Legislative Initiatives For Healthier Lives

A Collaborative Partnership:

The Health Law Institute

A Program of the Justice Resource Institute

And

Northeastern University School of Law

Law, Culture, and Difference Program

Law Office #2

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1 Introduction

This year's Law, Culture, and Difference Law Office #2 (LO) has continued the work of previous years' Law Offices in conjunction with the Justice Resource Institute (JRI), and the Health Law Institute (HLI), to investigate problems faced by homeless youth in Massachusetts. JRI is a not-for-profit Massachusetts based agency that provides treatment for children and adults with physical, emotional, or learning related needs. HLI, a program of JRI, provides advocacy services to JRI clients and primarily focuses on the needs of young adults and homeless youth, members of the gay and transgendered community, professional sex workers, and drug users. HLI clients are indigent and face significant barriers to much needed health and legal services. Although much of the information in this paper is generalizable to all minors, the research conducted by this LO, was guided by the plight of homeless and runaway youth.

One goal of this LO was to provide a comprehensive study of nationwide statutes that both positively and negatively affect homeless youth. From these models, this LO is able to make recommendations on how to guide future research. The future research may ultimately provide sound and reasoned recommendations that JRI, or other interested parties, can use in proposing new legislation that will more precisely focus on the best interest of youths affected by homelessness in the Commonwealth of Massachusetts.

1.1 Prior Law Office Work and Current Research

The prior LOs have done broad research on various aspects of the Massachusetts common law approach to emancipation and compared its approach to other states' common law or statutory models. In 1998-1999, LO #9 began preliminary research on the Massachusetts approach, examining policy perspectives from the Massachusetts legal community. In addition, they researched New York's common law approach, as well as the Minnesota, Connecticut, and California statutory models. In 1999-2000, LO #14 continued researching emancipation in Massachusetts, New York, California, and Minnesota, and began researching Wisconsin's

approach. Last year, LO #1 again continued prior research on the common law approach in Massachusetts, and conducted a more in-depth analysis of California's statute. LO #1 also introduced and analyzed Michigan's emancipation statute because of its narrow tailoring and formal procedures. Due to the negative field and legal research, and resultant analysis on emancipation, the prior LOs consistently recommended that HLI not focus on emancipation as an option. However, since HLI believes emancipation is an important objective, this LO continued to research and analyze federal and state case and statutory law, as well as interview professionals in the legal community, as well as service providers.

Continuing the three years of prior research, LO #2 examined jurisdictions throughout the United States. The information gathered focused on four substantive areas that address many of the needs of at-risk youth in Massachusetts. These areas include: emancipation; mature minors' ability to consent to health care; legal access; and shelter restrictions. LO #2 continued prior research in Arizona, California, Minnesota, and Michigan. Additionally, this year, research was conducted on the state of Alabama because of its consent to health care statute and Washington because of its shelter restriction laws. Both Alabama and Washington also have emancipation statutes. Further, in order to provide a more complete picture, the LO researched, compiled, and incorporated within this paper, charts that outline each jurisdictions approach to emancipation and the mature minor rule. These charts are located at the end of each respective section of this paper.

Homeless youths in Massachusetts are in a precarious position. Their adverse situations are compounded by the fact that confusion, inconsistencies, and ambiguities surround statutes aimed at helping them. Homeless youth are often too young to take advantage of a shelter without being reported to Department of Social Services (DSS), or they do not want to use a shelter for fear of being abused by older members. Many are "forced" to find refuge on the streets. Serious health problems often result from the lack of appropriate shelter. Generally, homeless youth under 18 have limited access to basic health services and are often unable to consent to their own general medical care. Additionally, minors in Massachusetts may be unaware of ways in which they can gain access to the legal system

for redress of their problems. As presented in the media, the choice of words and images depicting homeless youth is value-laden.[1] Rarely are homeless youth likened to "the kids next door," but rather are portrayed as being willfully homeless, "rebels," undisciplined, and not in the mainstream. Often, it is these images which shape our legislature's and judiciary's views of the problem,[2] which may preclude potential solutions. Therefore, another goal of this project is to alleviate these impediments by presenting a more accurate image of homeless youth as "average kids." By doing so, the LO hopes to encourage future legislation that will increase the rights of and protections for this population. In our own imaging of homeless youth throughout this paper, and for ease of reading, the LO uses feminine gender pronouns when referencing minors.

1.2 Constitutional Constraints

A substantial underpinning of laws affecting minors is the presumption that children are the property of their parents and, as a result, great deference is given to the parental/legal guardian role.[3] In a recent United States Supreme Court case involving visitation rights of children, "Justice Stevens reproached the plurality for suggesting that children are chattel."[4] In his dissent, Justice Stevens stated that parents often view their children with a possessory interest, writing, "parents serve the best interests of their children but – 'even a fit parent is capable of treating a child like a mere possession'."[5]

When minors are faced with the challenges of homelessness, their rights are often infringed upon, if not forgotten. However, a great deal of confusion and inconsistency in granting and confirming rights to homeless minors is a result of the vagueness of the law, because "[t]he issue of exactly what rights children have under the Constitution remains unclear."[6] There is

[1] Lucy A. Williams, *Article and Essay: Race, Rat Bites and Unfit Mothers: How Media Discourse Informs Welfare Legislation Debate,* 22 Fordham Urb. L.J. 1159, 1162 (1995).

[2] *Id.* at 1161.

[3] *Crocker v. Pleasant*, 727 So.2d. 1087 (Fla. 4th DCA 1999).

[4] 36 Harv. Civ.Rights-Civ. Libs. L. Rev. 225, 240 (2001), citing *Troxel v. Granville,* 530 U.S. 57, 120 S.Ct. 2054 (2000) (Stevens, J., dissenting) (suit of a mother to limit visitation rights of her children's' biological grandparents).

[5] *Id.* at 239, citing *Troxel v. Granville*, 530 U.S. 57, 120 S.Ct. 2054, 2071 (2000).

[6] Jay C. Laubscher, *Student Author, Note: A Minor of "Sufficient Age and Understanding" Should Have*

the additonal question of who will actually protect those rights. Further questions inherent in affording minors legal rights are: "[a]t what age should society first accord a child particular legal rights, [and] [a]t what age should society recognize a child to be autonomous for the purpose of making certain kinds of legal decisions."[7] Ironically, the very rights of a minor in question may not be represented in court, since minors often face obstacles in obtaining legal counsel for non-criminal matters.[8] The deeply rooted reluctance to "place protection of children above the liberties of biological parents and the policies of state legislators" underlies the legislature's and judiciary's hesitance to allow minors access to the legal system.[9] Also, some critics feel that granting counsel to minors would result in inconsistent application of law.[10]

1.3 Runaway and Homeless Youths

In addition to the legal problems inherent within possessing a minority status, many minors face insurmountable obstacles as a result of having run away. Many runaways become homeless, and homeless youths have a disproportionate share of health, emotional, and behavioral problems as compared to the general population. They may also have less access to sufficient resources or other appropriate services to obtain care.[11] Many runaway and homeless youth experience mental health problems, including depression, and many have contemplated or committed suicide.[12] "Homelessness in children produces chronic mental health and health problems and deficiencies in educational opportunities and abilities, and seriously undercuts

the Right to Petition For the Termination of the Parental Relationship, 40 N.Y.L. Sch. L. Rev. 565, 572 (1996).

[7]Martin Guggenheim, *Article: The Right To Be Represented But Not Heard: Reflections On Legal Representation For Children,* 59 N.Y.U. L. Rev. 76, 84 (1984).

[8]Laubscher, *supra* n. 7, at 575.

[9]36 Harv. Civ.Rights-Civ. Libs. L. Rev. 225, 251 (2001), citing Elizabeth Bartholet, *Nobody's Children: Abuse and Neglect, Foster Drift, and the Adoption Alternative*, 35-36 (1999).

[10]Guggenheim, *supra* n. 10, at 77; Alessia Bell, *Student Author, Public and Private Child: Troxel v. Granville and the Constitutional Rights of Family Members,* 36 Harv. Civ.Rights-Civ. Libs. L. Rev. 225, 274 (2001) (using best interest of child standard in legal proceedings has yielded "at best inconsistent results."

