other mental health professionals in this decision.

Part III examines the constitutional issues[17] presented by this proposal. Although there has been some recognition of a minor's consti-

---

15. This concern has been discussed in the psychological literature. *See, e.g.*, Vernon Lee Sheeley and Barbara Herlihy, *Counseling Suicidal Teens: A Duty to Warn and Protect*, 37 THE SCH. COUNS. 89, 94 (1989).

16. The focus of the discussion will be on a rule permitting rather than requiring disclosure, because a permissive rule would be a less substantial change in the current law than a mandatory rule would be. It should be noted, however, that the policies supporting a permissive rule are equally appropriate to the adoption of a mandatory rule.

17. It should be noted that a permissive rule might not pose a constitutional question because it might not be deemed state action. Jackson v. Metropolitan Edison Co., 419 U.S. 345, 351 (1974). If the provision were mandatory, however, it would constitute state action and would need to withstand constitutional scrutiny.

In addition, the constitutional analysis gives further insight into the appropriateness of such a rule because it provides the opportunity to test the value of the rule in the context of the law's most cherished principles.

tutional right to make her own treatment decisions, the role of a parent in her child's treatment decisions remains strong, and the right of a minor to make her own treatment decisions remains limited. Permitting a mental health professional to notify a parent if her child is potentially suicidal, therefore, is consistent with current constitutional law.

In addition, the right of a parent to make decisions regarding her child's health, although strong, is not absolute. To the contrary, it is limited by the state's *parens patriae* power to protect children. Therefore, limiting the rule to situations where notification would be in the minor's best interest should be constitutional.

## I. The Rationale for a Parental Notification Exception to a Suicidal Adolescent's Right to Confidentiality

The legal role of the parent in making medical decisions for her child is changing. The general common law rule deems minors incapable of making medical treatment decisions and assigns that decisionmaking power to their parents. Thus, under the general common law rule the mental health professional owes the information about the minor's condition to the parents. Courts and legislatures, however, have created a variety of exceptions to this rule. The three traditional exceptions have emerged in emergency situations, when a minor is emancipated, and when a minor is mature enough to make the medical treatment decision on her own.[18]

In addition, legislatures have created other exceptions to the need for parental consent for treatment of minors in a variety of areas, including contraceptive services, prenatal care and delivery, sexually transmitted diseases and HIV, substance abuse, mental health care, and even general nonemergency medical care.[19]

There have also been some changes in the parent's right to commit a child to a mental hospital. Most states have statutes that empower parents to commit their children to psychiatric hospitalization.[20] Although

---

18. For a discussion of the common law rule and exceptions, see Younts v. St. Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330 (Kan. 1970).

19. Twenty-four states and the District of Columbia allow minors to give informed consent to contraceptive services. In 27 states, pregnant minors may consent to prenatal care and delivery. Every state except South Carolina allows minors to consent to diagnosis of sexually transmitted diseases. Eleven states specifically provide for a minor's right to consent to diagnosis for AIDS. Forty-six states allow minors to consent for drug and alcohol counseling. Twenty-eight states allow minors to consent to mental health treatment. *See* Cristine Russell, *How States Stand on Medical Care of Minors*, Wash. Post, April 7, 1992, at 13.

20. For an extensive discussion of these laws, see James W. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Cal. L. Rev. 840 (1974).

generally considered under the rubric of "voluntary" commitments, these commitments are very different from voluntary commitments by adults, who can sign themselves in and out of a mental hospital at will. Once a child is committed, the child may not leave the hospital without the consent of the parent. More recently, however, some states have enacted statutes that allow children over a certain age to voluntarily commit themselves to psychiatric hospitalization.[21] Statutes that allow minors of a certain age to commit themselves also empower the minor to sign herself out if she wishes to do so.[22]

Minors, therefore, have become much more empowered to determine their own medical treatment and, thereby, have acquired the right of confidentiality that has traditionally flowed to the patient who consents to treatment. The following section analyzes the justifications for confidentiality and argues that there are compelling policy reasons to make an exception for parental notification when an adolescent is potentially suicidal.

### *A. Justifications for the Patient's Right to Confidentiality and Recognized Limitations on That Right*

The rationales underlying the state statutory privileges and the common law duty not to disclose confidences reflect great respect for the patient's privacy and deep concern about the efficacy of the psychotherapeutic-patient relationship if the patient's confidences are not maintained.

Most states have statutory privileges covering physician-patient and psychotherapist-patient relationships. In addition, states have a variety of statutory privileges covering counseling relationships with a mental health professional other than a licensed psychiatrist or a licensed psychologist.[23] Although common law psychotherapist-patient privileges have been recognized in a few states and a constitutionally based psychotherapist-patient privilege has been recognized in some other states, state statutes are the primary source of the mental health professional-patient privilege.[24]

---

21. *See, e.g.*, N.J. STAT. ANN. § 30:4-24 to -27.21 (West Supp. 1992), N.J. R. CT. 4:74-7(k) (a minor 14 years or older may request a voluntary commitment regardless of the wishes of the parents or guardian).

22. *See, e.g.*, *In re* Application of Williams, 356 A.2d 468 (Essex County Ct. 1976).

23. For a thorough discussion of these privileges, see Note, *Developments in the Law—Privileged Communications: IV Medical and Counseling Privileges*, 98 HARV. L. REV. 1450, 1530 (1985).

24. *Id.*

These privileges generally preclude forced disclosure by legal process of the communications between the mental health professional and patient. Exceptions exist: (1) when the patient introduces her mental condition as an element of a legal claim or defense, (2) when a psychiatric examination is ordered by the court and the patient is informed the communication will not be privileged, and (3) when a mental health professional in the course of diagnosis or treatment of the patient determines that commitment of the patient is appropriate.[25] Although the evidentiary privilege addresses only situations in which disclosure is sought in or through litigation, it reflects the broader professional rule of confidentiality.

As discussed below, there are three main rationales underlying these privileges. First, many believe that counseling relationships would suffer, indeed, that many people would not go into therapy at all, if people knew that their confidences might be disclosed in court. Second, the ability to control access to personal information about oneself is fundamental to our notions of privacy. Finally, professional ethics require that confidences be maintained.[26]

The notion that protecting confidences is necessary to a successful therapeutic relationship is basic to the establishment of a privilege. In *Allred v. State*,[27] for example, the court, in establishing a common law psychotherapist-patient privilege, discussed the four canons that evidence scholar John H. Wigmore suggested must be met in order to establish a privilege: (1) there must be confidences that should not be disclosed; (2) the element of confidentiality must be essential to a full and satisfactory relationship between the parties; (3) the relationship must be one which, in the opinion of the community, should be sedulously fostered; and (4) the injury that would befall to the relationship by disclosure of the communication must be greater than the benefit gained by correct disposal of the litigation.[28]

The court found that all four of these canons were met in the psychotherapist-patient relationship.[29] First, patients often make statements to psychotherapists that they would not make to their closest family members. They share the innermost recesses of their personality, the very portions of self which individuals seek to keep secret from the world at large. Revelations of these disclosures could have an irrevocably

---

25. *See* Steven R. Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing With the Other*, 75 KY. L.J. 473, 505 (1986).
26. *See id.* at 477-79.
27. 554 P.2d 411 (Alaska 1976).
28. *Id.* at 417.
29. *Id.*

harmful effect on their reputations and well-being.[30] Second, without the promise of confidentiality the patient would not share her innermost feelings, such as guilt and shame, and the therapeutic efforts would be worthless.[31] In addition, the psychotherapeutic relationship is a relationship of great importance to society and, therefore, the benefits derived from preventing the disclosure of the communications outweigh society's interest in having those communications available for the correct resolution of litigation.[32]

The rationale that psychotherapy works best when confidences are protected is closely intertwined with the notion that a patient has a privacy interest in not having the statements of a very personal nature that he or she has made to a therapist disclosed to a third person. This rationale was discussed at length by the California Supreme Court in *In re Lifshutz*,[33] a case in which the constitutionality of the patient-litigant exception to the California psychotherapist-patient privilege was challenged. The court, in recognizing the patient's substantial privacy interest in keeping her disclosures to her therapist confidential, quoted the following from a District of Columbia Circuit Court decision: "The psychiatric patient confides more utterly than anyone else in the world. . . . [H]e lays bare his entire self, his dreams, his fantasies, his sins, and his shame."[34] Thus, although the California court held that the patient-litigation exception was constitutional, it interpreted the exception narrowly in order to provide maximum protection to the patient's privacy.

