What About the Parents? The Ethics of Minor's Consent to Treatment

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On September 29, 2010, former California Governor Arnold Schwarzenegger approved the Mental Health Services for At-Risk Youth Act (Health and Safety Code 124260). As of January 1, 2011, minors can consent to outpatient mental health treatment/counseling if they are age 12 or older and deemed mature enough to participate intelligently in the treatment. The previous requirement that the youth also pose a risk of harming themselves or others (or are victims of child abuse) is no longer necessary. However, it is important to note that Health and Safety Code 124260 also stipulates that treatment of a minor "shall include involvement of the minor's parent or guardian, unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate." Although this directive may appear fairly straightforward, determining whether parental involvement is indeed "inappropriate" requires the treating clinician to consider a host of clinical and ethical issues. A comprehensive discussion of all of these issues is beyond the scope of this article; however, clinicians may find the following discussion useful when attempting to make this determination.

The General Principles of the APA Ethics Code (APA, 2002) may provide clinicians with an appropriate starting point. Utilizing the General Principle of Beneficence and Nonmaleficence, clinicians should consider when it might be helpful to the child to include the parents and when it might be helpful to the child not to include the parents. In uncomplicated situations, clinical judgment informs us that involving the minors' parent(s) has many potential benefits for both the child and the family. However, clinicians also need to ask themselves, when including or even notifying the parents would pose an undue risk of harm to the child (3.04). For example, in the case where a child has sought treatment due to physical abuse suffered at home, could contacting the parent in question put the minor at increased risk for more frequent or severe physical punishments? Similarly, in the case of sexual abuse, a parent may have warned of severe consequences if the child reported the abuse to others.

Even in the absence of behavior that constitutes "abuse," clinicians would be well advised to consider the less tangible emotional and psychological well-being of their clients. Utilizing the Principle of Fidelity and Responsibility, there may be times when parental involvement is counterproductive to the therapeutic goals and/or to the process of psychotherapy. For example, imagine a minor seeks treatment due to the emotional trauma of an intense custody dispute between his/her parents. In this scenario, how might including the parents complicate (or distract) from the target goals of treatment? Would/could the parents attempt to use the treatment as a way of forming a biased alliance with the child, or possibly even the therapist? Alternatively, what if, upon contacting the parents, one parent is open to the idea and the other is adamantly opposed? Could involving only one parent create an additional source of animosity within the divorce? How might this animosity play out at home for the child? Similarly, imagine that a minors' parents have a stigmatized view mental health treatment. In some cases, our clinical judgment may tell us that having little support for the treatment may be better than having a disruptive parent within it.

Once a decision is made about whether to include the parents, psychologists take reasonable steps to clarify at the outset of treatment who the patient is, the relationship the psychologist will have with each person (10.02a), and discuss the limits of confidentiality (4.02). Even in situations where the clinician decides to proceed with treatment without notifying the parents, a situation may arise that necessitates parental involvement. In some cases, parents may consent to the treatment but demand that the clinician share all information provided by the minor. Agreeing to such stipulations would be inconsistent with the standard to maintain confidentiality (4.01). In yet another scenario, imagine that the parent agrees to be involved in treatment with the expectation that they will be provided with ongoing therapy, by proxy. In these sorts of scenarios, it is important to note that 10.02b tells us that psychologists take reasonable step to clarify and modify, or withdraw, if called upon to perform potentially conflicting roles.

In conclusion, including the parents in the treatment of minor client is ultimately, a clinical *decision*, not a legal or ethical mandate. Excluding parents from a child's treatment is a significant decision. Clinicians would be well advised to consult with experienced colleagues, such as the members of the CPA Ethics Committee, the APA ethics code and proceed cautiously and thoughtfully when making this decision.

References

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060-1073.

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