[11]*Id.*

[12]Emily Paradise and Robert Horowitz, *Runaway and Homeless Youth: A Survey of State Law*, ABA Center on Children and the Law, 2 (1994).

their ability to receive sufficient schooling to function as adults."[13] In addition, HIV, AIDS, and pregnancy are particularly weighty issues to homeless youth. Nationally, the pregnancy rate for 13-15 year-old homeless girls was 14%, while 13-15 year-old non-homeless girls had a pregnancy rate of only 1%.[14] Homeless youth also must make complex daily decisions that may irreversibly affect their futures. "[I]t is assumed that if homeless youths do not know where or when they will receive their next meal or bed, they are unlikely to be concerned about developing AIDS 5 to 10 years in the future."[15] Homelessness among youths is not a problem that may be fixed in the short term only. As youths move into adulthood, the lessons and trials of their past shape their, and our, future. As one expert stated, "[o]ur society is developing a rapidly increasing subgroup of homeless children who will become comparatively incompetent and ineffective adults."[16]

Considering the growing population of homeless youth and their never-ending need for services, minors are fortunate to have organizations like JRI to represent their interests. Although this and last year's LO attempted to identify the population and determine how many homeless or at-risk minors live in Massachusetts, this task is not easy. Tracking this population is made more difficult by the 24-72 hour federally-mandated reporting requirements.[17] According to the American Bar Association, it is estimated that approximately two million minors in the United States run away or become homeless annually. Also, each year, roughly 127,000 minors are forced out by their parents who wish to abdicate responsibility for their child's care.[18]

Why do minors run away? Research indicates that family problems, including psychological problems, alcoholism, drug abuse, depression, or a criminal history on the part of the parents are significant contributory factors.[19] Also, high levels of violence within families,

[13]Charles A. Kiesler, *Homelessness and Public Policy Priorities*, 46 American Psychologist No. 11, 1245 (November 1991).

[14]*Id.*

[15]Mary Jane Rotheram-Borus, Cheryl Koopman, Anke A. Ehrhardt, *Homeless Youths and HIV Infection*, 46 American Psychologist No. 11, 1188 (November 1991).

[16]Kiesler, *supra* n.13

[17]Report of LO #1, 2000-2001, pg. 4; Paradise and Horowitz, *supra* n.12, at 2.; 45 C.F.R. § 1351.18.

[18]Report of LO #1, 2000-2001, pg. 4; Paradise and Horowitz, *supra* n.12, at 2.

[19]Paradise and Horowitz, *supra* n.12; Carol Sanger and Eleanor Willemsen, *Minor Changes: Emancipating*

histories of neglect, sexual, or physical abuse[20] are common among runaway and homeless youth.[21] Indeed, some studies examining the link between abuse and this population have indicated that as many as 75% of runaways and homeless youth have suffered from some form of abuse.[22] Although this population generally runs away to escape violence, unfortunately, homeless and runaway youth often experience further violence, exploitation, and many turn to stealing, drug dealing, and/or prostitution in order to survive on the streets.[23]

The legal obstacles that runaway and homeless youth face in Massachusetts often prevents them from leading stable and healthy lives. One such obstacle is that Massachusetts lacks a statutory emancipation law. Without this law, these minors are generally unable to acquire basic life needs, including housing and employment, that will provide a foundation for transitioning successfully into adulthood.

2 Emancipation

2.1 Introduction

Among the alternatives that are available to redress some of the problems faced by homeless youth is emancipation. This area is of particular interest to JRI because Massachusetts does not currently have an emancipation statute. Emancipation may be viewed as a 'catch-all' concept that operates to provide minors with the aggregate set of options discussed throughout this paper. As such, the reader will find emancipation concepts woven into discussions of the mature minor rule, legal access and shelter restriction. The 'catch-all' nature of emancipation, however, reveals both its strengths and weaknesses.

Children in Modern Times, 25 U. Mich. J.L. Ref. 239, 288 (1992) (most participants in their longitudinal study of emancipated minors in California stated that familial conflict, including physical violence, "played a significant role" in their emancipation decision).

[20]The Statistical Abstract of the United States, 2001, reports that in 1998, 1,457,703 of the Massachusetts population was under 18 years old and there were 37,091 reports of child maltreatment. Of those reports, 27,559 were subject to substantiated or indicated maltreatment.

[21]Kristine Alton, *Part Ten: Rights of Children: Emancipation in San Diego County*, 11 J. Contemp. Legal Issues, 662 (2000).

[22]Paradise and Horowitz, *supra* n.12.

[23]*Id.*

2.2 Definition

Emancipation has been long recognized and has developed along two lines, judicially, also known as common law, and statutorily. While statutory emancipation is often viewed as being available only to minors, judicial emancipation is often only available to a parent. In jurisdictions throughout the country, being "emancipated" is a legal status a minor attains by either petitioning the court in accordance with statute, or by common law through the operation of certain events, such as marriage, entrance into active military service, and in some cases, parenthood. Once emancipated, minors have both the rights and obligations of adulthood because the legal barriers that often hinder minors who have not yet reached the age of majority have been removed. The rights conferred by statutory emancipation generally encompass the ability to legally enter into contracts and be financially and socially independent from parent(s) or guardian(s), as well as the ability to freely consent to medical care. The obligations imposed upon emancipated minors are also similar to those that adults must shoulder. Emancipated minors must be able to provide housing to shelter themselves and the means with which to support themselves financially. In most states, once a minor is emancipated, any parental obligation to support her financially is obliterated, including any financial help owed in the form of child support. Most states thus require the minor to show that she will be able to fulfill these obligations before the petition for emancipation is granted. In sum, emancipated minors are adults in the eyes of the law, and have most of the same rights and burdens as those who have reached the age of majority.

The importance of statutory emancipation was articulated by Judge Kuhn of the Delaware Family Court in a decision, where the court, "regardless of [an apparent] temptation to act," was forced to dismiss a petition for emancipation for lack of subject matter jurisdiction.[24] The court stated that:

> The impact of this decision leaves this Court, the child welfare agencies, and adolescents themselves in a difficult position. It is an unfortunate reality that there are adolescents who have homes to which they cannot return and parents

[24] *In the Matter of S.L. v. A. and Sh. L.*, 735 A.2d 433, 445 (Del. Fam. Ct. 1999).

> who do not or cannot provide for them in any meaningful way. These adolescents, therefore, become entangled in a void in a system that is not adequately equipped to serve them. In some cases, a Petition for Termination of Parental Rights may be filed by the Department, or by an agency, even when a child is sixteen or seventeen years of age. The prospects for adoption of a teenager, however, are remote.[25]

Recognition of the notion that children should have increased freedom is also evidenced by the proliferation of emancipation statutes across the United States within the last thirty years.[26] Currently, twenty-six states have either an emancipation statute, statutory scheme, or statutes by which minors may obtain majority status for a specific purpose, such as for a real estate purchase. For a complete look at the status of emancipation law throughout the United States, see the chart at the end of this section.

2.3 Issues

Emancipation provides a strong option for minors in that it provides them with the same level of legal and medical access as adults, as well as providing arguably greater access to housing, whether private or in the form of a shelter. On the other hand, much of the criticism of emancipation statutes elsewhere in the country focuses on the fact that emancipation is often initiated or encouraged by someone other than the minor, in most cases by her parents. Statutes which are not clear as to who can petition the court for emancipation or, conversely, make it clear that parents can initiate proceedings, open the door for those parents who wish to legally cut all ties and obligations to their minor children. This results in situations wherein minors are given responsibilities they neither asked for, nor are ready to handle. In addition, an important part of understanding the possible implications of creating a statutory emancipation process in Massachusetts is the problem of continued parental financial support. Any organization that wishes to implement an emancipation law

[25] *Id.*

[26] Bruce C. Hafen and Jonathan O. Hafen, *Article: Abandoning Children to Their Autonomy: The United Nations Convention on the Rights of the Child*, 37 Harv. Int'l L.J. 449, 457 (1996).

in the Commonwealth must be cautious and consider that changes in current law might result in homeless or at-risk minors getting less financial support from their parents.

Massachusetts and other states that do not have statutory emancipation laws, generally bar minors from being their own decision-makers because of the assumption that minors are incapable of making important legal decisions, while their parents are. In a perfect world, this may be true, however, the homeless and runaway population are most often unable to, or do not wish to contact a parent, and have managed to live independent of their parent(s). In cases where familial ties were broken and reunification is not possible, and when the minor is self-sufficient, emancipation may be beneficial, because it will grant them the same rights afforded to adults over the age of majority.[27]

2.4 Questions Presented

The Law Office's research addresses several questions with respect to emancipation:

- How is the "best interest" standard utilized when deciding emancipation or other matters involving minors? Is there utility in this standard?
- Are there ways to limit judicial discretion when making best interest determinations in emancipation proceedings while utilizing the "best interest" standard?
- What are the federal legal implications of continued enforcement of parental support for emancipated minors?
- Under federal law, can a child be a payee for her own child support?
- Under Massachusetts law, can the state enforce parental support of a minor who has been emancipated?

[27] Paradise and Horowitz, *supra* n.12, at 13-14.

2.5 Massachusetts Analysis

Introduction

Since the three prior Law Offices have performed considerable research on Massachusetts' common law approach to emancipation, this report will contain a brief summary of their findings that will serve as a backdrop for this year's discussion. However, the mature minor rule, legal access and shelter restriction will be discussed in greater detail later in this paper.