Finally, the original purpose for privileges was to protect a professional's honor by not requiring the professional to disclose a confidence he or she promised to keep secret.[35] Although that rationale has been abandoned as a stated basis for legal protection of confidences, some commentators believe it still is a significant factor behind the adoption of privileges.[36]

Unlike the psychotherapist-patient privilege, which has developed primarily through statutes, the duty of mental health professionals to maintain confidentiality apart from legal proceedings is a growing trend in American jurisprudence that has neither statutory nor historical com-

---

30. *Id.*
31. *Id.*
32. *Id.* at 417-18.
33. 467 P.2d 557 (Cal. 1970).
34. 467 P.2d 557, 567 (quoting Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955) (quoting MANFRED S. GUTTMACHER ET AL., PSYCHIATRY AND THE LAW 272 (1952))).
35. JOHN H. WIGMORE, WIGMORE ON EVIDENCE § 2290 (J. McNaughton ed. 1940 & Supp. 1991).
36. Smith, *supra* note 25, at 479.

mon law roots.[37] Instead, it is a fairly recent development based upon the belief that a person who goes to a physician reasonably expects that the information the person shares with the physician will be kept confidential. The duty to maintain confidences has never been considered absolute; to the contrary, from its inception, courts have recognized an exception to this rule for instances where the disclosure of information is necessary to protect the health and safety of the public.[38] Nonetheless, it is now deeply entrenched in American case law, with most jurisdictions recognizing that such a duty exists.[39]

Although the duty not to disclose first developed in the context of the patient-physician relationship, it quickly was extended to the psychotherapist-patient relationship.[40] In establishing liability for disclosure, courts noted that there is often a stigma associated with undergoing psychotherapy and if therapists were free to reveal that a person was undergoing psychotherapy, the patient might suffer embarrassment and even economic loss.[41]

In addition, courts recognized that, as discussed above, psychotherapy is most effective when patients feel free to reveal their most private thoughts and emotions to the therapist. Because much of what they reveal might be humiliating or embarrassing to the patient if it were shared with another, courts reasoned that patients must feel free to disclose private information to their therapists without fear that it will be disclosed to others.[42]

---

37. *See* Marjorie B. Lewis, Note, *Duty to Warn Versus Duty to Maintain Confidentiality: Conflicting Demands on Mental Health Professionals*, 20 SUFFOLK U. L. REV. 579, 606 (1985).

38. *See* Simonsen v. Swenson, 177 N.W. 831, 832 (Neb. 1920) (recognizing that a wrongful breach of confidence gives rise to a cause of action for damages, but holding that a physician is privileged to disclose confidential information if the disclosure is necessary to prevent the spread of a contagious disease).

39. *See* Lewis, *supra* note 37, at 603.

40. Some courts have viewed the patient's right to privacy in the psychotherapist-patient relationship as so fundamental that they have found it constitutionally based. In *In re* B, 394 A.2d 419 (Pa. 1978), for example, the Pennsylvania Supreme Court recognized a patient's constitutionally based right not to have disclosed any information pertaining to her relationship with her psychotherapist. *Id.* at 425. *In re B* involved a juvenile delinquency proceeding concerning "B." During the course of the predisposition investigation, juvenile court personnel discovered that B's mother had received psychiatric treatment. The court held that the statutory doctor-patient privilege did not apply to the disputed records, but that the constitutional right of privacy protected the information from involuntary disclosure. *Id.* at 423-25. The court noted that although the state had a significant interest in obtaining the information, psychotherapy requires patients to reveal very intimate details of their lives and the patient's privacy in these communications must be protected. *Id.* at 425-26.

41. *See* Lewis, *supra* note 37, at 592.

42. *See, e.g.*, MacDonald v. Clinger, 446 N.Y.S.2d 801, 805 (N.Y. App. Div.

These traditional concerns were eloquently set out by Justice Clark in his dissent in *Tarasoff v. Regents of the University of California,*[43] a landmark case establishing a therapist's duty to breach a patient's confidence if the therapist has reason to believe a third party is in danger. In his dissent, Justice Clark argued that the majority did not give adequate consideration to the traditional policies underlying the duty not to disclose confidences and stressed the negative practical effect disclosure would have on the psychotherapeutic relationship.[44]

According to Justice Clark, confidentiality is essential to the therapeutic relationship for three reasons. First, without the assurance of confidentiality, those requiring treatment will be deterred from seeking assistance. The apprehension of the stigma associated with treatment, increased by the fact that many seeking treatment have low opinions of themselves, contributes to a well-recognized reluctance to seek aid. This reluctance would be significantly increased if there were disclosure of information conveyed during treatment.[45]

Second, even if a person were to seek treatment, confidentiality would be necessary for effective treatment. Patients have conscious and unconscious inhibitions against revealing their innermost thoughts and resistance would be magnified if there is a possibility of disclosure of such confidential information.[46]

Finally, even if there is full disclosure from patient to therapist, the assurance that the confidential relationship will not be breached is necessary to the maintenance of trust in the psychotherapeutic relationship. Justice Clark explained that the essence of psychotherapy is the development of trust in the external world and ultimately in the self.[47] This trust develops through modeling based upon the trusting relationship established during therapy. Treatment will be frustrated if there is collusion between the therapist and others.[48]

As indicated above, the duty not to disclose confidences, even in the psychotherapeutic relationship, is not absolute. To the contrary, some jurisdictions require mental health professionals to breach a patient's confidentiality to protect a third person.[49] This duty to warn, however,

---

1982) (holding that except where necessary to protect a threatened interest, a therapist has a duty of nondisclosure because the relationship between psychiatrist and patient is one of trust and confidence).

43. 551 P.2d 334 (Cal. 1976).

44. *Id.* at 354-62 (Clark, J., dissenting).

45. *Id.* at 359.

46. *Id.*

47. *Id.* (quoting Donald J. Dawidoff, *The Malpractice of Psychiatrists*, 1966 DUKE L.J. 696, 704).

48. *Id.* at 359-60.

49. In *Tarasoff*, Prosenjit Podder, a voluntary out-patient at the Cowell Memorial

has not been extended to suicidal patients. In *Bellah v. Greenson*,[50] for example, a California court held that the *Tarasoff* doctrine did not require a therapist to warn parents of a suicidal patient of the patient's suicidal inclination. According to the court in *Bellah*, *Tarasoff* did not require therapists to warn others of the likelihood of any and all harm.[51] The court in *Bellah* expressed concern that the therapeutic relationship would be compromised if therapists revealed that their patients manifested suicidal tendencies.[52] It further reasoned that, unlike the third party situation, the need for confidentiality is not outweighed by the risk of suicide because the imposition of such a duty could well inhibit psychiatric treatment.[53]

The decision that has come closest to establishing a duty to notify a parent that her child is potentially suicidal is the recent Maryland case of *Eisel v. Board of Education*.[54] In *Eisel*, the father of a thirteen-year-old child who was killed as part of a suicide-murder pact with another adolescent sued two guidance counselors for failing to disclose to him information the counselor received that the daughter had told friends she intended to kill herself. The theory of the father's lawsuit against the counselors was that had he been informed of his child's suicidal intentions he could have exercised his custody and control over her and prevented her death.[55] The guidance counselors, on the other hand, claimed that had they disclosed this information, children would be less inclined to come to them with their problems in the future.[56]

---

Hospital at the University of California at Berkeley, confided his intention to kill Tatania Tarasoff to Dr. Lawrence Moore, the treating psychologist. Dr. Moore contacted the campus police and requested that Podder be detained. The police apprehended Podder but released him because he appeared rational and promised to stay away from Ms. Tarasoff. Dr. Moore's supervisor directed that no further action be taken to detain Podder. Neither Ms. Tarasoff nor her family were warned of the threat. Two months later Podder went to Ms. Tarsoff's home and killed her.

The California Supreme Court held that when a therapist determines, or by the standards of her profession should determine, that her patient presents a serious danger of violence to another, the therapist incurs the obligation to use reasonable care to protect the intended victim against such danger. *Id.* at 343. The discharge of the therapist's duty will vary according to the circumstances, but may include warning the intended victim or others of the danger or notifying the police. *Id.* at 345-46. In reaching its decision, the court considered the argument that psychologists cannot predict dangerousness and responded that these considerations were met by the standard of due care. *Id.* at 344-45.