In Massachusetts, a minor may file a petition for emancipation with the Probate and Family Court in their county of residence. However, there is no statute, standard court procedure, or formal guideline for determining when emancipation is appropriate.[28] The burden of proof is on the minor to demonstrate to the court that she is her own best custodian.[29] Because most emancipation petitions are filed and granted by Probate or Juvenile Court, the cases are not available, thus analysis of the courts' rationales when considering emancipation petitions is not possible.[30] Emancipation is granted by the court on an individualized basis, using case precedent and "the best interest of the child" standard. However, the "best interest" standard allows the judiciary immense discretion in deciding whether to grant emancipation petitions, and case precedent does not provide much guidance because emancipation is rarely granted.[31]

A minor may become partially or completely emancipated.[32] In Massachusetts, a partially emancipated minor assumes adult status, but continues to receive financial support from her parents. Conversely, when a minor is completely emancipated, financial support from the parent is terminated.[33] In this state, complete emancipation is a rarity, and is generally found when an express agreement between the minor and the parent exists.[34] Because complete

[28]Report of LO #9, 1998-1999, p. 36.
[29]Report of LO #1, 2000-2001, p. 17.
[30]*Id.*
[31]*Id.*
[32]Report of LO #9, 1998-1999, p. 37.
[33]Paradise and Horowitz, *supra* n. 12, at 13 (providing a different definition of these two types: partial emancipation allows the emancipated minor to make only certain decisions whereas complete emancipation allows the minor to make all decisions independently).
[34]Report of LO #9, 1998-1999, p. 37.

emancipation terminates parental duty of support, many emancipation petitions are initiated by parents as a means to terminate their financial obligations.[35]

The lack of formal procedures to guide emancipation determinations, the potential termination of parental obligations to the minor, and the potential lack of maturity of the minor are reasons given by the judiciary for their unwillingness to grant emancipation petitions.[36] These valid concerns may be alleviated by examining and implementing characteristics of other states' statutes, particularly Michigan, and by specifying criteria that the petitioner must fulfill prior to the emancipation determination. Set criteria will reduce anxieties associated with determining whether the minor is mature enough to understand the rights and obligations that follow emancipation. These criteria are discussed in greater detail later in the paper.

Methodology

LO #2, has veered away from researching Massachusetts common law, and has instead focused on determining what standards of eligibility for emancipation might best serve minors, as well as recommending criteria for determining emancipation that are more narrowly tailored than the current "best interests of the child" standard. In doing so, and because a majority of the states with emancipation statutes also use this standard, this LO set out to find primary and secondary sources specific to emancipation. An exhaustive search on how the "best interest of the child" standard is used to determine emancipation was conducted within federal and state case law with the goal of producing an analysis used by a court in determining whether emancipation is appropriate or not. No informative case law was identified. Additionally, law review articles; psychological and sociological studies; books; and other similar authorities were searched to reveal how the "best interest of the child" standard may be used in connection with determining the appropriateness of emancipation, to no avail. However, court cases, law review articles, and studies interpreting this standard and how it is used in cases of adoption, custody, and visitation is readily available. Thus,

[35] *Id.*
[36] *Id.* at 37.

this discussion relies on those materials in addition to state statutes, discussed later in this paper, to make recommendations on how to more narrowly tailor the current "best interest" standard.

The available information leads the LO to conclude that an analogy may be made between emancipation, custody, and visitation with regard to the "best interest" standard. In these circumstances, each has the potential of terminating familial ties. Although research on adoption and termination of parental rights may appear most analogous to emancipation, this is actually not so. This is because adoption and termination of parental rights is often a lengthier process that requires careful deliberation by the participants, whereas emancipation is a "procedural snap."[37] Further, adoption usually implies infants, where emancipation most often deals with teenagers who are nearing the age of majority. Case law and law review articles involving visitation rights of grandparents and "best interest" determinations has also increased over the last few decades because of changes in family dynamics and the increased pressure on legislatures by the "increasingly influential generation of older Americans."[38] However, this research will not be incorporated into this discussion because this material generally involves disputes between the minor's parents and grandparents, and does not involve terminating ties between the minor and her grandparents.[39]

Utilizing the "Best Interest" Standard

> "Arbitrary decision, willful and lawless, is the enemy of liberty; but discretionary judgment is its essential servant."[40]

As previously stated, there is a dearth of available case law regarding emancipation that expound upon the courts' rationales when considering the "best interest" standard.

[37] Carol Sanger and Eleanor Willemsen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. Mich. J.L. Ref. 239, 247 (1992).

[38] Ross A. Thompson, Barbara R. Tinisley, Mario J. Scalora, Ross D. Parke, *Grandparent's Visitation Rights Legalizing the Ties that Bind*, American Psychologist, vol. 44, 1217-1222, 1219 (Sept. 1989); *see also Troxel v. Granville,* 530 U.S. 57 (2000).

[39] *See* Sanger and Willemsen, *supra* n. 37, at 319, for a discussion of how emancipation is similar to divorce.

[40] William Letwin as cited by Carl E. Schneider, *Symposium, One Hundred Years of Uniform State Laws: Discretion, Rules, and Law: Child Custody and the UMDA'S Best-Interest Standard*, 89 Mich. L. Rev. 2215 (1991).

Nevertheless, prior LOs have conducted interviews and located cases that do discuss judicial discretion and the "best interest" standard. LO #1 found that judges enjoy wide discretion in determining the best interest of a minor on a case-by-case basis. The Massachusetts Court of Appeals stated in *Matta v. Matta,* that determining the best interest of a child "is a subject peculiarly within the discretion of the judge,"[41] while the Massachusetts Supreme Judicial Court (SJC) stated in *E.N.O. v. L.M.M.*, that, "the 'best interest' standard is somewhat amorphous" and since the trial judge considers "the widest range of permissible evidence," appellate courts are apparently hesitant to second-guess a judge's discretionary determination.[42] These findings suggest that there is no set standard that judges use to make "best interest" determinations. A given judge's decision appears to be based on the evidence introduced and, perhaps to a large extent, her own personal beliefs, values, biases, and prejudices. Since the Massachusetts standard is so amorphous, an examination of how this standard is or is not defined by professionals is useful.

Criticisms of the "Best Interest" Standard

There is no consensus among legal professionals, either in general or in a particular case, as to what constitutes the child's "best interest."[43] However, although this standard and its meaning could be more explicitly stated, it provides the most useful standard for determining what it is in a minor's best interest.[44]

Despite its usefulness, criticisms of the "best interest" standard are numerous, and the recurring theme seems to be not only the lack of defined meaning but also the vast discretion of the judiciary in employing the standard.[45] Frequently, case law and statutes refer to the best interest standard without specifying how it is determined. Further, if specific factors are explicitly stated in statutes, no guidelines or definitions are provided for interpreting the criteria, nor is the criteria weighted to guide decision-makers as to which factors are more

[41] Report of LO#, 2000-2001, pg. 8; *Matta v. Matta,* 44 Mass. App. 946, 947 (1998)
[42] E.N.O. v L.M.M.," 429 Mass. 824, 828 (1999)(West 2001).
[43] Joan B. Kelly, *The Best Interest of the Child, A Concept in Search of Meaning*, Family and Conciliation Courts Review, Vol. 35, 377-387, 379 (Sage Publications, 1997).
[44] *Id.* at 377.
[45] *Id.*

important than others.[46] Another major problem with the current undefined "best interest" standard is that it is influenced greatly by the decision-maker's own psyche.[47] The decision-maker, in the instant case a judge, use her own "lens" when making judicial determinations, and likely allows her personal beliefs, experiences, or specialized knowledge of emancipation to influence her decision instead of deciding the petition on the basis of what is in the child's best interest.[48]

Similarly, the concept of the "best interest" standard has no objective content, and decision-making that utilizes open and flexible standards are often regarded as overreaching and arbitrary.[49] Illustrating this point, LO #1 found that many judges believe that no minor "could possibly know what is in his/her best interest."[50] Further, the reluctance of the courts to grant emancipation is seemingly based upon a presumption that in virtually all situations, minors should be in the custody of an adult, and on the assumption that familial relationships should be repaired and maintained.[51]

The Utility of the "Best Interest" Standard

Despite its drawbacks, the "best interest" standard is quite malleable and allows the judiciary to respond to changing situations, social mores, and values. This standard also offers the essential virtues of adaptability and flexibility.[52] Additionally, "our common law system appears designed to promote the exercise of discretion."[53] Decision-making under common law is designed to encourage doctrinal flexibility and also to enable judges to conform a rule to suit each particular case, thereby allowing fine distinctions to be made among individual cases to ensure that justice can be achieved.[54]

Moreover, because of the often imprecise language used in case and statutory law, not to

[46] *Id.* at 379-380.
[47] *Id.* at 384.
[48] Daniel A. Krauss and Bruce D. Sales, *Legal Standards, Expertise, and Experts in the Resolution of Contested Child Custody Cases*, Psychology, Public Policy, and Law, 843-879 (Dec. 2000).
[49] Schneider, *supra* n. 40, at 2221.
[50] Report of LO #1, 2000-2001, p. 17.
[51] *Id.* at 17-18.
[52] *Id.*
[53] Schneider, *supra* n. 40, at 2235.
[54] *Id.*

mention within the United States Constitution, discretion is necessary to interpret law.[55] It is virtually impossible for lawmakers to write a rule that will anticipate every problem the rule intends to solve.[56] Rules can malfunction and may have drawbacks.[57] Discretion allows a judge to deal with complex bodies of law, correct errors or omissions, promote the intent of the legislative body, and seek justice.[58] Further, issues of diversity, to which the United States has become increasingly more attentive to, may also be considered.