*See also* McIntosh v. Milano, 403 A.2d 500, 512 (N.Y. Sup. Ct. 1979); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980).

50. 141 Cal. Rptr. 92 (Cal. Ct. App. 1977), *aff'd*, 146 Cal. Rptr. 535 (1978).
51. *Id.* at 94-95.
52. *Id.*
53. *Id.* at 95.
54. 597 A.2d 447 (Md. 1991).
55. *Id.* at 448.
56. *Id.* at 455.

The court discussed the strong public policy against adolescent suicide and ruled that the counselors had a duty to take reasonable measures to prevent the child's suicide and that those measures might have included notifying her father.[57] In determining that the counselors had a duty, the court found that the risk of harm to a child who threatens suicide is so great and the burden on the counselors to take some kind of preventive action so minimal that "the scales tip overwhelmingly in favor of duty."[58]

Although *Eisel* did not deal with a breach of confidentiality because the information the counselors received was from students who did not have a confidential relationship with the counselors, the court's analysis is relevant to a discussion of the appropriateness of allowing mental health professionals to breach confidentiality in order to protect suicidal adolescents. We are, indeed, dealing with a tremendous risk of harm not only to the suicidal adolescent but to the suicidal adolescent's family and to other adolescents who might be affected by a suicide by one of their peers. Therefore, an aggressive stance in fighting this epidemic seems appropriate.

### *B. Policies That Support a Parental Notification Exception for Suicidal Adolescents*

As discussed above, if there are compelling reasons to do so, legislatures and courts will limit the scope of a patient's confidentiality. Allowing disclosure of an adolescent's suicidal impulses to her parents over the adolescent's objection would recognize the profound role that parents play in the lives of suicidal adolescents. It would give parents the opportunity to help children in the following ways:

First, as indicated in the Introduction to this Article, most suicidal adolescents are mentally ill and their illness is linked to family pathology. In order for the treatment of the child to be most effective, the parents should be involved in the treatment, even if their involvement is forced upon the child, so that the therapist better understands the family dynamics.

---

57. *Id.* at 456. The case was remanded for trial on whether reasonable measures were taken.

58. *Id.* at 455. Interestingly, the *Eisel* court based its decision on general negligence analysis and not on a special relationship between the counselor and the student. Traditionally, such a duty would arise only if there were a special relationship that created such a duty. See Margot O. Knuth, Comment, *Civil Liability for Causing or Failing to Prevent Suicide*, 12 LOY. L.A. L. REV. 967, 987-95 (1979), for a discussion of cases that held there was a legal duty of care to prevent a foreseeable suicide when there was a special relationship such as between hospital and patient.

Second, the involvement of the suicidal adolescent's parents in her treatment is critical to the preservation of the family unit. It is imperative that parents are involved in this process in a way that encourages family unity and confidence. As one commentator pointed out, children will be harmed if parents are made to believe that only professionals know what is best for their child.[59] Allowing parents to have input into the child's mode of treatment may help the child and reduce the stress that having a potentially suicidal adolescent places on a family.

Third, providing notice to the parents gives them an opportunity to take steps consistent with the values with which they have raised their child. Professionals do not know the child's background as well as her parents. For example, if a child has been raised in a particular religious tradition and the parents know of a counseling agency associated with her faith that might be beneficial to their child, giving the parents the opportunity to arrange such treatment might be beneficial to the parents and child.

Fourth, notifying the parents will give them the opportunity to seek out the best services for their child. Most adolescents are not as experienced as their parents in making choices regarding medical treatment. In addition, parents will, in reality, bear the cost of the child's treatment. Allowing parents to participate in the decision will help them choose a mode of treatment which will be best for the child and which the parents can afford.

Fifth, it is critical that home environments be as safe as possible for children at risk. Not all children who are potentially suicidal should be hospitalized. It is very difficult to determine whether a child is suicidal and what environment will be most helpful to that child's healing. If a child is living at home, it is critical that that environment be made as safe as possible for the child. For example, having guns in the home is a major facilitator of adolescent suicide.[60] A parent who is ignorant of a child's mental state might keep a gun in the house that the parent would remove if she knew her child was at risk.

Sixth, notification to the parents would give them an opportunity to observe their child and to take measures to prevent the potential suicide.

---

59. *See* Michael Wald, *State Intervention on Behalf Of "Neglected" Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985 (1975).

60. There is little doubt that ready availability of firearms makes violent acts, such as suicide, easier to commit. The fact that an individual can be temporarily deterred from committing a suicidal act enhances the chances for survival. This is particularly true for young persons because their emotions are changeable and their personalities are in a state of development toward maturity. Firearms and explosives account for the largest number of suicides by a significant margin, 57% of total deaths and 64% of deaths among males and over 38% of deaths among females. *See* CALVIN J. FREDERICK, *An Introduction and Overview of Youth Suicide*, *in* YOUTH SUICIDE, *supra* note 1, at 1, 8.

For example, substance abuse has been found to be not only significantly associated with adolescent suicide, but a serious symptom contributing to increased suicidal risks and more medically serious attempts. Substance abuse is often both a contributor to the suicidal process and the means for the suicidal act.[61] Thus, alerting the parents to a potentially suicidal child would allow them the opportunity to observe whether their child is abusing drugs and to take steps to help the child prior to a serious suicide attempt.

Seventh, the medical services currently available to minors do not provide them with the kind of warmth and personal attention that parents generally provide their children. For example, Justice Stewart noted in his concurrence in *Planned Parenthood v. Danforth*[62] that abortion clinics provide little individual attention and emotional support to minors getting abortions.[63] Although there is no indication that minors who go for abortions are emotionally ill and in need of special support, children who are suicidal are mentally ill and do need special support. Their deep ties with their parents, even those parents who may be resistant to, or threatened by, their child's suicidal impulses, indicate that most suicidal teenagers will benefit from having their parents involved in their treatment.

Finally, mental health professionals who deal with potentially suicidal adolescents are most effective when they have the support of others, including the parents. Numerous studies indicate the difficulty in predicting whether a person is suicidal.[64] The strain that mental health professionals experience when dealing with suicidal patients is also well documented.[65] Having the support of the parent of a suicidal adolescent can be helpful in reducing a therapist's stress and in making the treatment more beneficial.[66]

Yet, there are four potential problems with allowing therapists to notify a parent that her child is potentially suicidal over the child's objection: (1) the possibility that suicidal adolescents might be deterred

---

61. Almost half of the young people who commit suicide are high on alcohol or other drugs shortly before their death. *See* STEPHEN A. FLANDERS, SUICIDE 31 (1991). *See also* CURRAN, *supra* note 3, at 32.

62. 428 U.S. 52 (1976).

63. *Id.* at 91.

64. *See, e.g.*, Joseph J. Cocozza and Henry J. Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976).

65. *See* CURRAN, *supra* note 3, at 146.

66. Clear and open communication with pertinent family members . . . broadens the base of responsibility. . . . In the event of a suicide, the therapist is able to provide support for the family . . . as well as share the loss with them as a fellow survivor. Family members can be remarkably supportive and appreciative of the therapist's efforts. MOTTO, *supra* note 6, at 106.

from seeking help; (2) the possibility that, even if adolescents seek help, they might not feel free to disclose their feelings, thus undermining the effectiveness of the therapy; (3) the inherent and offensive violation of the adolescent's privacy; and (4) the practical difficulties in applying the rule.

Because many suicidal adolescents have troubled family relationships, they might not want their parents to know they are seeking help. As discussed in Part II, however, the proposed rule would allow parental notification over a suicidal adolescent's objection only when the mental health professional, along with two other mental health professionals, determines that it is in the adolescent's best interest. Such a limitation should alleviate the concern that suicidal adolescents would be deterred from seeking help out of fear that their parents would be notified of their suicidal impulses.

Moreover, the traditional notions underlying the value of confidentiality for the adult psychotherapist-patient relationship may not be as appropriate to the adolescent psychotherapist-patient relationship. Even more than with adults, most adolescents who attempt suicide do not wish to die, but, instead are expressing their need for help to deal with their pain.[67] If notifying the parents helps the adolescent feel better, it is doubtful that permitting a therapist to contact the adolescent's parents would deter other adolescents from seeking such aid.[68]

In addition, the general gain to society derived from involving a parent in the treatment of the suicidal adolescent should outweigh any minimal deterrence resulting from such a policy. Mental health professionals agree that effective treatment of suicidal adolescents under most circumstances requires family participation in the adolescent's treatment.[69] Therefore, any slight deterrent effect from permitting a mental health professional to notify an adolescent patient's parents that the child is suicidal would be outweighed by the benefit of having more families participate in the treatment of their suicidal adolescent children.

One might also argue that even if a suicidal adolescent goes for help, knowledge that the parents could be notified of the adolescent's suicidal feelings would undercut the effectiveness of the therapy because the adolescent would not feel free to disclose suicidal feelings. Again, the fact

---

67. *See supra* note 13.

68. Indeed, the opposite may well be true. As discussed earlier, in *Eisel*, for example, where friends told the guidance counselor a child was involved in a suicide-murder pact, the child denied it and her parent was not notified. The child went through with the plan and was murdered. The guidance counselor's lack of action in trying to protect the child might well have deterred others from going for help and had the child been saved, more, not fewer adolescents, might have sought help.

69. *See supra* note 13.

that parental notification would not be permitted in those circumstances where it would be harmful to the adolescent should alleviate this concern. Those adolescents for whom notification would be beneficial will most likely not be as threatened by parental notification and might actually welcome the opportunity for improved communication with their parents.

Of more concern is the offensiveness of requiring a violation of the adolescent's privacy. A child who is suicidal is suffering greatly and is often ashamed of his or her inability to cope and of the suicidal feelings. To strip the child of the right to a private therapeutic relationship and to subject the child to possible humiliation by parents who may not be sympathetic to those suicidal feelings may be counterproductive and violate fundamental notions of privacy.

As will be discussed in Part III, however, the state has wide latitude in taking action to protect children. Most suicidal adolescents are acting out of great pain and not out of the desire to die.[70] Therefore, it does not appear appropriate to allow general notions of privacy to prevent society from taking measures that might help to save the lives of suicidal adolescents, particularly when the breach of the adolescents' privacy is only to their parents, not to others, such as teachers or peers.

Finally, although it is hard to determine when a teenager is potentially suicidal, and a rule permitting parental notification might encourage a mental health professional to err on the side of notifying a parent even when a child is not suicidal, over-notification should not be a problem.[71] If an adolescent does not demonstrate any of the signs of being potentially suicidal, parental notification would be inappropriate. If the adolescent demonstrates sufficient signs of being potentially suicidal to raise serious questions in the therapist's mind, parental notification would be appropriate. To the extent that a therapist errs on the side of parental involvement when the therapist determines that it would be in the adolescent's best interest, for all the reasons discussed above, there is no cause for alarm. To the contrary, more parental involvement with seriously disturbed teenagers would be beneficial to them and might, indeed, forestall a future potential suicide.

In summary, allowing a breach of confidentiality for any purpose has serious implications and must be done only for an extraordinary reason. The prevention of adolescent suicide is such an extraordinary reason. Suicidal adolescents are crying out for help. Often, their parents, troubled

---

70. *See supra* note 13.

71. A similar concern was raised in *Tarasoff*, in that, because it is hard to predict dangerousness to third persons, therapists might overpredict dangerousness to protect themselves. The California Supreme Court responded that that concern should be met by the fact that therapists will continue to be bound by the general standard of care in their profession. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976).

as they may be, as in Alana's story, are a source of help to the therapist. A rule permitting a mental health professional to notify the parents that their child is suicidal, over the child's objection, might save lives. This appears to be sufficient justification to limit an adolescent patient's right to confidentiality in this circumstance.

## II. The Implementation of a Parental Notification Exception for Suicidal Adolescents

The development of a legal rule permitting a mental health professional to breach a suicidal adolescent's right to confidentiality raises the following questions: (1) To which suicidal adolescents should the rule apply? (2) Which mental health professionals should be affected by the rule? (3) What standard should the rule provide?

First, the rule should apply to all suicidal minors who are empowered to consent to their own mental health treatment. Because the right of minors to consent to treatment varies greatly among states, each state adopting this rule would need to define the class of minors to whom it would apply.

Second, the rule should apply to all mental health professionals currently bound by rules of confidentiality.[72] Again, this group would vary greatly from state to state.

Third, the rule should provide that a mental health professional is permitted to notify a parent of an adolescent's suicidal impulses over the objection of the adolescent if the mental health professional has reason to believe that the child would benefit more from having the parent notified than from not having the parent notified.

Finally, in order to adequately protect the adolescent's interest in maintaining confidentiality, the rule should require that the treating mental health professional could notify the adolescent's parent over the adolescent's objection only if two other mental health professionals concur in this decision.

This provision would have several benefits. First, it would relieve the therapist of the stress of having total responsibility for the decision.[73] Although it would be a slight burden on the treating therapist, obtaining

---

72. Although there are unlicensed mental health professionals for whom this rationale would logically apply, unlicensed mental health professionals raise a variety of issues that are beyond the scope of this article.

73. One study indicated that losing a patient to suicide had such a profound personal effect on therapists that almost half of the therapists surveyed who had lost a patient reported symptoms of stress in the weeks following the suicide comparable to that of an individual who had lost a family member. *See* Bruce Bongar and Mort Harmatz, *Graduate Training in Clinical Psychology and the Study of Suicide*, 20 Prof. Psychol. Res. & Prac. 209, 211 (1989).

concurring opinions is consistent with the current practice of mental health professionals.[74] Second, this provision is preferable to providing for a judicial determination. It is not appropriate for judges, untrained in the dynamics of suicide, to make determinations about the treatment of suicidal minors.[75] Trained mental health professionals, experienced with the complex dynamics between suicidal adolescents and their parents, are most qualified to assess whether parental notification would be beneficial to the suicidal child.

In addition, having more than one therapist make this determination might ultimately help the relationship between the adolescent and her therapist, because the treating therapist would not be the only person responsible for going against the adolescent's wishes. Although there is a risk that the adolescent will feel mental health professionals are conspiring against him or her, and thus increase the adolescent's feelings of desperation and isolation, a caring therapist should be able to present the decision to involve the adolescent's parents in a way that will not antagonize the adolescent.

In summary, whether the rule is developed through the common law or by statute, each jurisdiction would have to tailor the rule to make it consistent with the jurisdiction's definition of the minor's capacity to consent to medical treatment, the jurisdiction's definition of confidentiality, and the jurisdiction's classification of persons to whom confidentiality applies. Nonetheless, because most jurisdictions do recognize a cause of action for a breach of confidentiality and the trend is to expand the right of minors to consent to treatment, it is a rule that would provide much needed clarification to mental health professionals in most jurisdictions.

---

74. Consultation is the customary practice among mental health professionals when dealing with difficult issues pertaining to suicidal patients. Telephone interview with Dr. Jed Lehrich (Aug. 5, 1992), a family therapist who treats suicidal adolescents on a regular basis.

75. The Supreme Court has recognized the appropriateness of having mental health professionals make determinations based on their particular expertise. In Youngberg v. Romeo, 457 U.S. 307 (1982), for example, the Court noted that judges and juries are not equipped to make the kinds of decisions that mental health professionals are equipped to make. *Id.* at 322-23.

*Romeo* dealt with the issue of whether due process requires a mentally retarded person, involuntarily confined by the state, be provided with safe conditions of confinement, freedom from bodily restraint, and training or habilitation. The Court established that Romeo retained a liberty interest in safety and freedom from bodily restraint which required habilitation. In determining what training was reasonable, the Court emphasized that courts must show deference to the judgment exercised by a qualified professional. *Id.* Indeed, Justice Powell stated that a decision made by a professional is presumptively valid and the professional can only be liable when the decision by the professional is a substantial departure from accepted professional judgment. *Id.* at 323.

## III. The Constitutionality of a Parental Notification Exception for Suicidal Adolescents

As adolescents become increasingly empowered to determine the course of their treatment, it would appear that the choice of whether to involve the parents in treatment would be the minor's choice. An examination of the current state of constitutional law reveals, however, that a government-imposed rule allowing parental notification over a suicidal minor's objection would pass constitutional muster if notification would not be allowed when it would be harmful to the child.[76] Parents have a strong liberty interest in making decisions regarding the upbringing of their children. In addition, the United States Supreme Court has permitted substantial infringements of the two constitutionally recognized rights of minors to determine their own treatment.[77] Finally, any developing constitutional rights of minors to determine their own treatment would be outweighed by the state's strong interest in protecting minors and preventing adolescent suicide. Thus, the only constitutional constraint on parental notification would be the state's *parens patriae* interest in protecting children from harm.