Despite the utility of discretion in decision-making, its ultimate legitimacy relies upon how closely it comports with the rule or law in question. Also, discretion is not as unbridled as it used to be. It is limited by a multitude of constraints, including case precedent and statutes.[59] Further, the child's "best interest" principle operates not exclusively to, but rather in conjunction with, case precedent, rights, rules of law, guidelines, and presumptions. This is important since laws are created by rule makers who are in a better position to decide what justice is because legislators are able to acquire a full range of information about problems and societal concerns. Laws also legitimize decisions, suppress differences of opinion, treat similar cases alike, and serve a planning function. This function allows people to know in advance how a case will likely be decided.[60]

While some argue for developing universal criteria for determining a child's best interest,[61] other influential critics do not. For example, one critic argues that state-prescribed views of a child's best interest is not acceptable, since it is impossible to develop a view that does not "mindlessly refer to the majority's [or the judge's] preferences."[62] While this criticism is valid, this standard is deeply rooted in American law and it is unlikely that the discretion afforded to the judiciary in making "best interest" determinations will be abolished.

[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] Schneider, *supra* n. 40, at 2246.
[60] *Id.*
[61] Kelly, *supra* n. 43.
[62] Schneider, *supra* n. 40, at 2221.

Limiting Judicial Discretion

Since the best interest standard is used in virtually every state to determine whether an emancipation petition should be granted, it's fair to state that judicial discretion and the determination of whether emancipation is in the child's best interest are inextricably linked.[63] Thus, ways of guiding the court in making "best interest" determinations has been explored and the relevant discussions may be found in each states' emancipation section of this paper.[64]

Specific criteria are necessary to assist the judiciary in determining when emancipation is in the child's best interest. Additionally, when a minor meets the criteria set by statute, judicial discretion is greatly limited and decisions based upon personal biases or prejudices is significantly reduced. Setting criteria that a minor must meet also forces the minor to educate themselves about the rights, responsibilities, and obligations of emancipation, and assists minors in successfully transitioning into adulthood. Specifically, a minor must understand what rights they do or do not have under federal and state law to continued child support once they are emancipated.

Continued Enforcement of Child Support

Federal Analysis

Another area of interest to our client is whether there exists any federal law that would preclude continued child support of an emancipated minor. The LO did not find federal case law that specifically addressed this issue. Since no federal case law was found and because Michigan is the only state that mandates continued child support payments after emancipation, its statute was examined to determine whether there had been a conflict with any federal statutes or regulations. There are only five published opinions in Michigan state courts that deal with the emancipation provision of Mich. Stat. Ann. § 772.4. Four of these cases provide little guidance in resolving the question presented, as they deal with non-court

[63]Paradise and Horowitz, *supra* n.12, at 14.

[64]Mich. Stat. Ann. § 722.4(a) (LEXIS L. Publg. 2001). For example, some statutes, such as Michigan's, specify the criteria that a minor must demonstrate in order for her emancipation petition to be granted.

ordered emancipation, or mention the statute only in string citations. One case establishes that child support should no longer be given under the emancipation statute once the child turns 18, in accordance with the Michigan Age of Majority Act.[65]

It is reasonable to infer from the minimal case law in Michigan and the lack of federal cases that no federal obstruction to an emancipation statute mandating continued child support payments exists.

Child Support and the Representative Payee

In addition, the LO's research revealed no federal statutes or regulations that preclude the minor from being the payee of her own child support, in the event that a statute mandates continued support. It would be very beneficial for next year's LO to investigate the history behind the provisions cited from the United States Code and the Code of Federal Regulations in order to further investigate this issue. On the issue of whether or not a minor can be her own payee, the federal statutes are silent. However, there are guidelines for state administration of support services and payment generally that give wide latitude to the states, dictating only very broad and minimal mandates. A State plan for child and spousal support must –

> (1) provide that it shall be in effect in all political subdivisions of the State;
>
> (2) provide for financial participation by the State;
>
> (3) provide for the establishment or designation of a single and separate organizational unit, which meets such staffing and organizational requirements as the Secretary may by regulation prescribe, within the State to administer the plan;
>
> (4) provide that the State will–

[65] *Smith v. Smith,* 447 N.W.2d 715 (1951)(the Michigan State Legislature amended its emancipation statute to reflect the change of age of majority from 21 to 18).

(A) provide services relating to the establishment of paternity or the establishment, modification, or enforcement of child support obligations, as appropriate, under the plan with respect to–

(i) each child for whom (I) assistance is provided under the State program funded under part A of this subchapter, (II) benefits or services for foster care maintenance are provided under the State program funded under part E of this subchapter, (III) medical assistance is provided under the State plan approved under subchapter XIX of this chapter, or (IV) cooperation is required pursuant to section 2015(l)(1) of title 7, unless, in accordance with paragraph (29), good cause or other exceptions exist;

(ii) any other child, if an individual applies for such services with respect to the child; and

(B) enforce any support obligation established with respect to–

(i) a child with respect to whom the State provides services under the plan; or

(ii) the custodial parent of such a child[66]

The only provisions that could be located that seem appropriate to JRI's needs are those surrounding the concept of 'representative payees,' who would receive the support payments in lieu of the parent and would in turn pass them on to the minor.[67] This scheme appears to

[66]42 U.S.C. § 654 (West 2002).
[67]42 U.S.C. § 1383 (West 2002).

be the most promising means of getting support paid to the minor without payment having to be filtered through one parent first. The intent behind the representative payee provision in the Social Security Act seems to be to provide those who are in institutions or other types of managed care facilities access to financial support and benefits. Although these broad categories do not specifically encompass the minors whom JRI wishes to serve, they also do not bar their qualification. In brief, the representative payee would receive child support payments, therefore making those payments available to the minor without the involvement of the parent(s). The representative payee could be "a community-based nonprofit social service agency licensed or bonded by the State" or a federal agency that has been established for that purpose.[68] As of now, it does not appear that JRI could serve as this payee, as it has no residential housing services or custodial relationship with minors. However, the Code specifically states that these non-profit groups will be given preference over government-run agencies.[69] It is not clear if the minor could be represented by a financial institution and have the support payments deposited directly into an account to which she has access. Federal law does not specifically preclude this option. There are several requirements that must be met by the payee before they are approved: "representative [must] establish, to the satisfaction of the Commissioner of Social Security, that–

(I) such individual poses no risk to the beneficiary;

(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest; and

(III) no other more suitable representative payee can be found."[70]

The provisions surrounding the representative payee are very detailed and include penalties for over- or underpayment, and outline legal remedies the payee has if the provisions are taken advantage of by the representative. The acute detail shows the statute's focus on the individuals who require payees, and places emphasis on these individuals' best interests in proscribing specific directives and guidelines for the representative. If Massachusetts elected

[68] *Id.*
[69] *Id.*
[70] *Id.*

to pass an emancipation statute that included a provision for child support, this would be a very viable and positive option for getting the support directly to the minors. Massachusetts would do well to rely on the rationale and structures promulgated by other states that include this as part of their statutes.

Massachusetts Analysis

Not surprisingly, Massachusetts state law provides little guidance on this same issue. However, cases dealing with support issues in matters of divorce may provide potentially useful information. Frequently, Massachusetts divorce settlements provide for child support until all children are emancipated. This is not statutorily required but is ordered by a judge based upon set guidelines (unless the parents settle out of court). One interesting rule that appears in Massachusetts divorce cases is that minors are not automatically emancipated at any particular age. Even when Massachusetts reduced its age of majority from 21 to 18, this did not mean that all people between the ages of 18 and 21 were thus emancipated. Divorce settlements that predicated child support on non-emancipation were still binding even after age 18 if the child was not emancipated. Given that legislators are willing to hold parents financially responsible past the age of majority, a good foundation for the argument exists that support should be continued to a statutorily emancipated minor.

Although Massachusetts law provides little guidance on the issue of continued support for emancipated minors, decisions in neighboring jurisdictions suggest that such a system could be implemented in the Commonwealth. In New York, for example, § 101(1) of the Social Services Law provides that the parent of a child under 21 who is a recipient of public welfare is responsible for the child's support. Courts have interpreted this provision to mean that parental support is required even when the minor is emancipated.[71] Further research by future law offices in neighboring jurisdictions, such as New York, is recommended since it is not within the scope of this years' project.

[71] *Henry v. Boyd*, 99 A.D.2d 382 (1984); *Bickford v. Bickford*, 389 N.Y.S.2d 430 (1976).

2.6 Emancipation State Chart

The following chart represents the status of emancipation in the respective states, including statute or case law references. This chart may be useful when proposing legislation for an emancipation statutory scheme in Massachusetts. Since this chart reflects research conducted in January, February, and March of 2002 by the Law Office, the authors encourage readers to seek current information in conjunction with utilizing this chart. Further, since this research was aimed at capturing specific state statute or case law, and depending upon how the inquiry is framed, additional information may be located elsewhere relevant to a minor's obtaining majority status. As such, the authors encourage readers to consider additional sources of information.