### *A. The Constitutionally Grounded Parental Interest in Making Decisions Regarding a Child's Upbringing*

The Supreme Court first recognized a right of parental autonomy over the family in *Meyer v. Nebraska*.[78] In *Meyer*, a state court convicted a teacher who taught German to a ten-year-old child in violation of a state statute forbidding the instruction of modern languages to children below the ninth grade. The Supreme Court found that the statute violated the parents' liberty under the due process clause.[79] In defining liberty, the Court emphasized that liberty included not only the right to be free from bodily restraint, but also embraced those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men, including the right of parents to establish a home and bring up their children.[80] According to the Court, education and the acquisition of knowledge were matters of supreme importance and the statute unjustifiably violated a parent's right to control her child's education.[81]

---

76. *See supra* note 17.

77. *See* Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992); Parham v. J.R., 442 U.S. 584 (1979).

78. 262 U.S. 390 (1923).

79. *Id.* at 403.

80. *Id.* at 399.

81. *Id.* at 400-03.

A parent's right to direct his or her child's education was again recognized a few years later in *Pierce v. Society of Sisters of the Holy Names of Jesus and Mary*,[82] in which the Court enjoined enforcement of a statute requiring parents to send children between the ages of eight and sixteen to a public school. In holding that the statute unreasonably infringed upon a parent's liberty interest, the Court stated: "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."[83]

Years later, in *Wisconsin v. Yoder*,[84] the Supreme Court once more acknowledged the importance of the parents' right to direct the upbringing and education of their child. In *Yoder*, the Court upheld a challenge by Amish citizens to a compulsory education statute as violative of the Free Exercise Clause of the First Amendment. In so doing, the Court emphasized its holding in *Pierce* that the right of parents to direct their child's upbringing and education during the child's formative years has a "high place in our society"[85] and held that Wisconsin could not require members of the Amish Church to send their children to public school after the eighth grade.[86] The Court noted the adequacy of Amish education methods, the sincerity of Amish religious beliefs, and the interrelationship between Amish beliefs and the preservation of the Amish way of life.[87] It concluded that the state's interest in requiring one or two more years of education for Amish children was outweighed by the right of the parents to raise their children according to Amish customs.[88]

A rule allowing parents to be notified that their child is suicidal is consistent with the parents' liberty interest in caring for their child. As the Court indicated in *Parham v. J.R.*,[89] discussed below, the parents' liberty interest in caring for their child includes a "high duty" to recognize symptoms of illness and to seek and follow medical advice.[90] To care for a child's emotional well-being is certainly a "[privilege] long recognized at common law as essential to the orderly pursuit of happiness by free men."[91] Thus, the parental liberty interest is a strong constitutional basis for a parental notification rule.

---

82. 268 U.S. 510 (1925).
83. *Id.* at 535.
84. 406 U.S. 205 (1972).
85. *Id.* at 214.
86. *Id.*
87. *Id.* at 216-17.
88. *Id.* at 218.
89. 442 U.S. 584 (1979).
90. *Id.* at 602.
91. Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

### *B. The Power of the State to Substantially Infringe upon a Minor's Physical Liberty Interest and Reproductive Rights*

Traditionally, the only protection that children had against absolute control by their parents was the state's exercise of its *parens patriae* power. In recent years, however, as discussed below, the United States Supreme Court has recognized that children do have some independent rights, including the right not to be unnecessarily confined and the right of a female to make choices regarding whether to bear a child. The Court has not treated these rights as fundamental rights but, rather, as significant rights that can be substantially curtailed because of the youth and inexperience of minors.[92] Presuming that a parent will act in the best interest of her child, the Court has allowed state curtailments of these rights that have required significant parental involvement in a child's treatment.

In *Parham v. J.R.*, the Court recognized that minors have a substantial liberty interest in not being confined unnecessarily for medical treatment. However, it rejected a claim that Georgia's psychiatric commitment statute was unconstitutional because it provided for parental commitment of a child without a formal hearing and based simply upon an independent psychiatrist's concurrence. The Court stressed the importance of the parents' role in determining their child's medical treatment. The Court agreed that the nature of the commitment decision is such that parents cannot have absolute and unreviewable discretion to decide whether to institutionalize a child. Nonetheless, it ruled that absent a finding of abuse or neglect, the parent should retain a substantial, if not the dominant, role in the commitment decision.[93] In allowing parents this power, the Court reasoned that the law's concept of family rests on the presumption that parents possess what a child lacks in the maturity, experience, and capacity for judgment that are required for making life's difficult decisions.[94] In addition, the Court noted that natural bonds of affection generally lead parents to act in the best interests of their children.[95]

The great latitude that *Parham* gives to states to infringe upon a minor's physical liberty interest, by providing parents with a substantial role in the decision as to whether to commit a child, indicates that a rule allowing parental notification when an adolescent is suicidal would be constitutional. The children in *Parham* were emotionally ill, not suicidal; yet the Court allowed the state to substantially infringe upon their right of physical liberty because the Court presumed that a parent would not seek to commit a child unless it was in the child's best interest. Similarly,

---

92. *See infra* text accompanying note 98.
93. 442 U.S. at 604.
94. *Id.* at 602.
95. *Id.*

a court would most likely presume that, if a parent were notified that his or her child was suicidal, the parent would take steps to help the child. A court would, therefore, allow this infringement on the minor's right to determine his or her own treatment.

As with a minor's right to physical liberty, the Court, although recognizing a female minor's right to determine whether or not to bear a child, has allowed substantial restrictions on that right.[96] Again, the Court has allowed these restrictions based upon its concern about minors' lack of experience, lack of ability to make a healthy decision for themselves, and the presumption that parents will act in their child's best interest.

There is no question that a minor's privacy interest encompasses a decision as to whether or not to bear children.[97] Nor is there a question as to the constitutionality of a provision requiring parental consent, as long as there is an alternative procedure provided to the minor to avoid the need for parental consent in appropriate cases.[98] The more recent questions with which the Court has struggled have pertained to the nature of the alternative procedure that must be provided.

In *Bellotti v. Baird*,[99] a plurality made clear that a minor's liberty interest is not violated by a statute requiring parental notification if the statute has a "bypass" procedure that allows the minor to establish that she is mature enough to make her own decision regarding whether to have an abortion.[100] The Court struck down a Massachusetts statute that required parental consent for any unwed female under the age of eighteen to obtain an abortion. In striking down this statute, the Court emphasized three distinct reasons for justifying an infringement of a minor's rights: "the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing."[101] The Court also noted, however, the distinct nature of the abortion decision and ruled that a state that requires parental notice or consent for minors to obtain abortions must provide an opportunity for minors to go directly to court without first consulting or notifying their parents and, if the minor establishes that she is mature enough to make her own decision, the parental consent requirement must be waived.[102]

---

96. *See* Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992); Ohio v. Akron Center for Reproductive Health, 110 S. Ct. 2972 (1990); Bellotti v. Baird, 443 U.S. 622 (1979).

97. *See* Planned Parenthood v. Danforth, 428 U.S. 52, 74-75 (1976).

98. *Id.*

99. 443 U.S. 622 (1979).

100. *Id.* at 643-44.

101. *Id.* at 634.

102. *Id.* at 643-44. The statute in *Bellotti* provided that if one of the minor's parents

The degree of complexity that the Court has allowed in "bypass" procedures indicates once more, however, the court's willingness to allow states to infringe upon a minor's liberty interest. In *Ohio v. Akron Center for Reproductive Health*,[103] the Supreme Court held that a statute, which the appellants argued created substantial impediments to the minor's right to a bypass procedure, was constitutional.[104] The court of appeals had held the statute was unconstitutional because the "bypass" procedure was inadequate.[105] The majority of the Supreme Court disagreed. The Court rejected, for example, the appellee's constitutional challenge to placing the burden on the minor of proving by clear and convincing evidence that she was mature enough to make her own determination regarding the abortion, or that it was in her best interest to have the abortion. The Court reasoned that it was appropriate to require a heightened standard of proof because the bypass procedure was an *ex parte* proceeding at which no one opposed the minor's testimony.

In the most recent Supreme Court decision, *Planned Parenthood v. Casey*,[106] the Court again made clear the limited nature of a minor's liberty interest by upholding a parental consent provision with a judicial "bypass" within a general law that provided for informed consent. The statute at issue provided that, except in a medical emergency, at least twenty-four hours before performing an abortion, a physician must inform the woman of: (1) the nature of the procedure; (2) the health risks of

---

refused consent, the abortion could be obtained by order of a judge "for good cause shown." *Id.* at 644. The Massachusetts Supreme Court, however, had interpreted the statute to mean that the minor must first seek the consent of her parents and, only if one of her parents refused consent, could she then go to a court for permission to have the abortion. *Id.* at 646.

103. 110 S. Ct. 2972 (1990).

104. *Id.* at 2983. The "bypass" procedure required the minor to file a complaint in the juvenile court, stating that she had sufficient maturity and information to make an intelligent decision whether to have an abortion or that one of her parents had engaged in a pattern of physical, sexual, or emotional abuse, or that notice was not in her best interests. The minor was also required to state that she was pregnant, unmarried, under eighteen and emancipated, desired to have an abortion without notifying one of her parents, and whether she had retained an attorney.

In order to file a complaint, a minor had to select one of three forms: one alleging that she was mature enough to make her own decision, another alleging that the abortion was in her best interest, and the third form alleging that she was mature enough to make her own decision and that it was in her best interest. The minor was required to sign the form and to provide the name of her parents on the form. Whether the minor alleged that she was mature enough to make the decision on her own or that an abortion was in her best interest, she had to prove her allegations by clear and convincing evidence. A closed hearing was to be held so that the anonymity of the complainant was preserved and all papers were to be kept confidential.

105. *Id.* at 2978.

106. 112 S. Ct. 2791 (1992).

abortion and of childbirth; (3) the probable gestational age of the unborn child; and (4) the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies that provide adoption and other services as alternatives to abortion.[107] In addition, the law provided that an abortion could not be performed unless the woman certified in writing that she had been informed of the availability of these printed materials and had been provided with a copy if she wished to see them. The parental consent provision required that one parent of a pregnant minor also receive such information and that both one parent and the minor give informed consent to the procedure.

In upholding the parental consent provision of this statute, the plurality opinion held that the only difference between this and previously upheld parental consent provisions was that it required that parental consent be informed in a very specific sense.[108] The Court held that the same reasons justifying the imposition of informed consent generally were applicable to minors.[109] Indeed, according to the Court, they applied even more so because the waiting period, for example, might provide the parents of a young woman with the opportunity to consult with her in private and to discuss the consequences of her decision in the context of the values and moral or religious principles of her family.[110]

These abortion cases make clear that the state can impose substantial restrictions on a minor's exercise of her right to determine her medical treatment. Although many of the restrictions imposed on minors desiring abortions have to do with protection for the fetus, the reasoning upholding restrictions in the abortion cases rely primarily upon the minor's inexperience and lack of judgment in making such critical decisions. Abortion is obviously less irrevocable than suicide because the adolescent who chooses to abort will go on with her life and typically will still be able to bear children in the future. It appears, therefore, that greater restrictions on the right of a suicidal minor to determine her treatment would be tolerated and that a parental notification provision for suicidal adolescents with a "bypass" procedure would be constitutional.

### *C. The Power of the State to Regulate a Minor's Developing Right to Determine His or Her Own Medical Treatment*

Although the Supreme Court has explicitly recognized the constitutional rights of minors to determine their treatment only in the areas

---

107. *Id.* at 2823.
108. *Id.*
109. *Id.* at 2832.
110. *Id.*

of physical liberty and reproductive rights,[111] many states have recognized by statute the rights of minors to determine their treatment in other areas.[112] Assuming that the Court were to find that these rights are constitutionally based, an analysis of the existing right-to-determine-treatment cases makes clear that the right is not absolute and that the state's interest in preventing adolescent suicide would outweigh any privacy interest the suicidal adolescent has in not having her suicidal impulses disclosed to her parents.

The cases concerning a patient's right to control medical treatment generally arise when a patient seeks to refuse a recommended course of medical treatment. The court decisions whether to allow a patient to refuse treatment follow a two-step process: (1) the court must determine whether the patient is competent to make the decision and, if not, who is to make the decision for her; and (2) the court must weigh the patient's interest in determining the course of her medical treatment against the state's interest in insisting the patient be treated.

As demonstrated below, the courts generally take two approaches to the determination of whether to allow a patient to refuse treatment: (1) If the patient is competent, the court will usually defer to her wish to refuse treatment if it can distinguish honoring her preference from the sanctioning of suicide; and (2) If the patient is not competent to determine her treatment, the court will balance the patient's prognosis and the intrusiveness of the treatment involved with the state's interest in preserving the life of the patient.

The wish of suicidal adolescents not to involve their parents in their treatment is tantamount to a wish to refuse treatment. Although courts use a variety of tests to determine whether patients are competent, most of them include at a minimum, the patients' appreciation of the con-

---

111. The only Supreme Court decision thus far dealing with a minor's right to contraception has followed the same kind of significant state interest analysis as the abortion cases. In Carey v. Population Serv. Int'l, 431 U.S. 678 (1977), the Court, in a plurality decision, struck down a New York statute prohibiting the distribution of contraceptives to those under sixteen except by a physician in the course of practice. *Id.* at 691. The state contended that the statute was constitutionally permissible as regulation of the morality of minors and in furtherance of the state's policy against promiscuous sexual intercourse. The plurality opinion held that the right of privacy extends to minors as well as to adults and that the state did not have a significant state interest in denying minors access to contraception. *Id.* at 693-94. Justice Brennan, writing for the plurality, compared the interest of the state in the mental and physical health of the pregnant minor and in protection of potential life in the abortion decision to the area of contraceptives. *Id.* at 694. He stated that since those interests are clearly more implicated in the abortion decision a blanket prohibition of the distribution of contraceptives to minors was a fortiori closed. *Id.*

112. *See supra* note 19.

sequences of their decision and an understanding of the alternatives available to them. The emotional state of most suicidal adolescents would preclude them from meeting this standard and, therefore, a suicidal adolescent would not likely be considered competent to determine appropriate treatment.

Courts have used five common tests to determine whether a person is competent to make decisions regarding one's medical treatment:[113]

> The test most deferential to patient autonomy requires an individual merely to articulate a treatment choice. . . . A second test, frequently employed by medical and legal professionals, compares the patient's decision to the choice a reasonable person would make under similar circumstances. If the patient's decision seems unreasonable, then he or she is deemed incompetent . . . . The third test "examines the reasons for an individual's decision to accept or refuse treatment. . . . [A] person who gives rational reasons for his or her decision is competent, while one whose decision is 'due to or a product of mental illness' is incompetent."[114]

Finally, the fourth and fifth tests focus on the patient's ability to engage in the decisionmaking process, one measuring competence by the individual's apparent ability to understand generally the facts important to the treatment decision and the other questioning the patient's understanding of the specifics regarding the particular treatment in question.[115]

Courts applying the fourth and fifth tests have deemed patients competent even when there was evidence of some lack of proper mental functioning. For example, in *Lane v. Candura*,[116] the court judged a person competent who did not want to have her leg amputated. The court found that her testimony demonstrated lucidity on some matters and not on some others but that she did demonstrate a full appreciation of the consequences of the decision of whether to have her leg amputated and, therefore, was competent to make the decision.[117]

The only one of the above tests that the suicidal adolescent would satisfy is the first, the articulation of a treatment choice. However, given the state's strong interest in preventing suicide, a court would probably not apply this test to determine the competence of a suicidal adolescent

---

113. See discussion of Roth, Meisel, and Lidz's analysis of these tests in Rebecca Dresser, *Article and Commentary on Anorexia Nervosa: Feeding the Hunger Artists: Legal Issues in Treating Anorexia Nervosa*, 1984 WIS. L. REV. 297, 349.

114. *Id.* at 349-51.

115. *Id.* at 351-52.

116. 376 N.E.2d 1232 (Mass. App. Ct. 1978).