STATUTORY AND JUDICIAL EMANCIPATION OF MINORS IN THE UNITED STATES[a]

STATE	STATUTORY EMANCIPATION PROCEEDINGS	JUDICIAL EMANCIPATION
ALABAMA	Title 26, Chapter 13, Sections 26-13-1— 26-13-8	
ALASKA	Title 9, Chapter 55, Article 8, Section 09.55.590	
ARIZONA		*Tencza et al. v. Aetna Casualty and Surety Company*, 111 Ariz. 226; 527 P.2d 97 (1974)
ARKANSAS	Title 9, Subtitle 3, Chapter 26, Subchapter 1	
CALIFORNIA	Family Code, Division 11, Chapter 1, Sections 7000 — 7002; Chapter 2, Sections 7050 — 7052; Chapter 3, Article 1, Sections 7110 — 7111; Chapter 3, Article 2, Sections 7120 — 7123; Chapter 3, Article 3, Sections 7130 — 7135; Chapter 3, Article 4, Sections 7140 — 7143 Sections 7000 —7002	
COLORADO		*In re the Marriage of: Roal S. Robinson, Petitioner, and Lavelle S. Robinson, Respondent*, 629 P.2d 1069 (1981)

[a] This chart provides statutory schemes in the respective states that provide procedural bases upon which a minor may seek a judicial declaration of emancipated status. In the absence of a statutory scheme in a given state, a representative common law case with respect to emancipation is cited. Because not all states wish to confer upon minors the status of "emancipated," the cases cited in the "Judicial Emancipation" column are those that are demonstrative of those circumstances under which a court in the given state may find that emancipation of the minor has been or could be effectuated or, alternatively, demonstrate that the state restricts the status of minors, and is reluctant to find a minor, or allow a minor to be declared, emancipated. The Law Office has submitted in tandem with this report a reproduction of this chart and a corresponding appendix, in which all statutes and case law referenced in this chart have been compiled. That submission also contains important information as to the methodology employed, and the caveats of the chart. Thus, readers are encouraged to refer to those materials, as well.

STATE	STATUTORY EMANCIPATION PROCEEDINGS	JUDICIAL EMANCIPATION
CONNECTICUT	Title 46B, Chapter 815t, Part I, Section 150	
DELAWARE		*In the Matter of S. L., (date of birth 5/82), A Minor Child v. A. and Sh. L.*, 735 A.2d 433 (1999)
DIST. OF COLUMBIA		*Kuper v. Woodward*, 684 A.2d 783 (1996)
FLORIDA	Title XLIII, Chapter 743, Sections 743.0 — 743.09[b]	
GEORGIA		*Street v. Cobb County School District*, 520 F. Supp. 1170 (1981)
HAWAII	Division 3, Title 31, Chapter 577, Section 25[c]	
IDAHO		*Embree v. Embree*, 85 Idaho 443; 380 P.2d 216 (1963)
ILLINOIS	Chapter 750, Sections 30-1 — 30-11	
INDIANA	Title 31, Article 34, Chapter 20, Section 6; Title 31, Article 37, Chapter 19, Section 27	
IOWA[d]		*Vaupel v. Bellach*, 261 Iowa 376; 154 N.W.2d 149 (1967)
KANSAS	Chapter 38, Article 1, Sections 108 — 110[e]	
KENTUCKY		*Carricato v. Carricato, et al.*, 384 S.W.2d 85 (1964)

b Removal of the disabilities of age of minors 16 and older must be initiated by a guardian or guardian ad litem, with the exception of borrowing money for educational purposes (automatically allowed at age 16 by Fla. Stat. § 743.05 (2001)) and donation of blood (automatically allowed at age 17 by Fla. Stat. § 743.06 (2001)), or if the minor previously has been adjudicated an adult by the Department of Correction (Fla. Stat. § 743.066 (2001)).

c Under Division 3, Title 31, Chapter 577, Section 25, a minor becomes emancipated as a result of marriage. Because this statute does not form a procedural basis upon which a minor may become emancipated, and thus, did not fall within the scope of this analysis, and because Hawaii had no case law discussing emancipation of minors, this statute is included in the appendix.

d Title VI, Subtitle 6, Chapter 252, Section 16 states, "An emancipated minor is one who is absent from the minor's parents with the consent of the parents, is self-supporting, and has assumed a new relationship inconsistent with being a part of the family of the parents." However, this statute concerns state support of poor individuals. Iowa does not have statutes by which a minor could become emancipated.

e Limited to contracts, and real and personal property.

STATE	STATUTORY EMANCIPATION PROCEEDINGS	JUDICIAL EMANCIPATION
LOUISIANA	Civil Code, Book I, Title VIII, Chapter 2, Section 4, Article 385; Code of Civil Procedure, Book VII, Title V, Articles 3991 — 3993	
MAINE	Title 15, Part 6, Chapter 511, Section 3506-A	
MARYLAND		*Holly et al. v. Maryland Automobile Insurance Fund et al.*, 29 Md. App. 498; 349 A.2d 670 (1975)
MASSACHUSETTS		*Larson v. Larson*, 30 Mass. App. Ct. 418; 569 N.E.2d 406 (1991)
MICHIGAN	Chapter 722, Section 4	
MINNESOTA		*In re Application of County of St. Louis to Determine Settlement of LaDean Fiihr. County of St. Louis v. County of Scott*, 289 Minn. 322; 184 N.W.2d 22 (1971)
MISSISSIPPI	Title 93, Chapter 19, Section	
MISSOURI		*Wurth v. Wurth*, 322 S.W.2d 745 (1959)
MONTANA	Title 41, Chapter 3, Part 4	
NEBRASKA		*Accent Serv. Co. v. Ebsen*, 209 Neb. 94, 306 N.W.2d 575 (1981)
NEVADA	Title 11, Chapter 129, Sections 010, 020, 080, 100	
NEW HAMPSHIRE[f]		*The Concord Group Insurance Companies v. Eric R. Sleeper and Kenneth J. Anderson*, 135 N.H. 67; 600 A.2d 445 (1991)

f New Hampshire does not have a statutory emancipation procedure; however, under Title 1, Chapter 21-B:2, the state will recognize the legally emancipated status of a minor conducted judicially in another state.

STATE	STATUTORY EMANCIPATION PROCEEDINGS	JUDICIAL EMANCIPATION
NEW JERSEY[g]		*Bishop v. Bishop*, 287 N.J. Super. 593; 671 A.2d 644 (1995)
NEW MEXICO	Chapter 32A, Article 21, Sections 1 — 7	
NEW YORK[h]		*In the Matter of Alice C. v. Bernard G.* C., 193 A.D.2d 97; 602 N.Y.S.2d 623 (1993)
NORTH CAROLINA	Chapter 7B, Subchapter 4, Article 35, Sections 3500 - 3509	
NORTH DAKOTA[i]	N/A	N/A
OHIO		*Powell v. Powell*, 111 Ohio App. 3d 418; 676 N.E.2d 556 (1996)
OKLAHOMA[j]	Title 10, Chapter 4, Sections 91 –94	
OREGON	Title 34, Chapter 419B, Sections 550, 552, 555, 558	
PENNSYLVANIA		*Berks County Children and Youth Services v. Margaret Rowan; Berks County Children and Youth Services v. Noel M. Rowan*, 428 Pa. Super. 448; 631 A.2d 615 (1993)
RHODE ISLAND		*Siravo v. Siravo*, 424 A.2d 1047 (1981)

g Emancipation is recognized under N.J. Stat. § 55:14L-1 (2001), but is there limited to individuals living with human immunodeficiency virus (HIV) who are currently homeless or at risk of homelessness, for the purposes of services relating to HIV status only. *See* N.J. Stat. § 55:14L-1 (2001).

h Chapter II, Subchapter B, Article 1, Part 349, Section 5 defines an emancipated minor as "a person over 16 years of age who has completed his compulsory education, who is living separate and apart from his family and is not in receipt of or in need of foster care," but this statute only applies to grants of public assistance to emancipated minors.

i North Dakota has neither a statutory emancipation scheme, nor a history of common law on emancipation. This may be because under Title 14, Chapter 10, minors are often afforded the rights and protections of adults despite their lack of majority (*e.g.*, N.D. Cent. Code § 14-10-03 (2001), civil liability for wrong done; N.D. Cent. Code § 14-10-10 (2001), power to contract; N.D. Cent. Code § 14-10-17.1 (2001), receipt of emergency examination, care, or treatment in a life threatening situation).

j Limited to contracts and conducting business in the state.