117. *Id.* at 1235-36.

to make decisions regarding her treatment. Instead, there is a greater probability that a court would apply one or more of the other competency tests. If so, the court would most likely make one or more of the following determinations: (1) a reasonable person would not choose to exclude her parent from participating in her treatment if the parent's participation might help to save her life; (2) the suicidal adolescent's reasons for wishing to exclude her parents are not rational but the product of emotional illness; or (3) the impairment of the suicidal adolescent's mental functioning unlike, for example, the patient in *Lane*, is causing her to not fully appreciate the consequences of her actions.[118]

Moreover, even if a court were to find a suicidal adolescent competent to make a decision to refuse treatment, as discussed *infra*, the right to refuse treatment is not absolute. To the contrary, it involves a balancing of the patient's autonomy interest with the state's interest in protecting the patient and others. The state's interest in protecting the suicidal adolescent, the family, and others who would be affected by the suicide would most likely outweigh the suicidal adolescent's autonomy interest. Although the Supreme Court has not considered a case where a competent patient has wished to decline medical treatment, in *Cruzan v. Missouri Department of Health*,[119] a case dealing with the right of an incompetent patient to refuse treatment, the Court has addressed the right of competent patients to refuse treatment. The Court stressed that a competent patient's right to refuse treatment is not absolute and summarized the four state interests to be considered in determining whether to honor the wish of a competent patient to decline life-sustaining treatment: (1) preservation of life, (2) prevention of suicide, (3) safeguarding of the integrity of the medical profession, and (4) protection of innocent third parties.[120] The Court noted that, in cases that do not involve the protection of the actual or potential life of someone other than the decision-maker, the state's interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of her own life.[121]

---

118. There are many similarities between anorectic and suicidal adolescents and the issues pertaining to their competence to refuse treatment are analogous. *See* Dresser, *supra* note 113, at 347-49.

In a recent New Jersey case, the parents of an anorectic petitioned the court to declare their nineteen-year-old daughter incompetent so that they could have the authority to compel her to be treated. The petition was granted. Robert Hanley, *Parents File Suit to Battle 19-Year-Old's Anorexia*, N.Y. TIMES, July 18, 1992, at L29.

119. 110 S. Ct. 2841, 2851-52 (1990) (recognizing that both competent and incompetent patients have a liberty interest in making decisions regarding their medical treatment).

120. *Id.* at 2847-48.

121. *Id.* at 2847.

Before allowing a competent patient to refuse treatment, however, state courts have carefully weighed the patient's strong autonomy interest against the state interests summarized in *Cruzan*. *In re Farrell*,[122] for example, is a landmark case on the right of a competent patient to refuse life-sustaining treatment even if the refusal to maintain the treatment will result in her death. Ms. Farrell was a thirty-seven-year-old woman suffering from amyotrophic lateral sclerosis (ALS), often known as Lou Gehrig's disease. At the time of diagnosis, a victim's life expectancy, even with the life-sustaining treatment, was usually one to three years and there was no available treatment or cure. After she became ill, Ms. Farrell was admitted to a hospital where she underwent a tracheotomy and was connected to a respirator. When the hospital could provide no further help for her condition, she was returned home. She was paralyzed, confined to bed, and needed around-the-clock nursing care.

Ms. Farrell's husband petitioned the court to appoint him special medical guardian for his wife with specific authority to disconnect her respirator. A trial was conducted at Ms. Farrell's home. She testified that she had discussed her decision to withdraw the respirator with her husband, sons, parents, sister, and psychologist and that she had discussed the consequences of her decision with a respiratory specialist. She decided to disconnect her respirator because she was tired of suffering. The psychologist testified that the decision was not the result of a mere whim, but based on weekly discussions she had been having with Ms. Farrell over a six-month period.

The New Jersey Supreme Court distinguished allowing Ms. Farrell to disconnect her respirator from suicide in that her refusal of medical intervention merely allowed her disease to take its natural course.[123] If death were to occur eventually, it would be the result of the underlying disease, not of a self-inflicted injury.[124] The court further held that medical ethics created no tension in this case because the court's review of well-established medical authorities gave unanimous support to the right of a competent and informed patient such as Ms. Farrell to decline medical treatment.[125] Finally, the court noted that her children would not be harmed by the decision in that Mr. Farrell's capacity to care for them was unquestioned and she based her decision in part upon her recognition that her medical condition had already put the children under extreme stress.[126]

---

122. 529 A.2d 404 (N.J. 1987).
123. *Id.* at 411 (quoting *In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985)).
124. *Id.*
125. *Id.* at 411-12.
126. *Id.* at 413.

Even if a suicidal minor were considered competent to determine her own course of treatment, application of the state interests discussed above makes clear that the state's interest in protecting adolescents from suicide would outweigh the adolescent's right to refuse parental participation in her treatment for several reasons.

First, the state's interests in preserving the life of a suicidal adolescent and in preventing her suicide are particularly strong because most suicidal adolescents do not wish to die[127] and are not able to understand the consequences of the suicidal act. In fact, the state would only be temporarily depriving the minor of any right to kill herself. Unlike the abortion situation, where intervention can only occur up to a specific time, a minor would always be able to take her life later.

Second, a provision allowing mental health professionals to notify the parents of a potentially suicidal adolescent patient that their child is suicidal would be consistent with the training[128] and the needs of mental health professionals.[129]

Third, the impact of an adolescent's suicide greatly affects the people around the adolescent.[130] Family members are deeply affected by the loss, as are other adolescents who are susceptible to the contagion of suicide. Therefore, the protection of the rights of others is implicated. In *Farrell*, in which there was a father who was willing and able to take care of the two mature children, in which the children had watched the mother's health decline and had seen her suffer, and in which the children were consulted about the mother's wish to remove her life sustaining support, the court reasoned that the mother's refusal of treatment would cause no harm to her children.[131] With suicide, the opposite is true. Those left behind will have had no opportunity to be aware of the adolescent's struggles and to be consulted on the effect of those struggles on themselves.

In addition, those adolescents who are not family members but who are profoundly affected by the suicide of another adolescent must be

---

127. *See supra* note 13.

128. "Once the patient's suicidal thoughts are shared, the therapist must take pains to make clear to the patient that he, the therapist, considers suicide to be a maladaptive action, irreversibly counter to the patient's sane interests and goals; that he, the therapist, will do everything he can to prevent it . . . . It is equally essential that the therapist believe in the professional stance; if he does not he should not be treating the patient within the delicate human framework of psychotherapy." Harvey M. Shein, M.D. & Alan A. Stone, M.D., *Psychotherapy Designed to Detect and Treat Suicidal Potential*, 125 AM. J. PSYCHIATRY 1247, 1248-49 (1969).

129. CURRAN, *supra* note 3, at 146.

130. Stress on relatives can lead to physical exhaustion, migraines, hypertension, ulcers and even death. It almost invariably has a traumatic impact on parents. *See* FLANDERS, *supra* note 61, at 39.

131. 529 A.2d at 413.

considered. The death of a woman such as Ms. Farrell, who suffered from Lou Gehrig's disease, is a tragic loss to her family but an understandable one which a family can ultimately accept. It has no negative effect on society. The death of a physically healthy youngster through suicide, on the other hand, can have a traumatic and, indeed, deadly effect not only on her family but on many other vulnerable adolescents. Therefore, it strongly affects third parties and the state has a strong interest in taking measures to prevent this kind of death.

Thus, even if a suicidal adolescent were considered competent, the chances are extremely small she would have the right to refuse treatment. As demonstrated below, the chances are even smaller if the adolescent were considered incompetent to determine her treatment. The decision as to whether to allow an incompetent person to terminate treatment is a balancing process that has arisen mainly in cases where persons are in states of extreme and irreversible physical deterioration. Courts have authorized the refusal of treatment only when the patient's prognosis for the future was dim and the burden of the treatment under consideration was great. With proper treatment, a suicidal adolescent can recover.[132] Moreover, the treatment necessary, although painful, is not burdensome in the same way that the treatments under consideration in the "right-to-die" cases have been burdensome. Therefore, a court most likely would not allow a judgment to be made on behalf of a suicidal adolescent that the adolescent, if competent, would wish to refuse treatment.