STATE	STATUTORY EMANCIPATION PROCEEDINGS	JUDICIAL EMANCIPATION
SOUTH CAROLINA		*Timmerman v. Brown*, 268 S.C. 303; 233 S.E.2d 106 (1977)
SOUTH DAKOTA	Title 25, Chapter 25-5-19; 25-5-21; 25-5-24 — 25-5-28	
TENNESSEE		*Morgan v. Morgan*, 1988 Tenn. App. Lexis 792 (1988)
TEXAS	Family Code, Title 2, Subtitle A, Chapter 31, Sections 001 — 007	
UTAH		*State of Utah, In The Interest of R.R. v. C.R. and R.R.; State of Utah, In The Interest of R.D.H. v. K.G.*, 797 P.2d 459; 142 Utah Adv. Rep. 16 (1990)
VERMONT	Title 12, Part 10, Chapter 217, Sections 7151 — 7159	
VIRGINIA	Title 16.1, Chapter 11, Article 15, Sections 331 — 334.1	
WASHINGTON	RCW 13.64, Sections 010 — 080	
WEST VIRGINIA	Chapter 49, Article 7-27	
WISCONSIN[k]		*Niesen v. Niesen*, 38 Wis. 2d 599; 157 N.W.2d 660 (1968)
WYOMING	Chapter 49, Article 7, Section 27; Title 14, Chapter 1, Article 1, Section 101; Title 14, Chapter 1, Article 2, Sections 201 — 206	

k Wis. Stat. § 48.987 (2000), "Earnings of self-supporting minors," allows that "During any time when a parent of a minor neglects or refuses to provide for the minor's support, or support and education, the earnings of the minor shall be the minors' sole property as against such parent or any creditor of such parent."

3 Mature Minor Rule

3.1 Expanded Health Care Consent Statutes for Minors: "Mature Minor Rule"

Introduction

One of the areas in which homeless minors in Massachusetts may also benefit by statutory change is in the topic of minors' health care needs. While American parents and guardians have long held substantive constitutional rights to make decisions concerning their children's health care and welfare, American children, including Massachusetts children, traditionally had not been empowered with legal autonomy rights to consent to their physical and mental well-being.[72] This is because American society has held steadfast to, and legislatures and courts have maintained and perpetuated, a presumption that minors lack the requisite maturity and wisdom to correctly determine their medical needs. As a result, minors have been deemed incapable of making many medical decisions for themselves.[73]

The term "capacity," a widespread legal concept, is generally utilized in a shielding posture when referring to minors. However, for homeless youth, this shield can act as a particularly dangerous sword. Minors on the streets who need medical items such as antibiotics for colds, inhalers for asthma, and stitches for cuts, may be unable to legally consent to and receive such services without parental consent in the state of Massachusetts due to the construction of Massachusetts' health care statute concerning minors.[74] The realistic result of the parental consent rule, then, may be that homeless and at-risk youth in need of medical attention are

[72] *See* Angela R. Holder, *Children and Adolescents: Their Right To Decide About Their Own Health Care,* in *Children and Health Care: Moral and Social Issues*, 161 (Loretta M. Kopelman & John C. Moskop eds. 1989); Eve W. Paul, *Legal Rights of Minors to Sex-Related Medical Care,* 6 Colum. Hum. Rts. L. Rev. 357, 359-60 (1974); and Tania E. Wright, *A Minor's Right to Consent to Medical Care*, 25 How. L.J. 525, 525-26 (1982). For a comprehensive discussion of the rivaling interests of parents, children, and the state implicated in medical decision-making for children, *see* Elizabeth J. Sher, Note, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. Rev. 157, 169 (1983).

[73] *Id.*

[74] Mass. Ann. Laws ch. 112, § 12F (2002).

left untreated, which leaves them suffering.[75] Service providers attendant to homeless youth are often placed in a moral position of having to "skirt the laws" by not asking a homeless minor's age in order to properly address their health care needs.[76] This state of affairs commands legislative attention.

Definition

In examining expanded health care statutes for minors, the amorphous "mature minor" doctrine has been discussed by previous Law Offices. However, the mature minor doctrine, long an instrument in American law for allowing minors to consent to medical treatment, actually comes into play in the absence of a statutory scheme for the provision of health care services to minors. The term "mature minor" is not used in Massachusetts statutory law,[77] and generally has no formal definition that is consistently applied.[78] However, history reveals the development of the mature minor doctrine: at common law, a minor was presumed to acquire the capacity to consent when she had the ability of the average person to understand and weigh the risks and benefits of a proposed course of action.[79] Early exemptions from this

[75] *See infra* Appendix A: Interview with Genny Price, Clinical Dir., Bridge Over Troubled Water (Feb. 20, 2002). According to Ms. Price, the inability to consent to health care "can be a barrier for kids that are on the run sometimes in getting treatment."

[76] *See infra* Appendix A: Interview with David Clark, Dir., Youth On Fire (Feb. 21, 2002).

[77] Nevertheless, for purposes of consistency with past Law Office projects, and uniformity within this discussion, this paper utilizes the same "mature minor rule" phraseology when referring to statutes that focus on the rights of minors to consent to their own health care. However, when working with this issue in the future, it will be important to apprehend the semantics of the "mature minor" common law doctrine, and to present the goals of JRI to the legislature utilizing the proper terminiology. That is to say, when discussing expansion of the Massachusetts statutory scheme for minors' health care, instead of phrasing the issue in terms of expanding the "mature minor rule," better phrasing may be "minor consent statutes" or "minor's health care consent statutes."

[78] Walter Wadlington, *Minors and Health Care: The Age of Consent*, 11 Osgood Hall L.J. 115, (1973), however, elucidated upon cases in which the "mature minor" doctrine had been applied, and found it to have the following commonalities: (1) treatment was undertaken for the benefit of the minor, as opposed to a third party; (2) the minor was near the age of majority, or at least 15 years of age, and was deemed to have sufficient mental capacity to fully understand the nature and importance of the proposed medical procedures; and (3) the medical procedures could be described by a court as not "major" or "serious."

[79] To reflect minors' progressing reasoning abilities through various developmental stages, capacity is often determined by a so-called "Rule of Sevens." *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987). The Rule of Sevens provides that under the age of seven, a child has no capacity; between the ages of seven and fourteen, there exists a rebuttable presumption that the minor has no capacity; and between the ages of fourteen and twenty-one, there exists a rebuttable presumption that the individual has capacity.

common law rule emerged in order to address emergency medical treatment needs of minors,[80] as well as liability concerns for medical care providers for providing services to minors without parental consent (which constituted the tort of battery).[81] Over time, modern exceptions to the common law rule, collectively termed the "mature minor doctrine," became codified in minor treatment statutes.[82] These statutes typically were designed to specify a particular age "at which a minor may be considered completely independent for health care purposes and treatment may be given as if he or she were an adult," as well as to provide other restrictions deemed warranted by state legislatures (*e.g.*, notification of parents).[83] Most of the statutes that were enacted were not designed to hinge on the maturity of the minor, or to otherwise expand any right of a minor except that specifically addressed within the statute,[84] but rather, the focus was placed on treating and preventing specific diseases or conditions, or to allow for certain treatments.[85]

For example, in the 1960s many states enacted statutes that allowed minors access to communicable disease treatment in response to a mounting incidence of sexually transmitted diseases among minors.[86] Balancing society's interest in halting the spread of sexually transmitted diseases with the rights of parents, and fearing that parental notification of, and consent to, treatment would encroach upon minors seeking out these services, several states enacted statutes by which minors could give their own consent to such treatment.[87] Consid-

[80] Lisa Anne Hawkins, Note, *Living Will Statutes: A Minor Oversight*, 78 Va. L. Rev. 1581, 1586 (1992) ("Early common law, recognizing that physicians' fear of liability might discourage prompt treatment, implied consent in emergency situations. This type of exception is 'situational,' because its applicability turns on the type of treatment decision involved.").

[81] *See e.g.*, *Baird v. Attorney General*, 371 Mass. 741, 753, 360 N.E.2d 288, 296 (1977) ("We have never held or implied on common law grounds that a physician may operate on a minor, where there is no emergency, without the consent of at least one parent. We have indicated that such an unauthorized operation constitutes an intentional tort.")

[82] *See infra* "Mature Minor Rule" chart.

[83] *See* Angela R. Holder, *Children and Adolescents: Their Right To Decide About Their Own Health Care, in Children and Health Care: Moral and Social Issues*, 161 (Loretta M. Kopelman & John C. Moskop eds. 1989).

[84] *See* Jessica A. Penkower, *Comment: The Potential Right of Chronically Ill Adolescents to Refuse Life-Saving Medical Treatment - Fatal Misuse of the Mature Minor Doctrine*, 45 DePaul L. Rev. 1165, at 1178 (1996).

[85] Tania E. Wright, *A Minor's Right to Consent to Medical Care*, 25 How. L.J. 525, 531 (1982).

[86] Angela R. Holder, *Legal Issues in Pediatrics and Adolescent Medicine*, 129, 130 (2d ed. 1985).

[87] *Id.*

ering this background, we now turn to the LO #2 project goals with respect to analysis of the current MMR in Massachusetts.

3.2 Questions Presented

- What health services does the current MMR allow treatment for without parental consent?
- How is this statute a constraint for both at-risk youth and health care providers?
- How should the MMR be broadened?
- What standard(s) should be used to determine if a minor is mature enough to access health care without parental consent?

3.3 Massachusetts Analysis

The current Massachusetts Mature Minor Rule (MMR)[88] only allows minors to access health care without parental consent for very specific health issues. LO #2's ultimate goal with respect to the MMR is to provide JRI with options for writing legislation to expand the MMR in Massachusetts, in order to ensure that at-risk youth and youth generally have greater access to medical services, which is a critical step in maintaining a healthier life. To analyze potential options for an expanded MMR, the following section focuses on three areas: current treatment allowed under the Massachusetts MMR and legislative history; how the current statute acts as a constraint for both at-risk youth and health care providers including mental health and payment matters; and options for expanding the MMR as a solution to those constraints encompassing research on the standard to determine if a minor is mature enough to access health care without parental consent.

[88]Mass. Gen. Laws ch. 112, § 12F (2002).

Health Service Treatment Currently Allowed Without Parental Consent Under the MMR

The MMR in Massachusetts allows minors to obtain limited health care without parental consent. The situations in which minors may consent to their own medical or dental health care without parental consent include if:

> "(i) he is married, widowed, divorced; or (ii) he is the parent of a child, in which case he may also give consent to medical or dental care of the child; or (iii) he is a member of any of the armed forces; or (iv) she is pregnant or believes herself to be pregnant; or (v) he is living separate and apart from his parent or legal guardian, and is managing his own financial affairs; or (vi) he reasonably believes himself to be suffering from or to have come in contact with any disease defined as dangerous to the public health pursuant to section six of chapter one hundred and eleven; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease."[89]

In addition, the abortion consent statute provides that:

> "if a pregnant woman, less than eighteen years of age, has not married and – if she elects not to seek the consent of one or both her parents or guardians, a Judge of the Superior Court department of the trial court shall, upon petition, motion, and after an appropriate hearing, authorize a physician to perform the abortion (1) if said judge determines the pregnant woman is mature and capable of giving an informed consent to the proposed abortion, or (2) if said judge determines she is not mature, but that the performance of an abortion upon her would be in her best interests."[90]

Furthermore, Massachusetts statutes allow for a minor to specifically obtain alcohol abuse treatment without age restriction;[91] drug abuse treatment if she is 12 years of age and

[89] *Id.*
[90] Mass. Gen. Laws ch. 112, § 12S (2002).
[91] Mass. Gen. Laws ch. 111B, §§ 7, 10 (2002).

two or more physicians make a drug dependency diagnosis;[92] prenatal and contraceptive care without age restriction,[93] and treatment for venereal diseases without age restriction.[94] Although Massachusetts does not specifically allow minors to consent to either inpatient or outpatient mental health care by statute, in tandem with 104 Code of Mass. Regs. 25.04 (2002) of the Department of Mental Health, "mature minors" are viewed as being able to consent to such services. Thus, Massachusetts, by and large, statutorily provides minors with important health care services.

While the above circumstances, although limited in scope, appear fairly self-explanatory, it is important to consider what is missing and why it is missing, as well as analyze how this currently affects JRI's target population. For example, the most obvious clause that affects homeless and at-risk youth is clause (v), which deals with the requirements of a minor living separate and apart from her parent and managing personal financial affairs. If JRI is concerned about the homeless youth population, this language appears to remedy the situation. Although legislative intent is unknown, we could assume that the issue of homeless youth acted as the potential catalyst in writing the statute with these requirements. Since homeless youth live separately from their parents and manage their personal finances, this statute speaks directly to the homeless youth population that this project seeks to help without possessing language that directly identifies them. If health care providers knew about this clause, they might feel able provide services to minors who fit these requirements without needing parental consent. At the same time, if homeless youth learned about this clause, then they, too, might feel empowered to seek services, realizing that they would not need parental consent.

[92]Mass. Gen. Laws ch. 112, § 12E (2002).

[93]See Mass. Gen. Laws ch. 111, § 24E. (2002), mandating the Department of Public Health to "establish within its health promotion division a program for comprehensive family planning services for all persons without regard to religion, race, color, national origin, creed, handicap, sex, number of pregnancies, marital status, age, or contraceptive preference, who do not receive medical assistance under chapter one hundred and eighteen E," which states, in pertinent part, that "For the purposes of this section, the term "comprehensive family planning services" shall mean those medical, educational, and social services that assist individuals of childbearing age, including sexually active minors."

[94]Mass. Gen. Laws ch. 111, § 117 (2002).

However, since being a homeless youth is currently a status crime in Massachusetts,[95] this clause may conflict with a service provider's legal responsibility as a mandated reporter. For example, if a homeless youth identified herself as homeless in order to receive and consent to her own heatlh care, the provider would be legally required to report that youth to DSS. Therefore, a homeless youth would find herself in a awkward situation whereby she could legally consent to her care, but then be reported for being homeless.

On the other hand, the ambiguous language may work to the minor's advantage. By not clearly defining clause (v) in terms of homeless youth,[96] the legislators left an opening in which a homeless or at-risk youth who is no longer living with her parent and is managing her own finances could consent to her own care. In this way, she would not necessarily have to self-identify as a homeless youth, since there could be other possibilities (such as living with a friend). Without identifying herself as homeless, she would still be legally permitted to consent under clause (v), while also not triggering the provider's duty to report. With such indeterminate requirements, the provider and minor could become creative in defining the circumstances and therefore a fairly liberal consent policy could exist in practice that is legally sanctioned as well. Since this language has not yet faced any legal challenges setting precedent, it is open to provider interpretation. Therefore, this clause would offer to JRI an important tool in assisting their target population in realizing their right to legally consent to health care, especially if publicized to health care providers and youth.

The other important area of analysis of this statute deals with the theme of inconsistency and public policy. Clause (vi) allows a minor to consent to health care for specific diseases "defined as dangerous to the public health"[97] but a minor may only consent to the diagnosis and treatment of *those* specific diseases. This leads to questioning the legitimacy of the statutory purpose. If a minor may consent to health care for "dangerous" diseases, then this suggests that the law recognizes any minor's capacity and judgment for self-consent,

[95]Interview with Genny Price, *supra* n. 75.

[96]*See* State Research Section for Arizona as an example of specifically defining homeless minor within the statute. While having a clear definition is preferable, in Massachusetts it might provide fewer options where youth homelessness is a status crime.

[97]Mass. Gen. Laws ch. 112, § 12f (2002).

especially surrounding issues of extreme gravity and significance. Why, then, is a minor generally not allowed to consent to such matters as preventive care, mental health services, asthma, or ear infection treatment which fail to fall under the sanctioned clauses? Indeed, under this statute, if a minor presents herself to a healthcare provider with an STD concern, and at the same time has an unrelated cough, she would be barred from receiving any treatment for that cough, but could consent to the STD treatment. While this may seem illogical, it brings us back to the concept of children as property, and the need for parents to maintain control over their children, at least in some aspects. A general consent statute may also challenge the image that parents and legislators have that their own children would not need or want to get health care without parental consent. In addition, the concept of allowing minors the right to consent to all care may not sit well with legislators who may fear parental backlash in the voting booths.

While it is important to analyze the statute as it currently appears, it is also significant to look at the legislative history of the statute.

Legislative History

This MMR statute, Mass. Gen. Laws ch. 112, § 12F, was passed in 1970, renumbered once in 1971, and amended once in 1975. While researching the legislative history, the LO learned that the Judiciary Committee introduced the original bill to the Senate on April 28, 1970, it was accepted the next day, and then reconsidered and laid on the table the following day on April 30. The Journal of the Senate notes indicated unanimous consent to the reconsideration of the "legislation to permit emergency medical treatment and relative to the liability of physicians in said emergency treatment."[98] However it also mentions the following: "pending the recurring question on accepting the report, it was laid on the table, on further motion of the same Senator" who sponsored the bill.[99] While we do not know at this point what the pending question entailed, the legislation was not taken up again until August 19 of the same year. However, once the Senate promptly passed the bill, it moved

[98] Journal of the Senate, p. 1170, Thursday April 30, 1970.
[99] *Id.*

quickly through the third reading in the Senate, engrossment, the House of Representatives, and was sent to the Governor five days later on August 23 and signed into law on August 31, 1970.[100]

Similar swift movement occurred during the 1975 Amendment process. Introduced to the House of Representatives on June 18, 1975, by the Health Care Committee, this bill permitted "certain minors to consent to certain medical care."[101] With some apparent fast moving amendments adopted by both the House and the Senate, it was sent to the Governor on August 18 and signed into law on August 28. This rapid progress may indicate a lack of opposition or a pressing need at the time to pass such legislation. Indeed, the Bulletin of Committee Work, which reports the acts approved by the Governor for 1975, states: "Approved August 28. Declared to be an emergency law by the Governor, effective, October 29."[102] This leads to the question of why a statutory Amendment was needed at this time. It also leads us to the question of why this statute has not been expanded since then. Has there been no need for minors expanded consent or possibly no advocates to bring the issue to Legislators attention?