*Cruzan* is typical of the fact pattern of the cases in which courts have been faced with the wish of an incompetent patient to refuse medical treatment. Ms. Cruzan had been in a vegetative state for five years, and her doctors agreed there was no hope she would recover. Her parents had sought authorization to remove her feeding tubes and needed to prove that their daughter would have wished to terminate treatment if she were competent to make that decision. An issue before the Supreme Court was the standard by which the parents had to prove their daughter's intent to refuse treatment.[133] The Court held that states may require clear and convincing evidence of an incompetent patient's desire to withdraw life sustaining equipment.[134]

---

132. The path to recovery of one suicidal adolescent is presented in the story of Alana, *see supra* Introduction. In addition, a moving depiction of the recovery of a suicidal adolescent can be found in the 1980 film ORDINARY PEOPLE (Wildwood Enterprises 1980), which Curran describes as "brilliantly" portraying the struggle of a family to reintegrate a teenage son into the home following his hospitalization for a suicide attempt. CURRAN, *supra* note 3, at 88.

133. 110 S. Ct. at 2852.

134. *Id.*

Even when a state does not require clear and convincing evidence of a patient's desire to refuse treatment, similar considerations about the potential quality of the patient's life are taken into consideration when allowing the patient to refuse treatment. For example, in *In re Quinlan*,[135] a landmark case in which the New Jersey Supreme Court unanimously held that the right of privacy encompasses an incompetent patient's decision to decline medical treatment, the court allowed the parents and family of Karen Quinlan to determine that she would have wished to refuse treatment only after thoroughly balancing the interest of the state in preserving life against the interest of Ms. Quinlan in having the right to refuse medical treatment.[136] As a result of a coma, Ms. Quinlan was in a persistent vegetative state. The court noted that the state's interest weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.[137] The court acknowledged the state's interest in preventing suicide but distinguished between the self-infliction of deadly harm and the self-determination against artificial life support or radical surgery in the face of irreversible, painful, and certain imminent death.[138]

As to determining Ms. Quinlan's intent, the court held that Ms. Quinlan's guardian and family should determine whether she would exercise the right of privacy under these circumstances.[139] If the guardian and family decided Ms. Quinlan would wish to terminate her treatment, this determination should be accepted by a society, the overwhelming majority of whose members would, in similar circumstances, exercise such a choice for themselves or for those closest to them.

Applying these standards, if a suicidal adolescent were considered incompetent to decide whether to refuse treatment, a court clearly would not authorize the refusal of treatment for the adolescent. Suicidal adolescents can recover. The intrusiveness of the treatment required is

---

135. 355 A.2d 647 (N.J. 1976).

136. *Id.* at 663-64.

137. *Id.* at 664. The prognosis was that Ms. Quinlan would never resume cognitive life and the bodily invasion was great, including 24-hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter, and feeding tube.

138. *Id.* at 669-70. The court held that upon concurrence of Mr. Quinlan and the family of Ms. Quinlan, if the responsible attending physicians concluded that there was no reasonable possibility of her ever emerging from her comatose condition to a cognitive, sapient state, and that the life support equipment should be discontinued, they should consult with the hospital "Ethics Committee" or like body of the institution in which Ms. Quinlan was hospitalized. *Id.* at 671-72. If this body agreed that there was no reasonable possibility of Ms. Quinlan's ever emerging from her comatose condition, the life support system could be withdrawn without any criminal or civil liability on the part of any participant. *Id.* at 672.

139. *Id.* at 664.

relatively minor. In addition, the determination of a suicidal adolescent not to allow her parents to participate in her treatment even if her parents' participation might help to save her life is not a determination that would be made by most members of our society for themselves or for those closest to them.

### *D. The Exercise of the State's* Parens Patriae *Power as a Limit on Parental Rights*

As indicated in Part A of this section, at the same time that the Supreme Court has made clear that parents have a constitutionally protected interest in raising their children, the Court has also made clear that this interest is not absolute. To the contrary, the state's *parens patriae* interest in protecting children allows it to curtail the rights of parents when their actions are harmful to their child. Thus, allowing parental notification that an adolescent is suicidal should be constitutional if limited to those situations where the mental health professional has reason to believe that notification would be in the child's best interest.

In the landmark case *Prince v. Massachusetts*,[140] the Court made clear that the state in its role as *parens patriae* can restrict a parent's liberty interest, even when the parent's right of religious expression is implicated.[141] In *Prince*, the Court upheld the application of a law prohibiting the sale of merchandise in public places by minors to a nine-year-old child who was distributing religious literature with her guardian. The Court found that the state's interest in the health and well-being of young people was a significant secular end that justified the incidental burden on freedom of religion.[142] The Court stated unequivocally that the right to practice religion freely "does not include the liberty to expose the community or the child to communicable disease or the latter to ill health or to death."[143]

Although the Court has not issued an opinion in a case involving a parent's right to decide upon a child's medical treatment, it summarily affirmed a case that affirmed the reasoning in *Prince*. In *Jehovah's Witnesses v. King County Hospital*,[144] the district court upheld two Washington statutes pursuant to which several of the plaintiff's children had been declared wards of the court for the purposes of administering blood transfusions. Relying on *Prince*, the district court held that it was appropriate to curtail a parent's autonomy in order to protect the health

---

140. 321 U.S. 158 (1944).
141. *Id.* at 170.
142. *Id.* at 170-71.
143. *Id.* at 166-67.
144. 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968).

and well-being of her children, even when a parent's refusal to allow the blood transfusions was based on religious conviction.[145]

Thus, if the state determines that the parent's exercise of her liberty interest in directing the upbringing of her child is likely to be harmful to her child, the state's *parens patriae* power will prevail over the parent's liberty interest. Therefore, a rule providing for parental notification that an adolescent is suicidal only when notification to the adolescent would be beneficial to the child is within the state's *parens patriae* power and would be constitutional.

## IV. Conclusion

Suicide has touched most of us at one time in our lives. I remember my friend Suki, a wonderful, lively, shining young woman, whom I met the summer before I went to college. We were both starting colleges in the Boston area and I visited her at her school one day in the fall. She seemed upset, homesick, and concerned about how she was adjusting to her new environment. The next time I called her she was no longer at school. When I called her at home, her parents told me she had killed herself.

This happened almost thirty years ago and I see Suki's face before me as clearly now as I saw it then. I do not know if she went for

---

145. *Id.* at 504-05. Lower courts have followed the Supreme Court's lead in putting a child's health before a parent's right to carry out her religious beliefs in medical decisions pertaining to her children. In *In re* Sampson, 317 N.Y.S.2d 641 (N.Y. Fam. Ct. 1970); *aff'd*, 278 N.E.2d 918 (1972), for example, a New York family court held that, even though a mother's objections to the administration of a blood transfusion to her deformed son were founded on scripture and sincerely held, they must give way before the State's paramount duty to insure his "right to live and grow up without disfigurement . . . his right to live and grow up with a sound mind in a sound body." 317 N.Y.S.2d at 652. Similarly, in *In re* Willmann, 493 N.E.2d 1380 (Ohio Ct. App. 1986), the Ohio Court of Appeals ordered the state to remove a cancer-stricken child from his parents' custody temporarily so that he might undergo potentially life-saving chemotherapy: "[T]he faith of the parents . . . does not permit them . . . to expose [their son] to progressive ill health and death." *Id.* at 1389.

Unless it is clear that a child will benefit from a proposed treatment, however, courts generally will not usurp a parent's autonomy to make decisions pertaining to her child's health. Thus, in *In re* Phillip B., 156 Cal. Rptr. 48 (Cal. Ct. App. 1979), for example, the court was asked to impose surgery over the objections of the parents of a 12-year-old child who suffered from both Down's syndrome and a congenital heart defect. The child's cardiologist recommended corrective heart surgery. Without the operation, Philip faced a life of only 20 years at the most, during which the heart defect would increasingly impair his energy and finally lead to a bed-to-chair existence. With the surgery, Philip faced possible complications, including the risk of death. The California Court of Appeals held that the state must satisfy a "serious burden" in order to justify the abridgement of parental autonomy and that the burden had not been met given the risks of the operation. *Id.* at 51.

counseling. If she did, I do not know if the counselor had reason to believe she was suicidal. And, if the counselor had reason to believe she was suicidal, I do not know whether the counselor contacted her parents. However, my sense was that Suki never gave herself or her parents a chance to work through her pain and to help her to heal. Perhaps if she had done so, she might be alive today.