Although LO #2 recommends furthering this background research, the next LO will have to decide if continuing the legislative history will be a priority or if this background information is sufficient.

MMR as a Constraint for At-Risk Youth and Health Care Providers

The MMR acts as a constraint for at-risk youths and health care providers in various ways, including those mentioned above surrounding the inconsistency of granting minors the right to consent to some health care, but not all. A further constraint consists of a lack of knowledge on the part of health care providers regarding what this statute covers or does not, and even the existence of this statute.[103] Providers need to be educated about when they legally need to obtain parental consent and when it is not necessary. Indeed, providers

[100] *See* Appendix A.
[101] *See* Appendix A.
[102] Bulletin of Committee Work, p. 466A (1975).
[103] *See e.g.*, interview with Genny Price, *supra* n. 75.

may feel caught in a tug-of-war, since they may believe that parental consent is necessary, while they have also been told that they could be just "as liable for not [giving treatment] as you can be for [giving treatment],"[104] especially if the minor suffers a negative consequence after the provider refuses to give treatment without parental consent.

Additionally, minors who graduate high school prior to the age of 18 may face a constraint in receiving health services. For some, the unfair reality may be that although they are independent from their parents in many ways, they are legally not permitted to consent to their own health care. While the number of minors facing this dilemma might be small, it is nevertheless a constraint of the current MMR. In expanding this statute, Massachusetts could look to Alabama, which expressly acknowledges this group's predicament by including the phrase "graduated from high school" as one of its criteria for permitting minors' consent.[105]

Recommendations to further the goals of expanding the MMR include interviews with at-risk and homeless youth to learn how the current statute specifically impacts this population, as well as working toward educating health care providers about the MMR.

Mental Health Services

Since mental health is not specifically indicated within the current MMR, this could be considered a constraint.[106] As the statutory text indicates, MMR in Massachusetts does not cover consent to mental health services, unless one considers mental health to be part of medical care.[107] Nevertheless, the LO found a regulation by the Department of Mental Health pertaining to mature minors:

> "Throughout 104 CMR, there are instances where the rights of emancipated or *mature minors* may be relevant. The regulations do not attempt to identify them. However, where, by operation of law pursuant to M.G.L. c. 112, §§ 12E or 12F,

[104] *Id.*
[105] *See infra* State Research Section, Alabama, Ala. Code § 22-8-4 (1975).
[106] Interview with Genny Price, *supra* n. 75.
[107] However, other states maintain separate statutes or use explicit language to express ability to consent to mental health care. *See e.g.*, *infra* State Research Section, Michigan, Mich. Comp. Laws § 330.1707 (2001), Mich. Comp. Laws § 330.1498d (2001), and Washington, Wash. Rev. Code Ann §70.34.042 (2002).

> a minor is an emancipated minor entitled to consent to drug or medical or dental treatment and is competent to do so, he or she shall be entitled to consent in the same manner as an adult. Further, a facility or program may determine, pursuant to applicable Massachusetts law, that a *minor is a mature minor and is therefore able to provide consent to treatment and may decide, in certain circumstances, not to notify the parents. Such determinations should be made by facilities and programs in consultation with their legal counsel.*" (emphasis added)[108]

Ostensibly, this mental health regulation falls under the auspices of a general medical care definition for youths seeking treatment. However, because of the vague language, it leaves available a broad spectrum for interpretation and possible litigation. A recommendation for the Massachusetts legislature would be to either explicitly provide for mental health for youths in the MMR, or draft an additional statute that could be utilized by providers seeking to help youths needing mental health care who have not yet achieved the age of majority. As this regulation has not been challenged it could be utilized by mental health care providers to allow mental health treatment of minors without parental consent. The LO recommends that JRI publicize this regulation to mental health care providers in an effort to educate them, since health care providers may be unaware of the regulation.[109] In addition, this regulation could be included in a packet that JRI sends to providers. However, one strategy may include not advertising the regulation to legislators since it has not yet been challenged establishing precedent. Therefore, it might not be prudent to call attention to it.

Payment for Services

The LO did preliminary research on the issue of payment for medical services. While payment was not an original LO research question for this year, the LO determined that it could be a concern for those who will eventually draft legislation and deal proactively with legislators' concerns. In addition, payment often is a constraint when dealing with health

[108] 104 Code Mass Regs. 25.04 (2002).
[109] *See* Interview with Genny Price, *supra* n. 75.

care. Therefore, it is important to learn how services are currently paid for, which may lead to ideas on how to propose expanded legislation with payment options.

Preliminary payment research revealed that the state of health insurance in Massachusetts leaves room for interpretation when providing coverage for residents under the age of 18. It seems possible that through the use of an expanded Mature Minor Rule, general health care for homeless youths could be financially covered through existing state and federally-subsidized health insurance. The children's Health Insurance Program (CHIP or Title XXI of the Social Security Act), passed in August 1997, is a federal program that provides $24 billion in matching funds to states over five years for their health insurance expansion efforts. Mass. Ann. Laws ch. 118E, §9A (1997), is the formal authorization of the CHIP expansion and extended MassHealth (Massachusetts Medicaid) coverage to children who live in families below 200% of the federal poverty level. Coverage includes eye examinations, hearing tests, mental health, and dental care. The Department of Medical Assistance administers MassHealth.

It is unclear if homeless youth are able to obtain MassHealth coverage independent of their family. Children under 19 are covered, but it is not specified if they must be part of a family. Additionally, CommonHealth provides health care benefits to children under 19 who do not qualify under MassHealth standards. Further research should investigate what provisions of MassHealth children may not qualify for that CommonHealth may alternatively provide. Furthermore, Special Kids/Special Care is a Massachusetts health care program for minors in foster care. Care is provided by a nurse practitioner from Neighborhood Health Plan (NHP) who works with a DSS case manager, DSS family resource worker, foster family, and primary care physician. While homeless youths are not part of the DSS system, this health plan could potentially be modified to form a compromise wherein youths could obtain generalized medical care, and any abuse of the system could be kept in check as a function of state oversight.

In addition, interviews with youth caseworkers could determine the practical current application of any or all of these options. With this information, next year's LO could

further research payment for medical care obtained by homeless youth, or, in contrast, it may not be a direction in which JRI wishes its resources to be spent.

How Should the MMR be Broadened?

A range of possibilities exists for accomplishing the goal of providing greater health care access to homeless and at-risk youth in Massachusetts. Some of the avenues JRI may explore are: a completely new process-based statutory enactment; an expansion of the current consent statute by adding a broad new clause to cover minors' rights to consent to general health care or amending current clauses to acknowledge specific constraints; and active educational measures.

Statutory Enactment

In keeping with the current system of the Massachusetts judiciary's right to adjudicate a minor's request for an abortion, a similar process could encompass general health care requests, in which a judge would authorize a minor to be declared a "mature minor" for the purposes of consenting to general health care on a case by case basis. Within this scheme, a minor would be declared mature enough to consent to all of her own health care treatment, whether it be medical, dental, mental health, or surgical procedures (including or not including abortive procedures, depending upon how the scheme is structured) for the period of time she is living separate from her parents, but has not yet reached the age of majority. Legislators may support this option since it guarantees that most youth will not easily choose this process unless necessary. Therefore, it would allow most parents to retain control of their child's/children's health care decisions, while allowing for individual exceptions. However, this option could burden the court with extensive litigation, and is closely tied to minors' difficulties in accessing legal counsel. Legislator's fear of increased litigation, inherent costs, and developing a workable "maturity" standard must be kept in mind when considering expanding the process for affording youth the title of "mature." In addition, future LO's should be cognizant of concerns surrounding the difficulty that at-risk youth would face if the process were expanded, as well as the inherent challenge in passing

this type of in-depth statute.

Statutory Expansion

It is more likely that the legislature would embrace a statutory expansion of the MMR. It would be in the best interest of Massachusetts youth to amend the MMR to encompass general health care that could be used as preventative, and not only available for catastrophic illness and injury.[110] Massachusetts could completely change their consent statute by employing a bright line age test, such as that found in Alabama.[111] This would have the effect of ending the inconsistencies found within the statute, while acknowledging a minor's right to privacy and control of their own health care.

However, if legislators do not favor such a broad expansion, then an alternative would be to expand the current consent statute provisions so as to fix some of the specific constraints. For example, Massachusetts does not specifically allow minors to consent to either in-patient or outpatient mental health care. Under current provisions, mental health could arguably fall under "general medical care" – that is, with an expansive interpretation of, and reliance on, current regulations. However, as this is a risky and imprecise methodology of providing mental health care for those who require care, MMR should be broadened to specifically encompass and provide mental health benefits for homeless youth who have not yet reached the age of majority. This may be accomplished by adding the term "mental health care" to the statute, such as the general health care statutes in Alabama[112] and Minnesota.[113] Not only must the MMR specify the type of care, but also the age at which such care is available to minors.

In addition, Mass. Gen. Laws ch. 112, § 12F (2002) provides that "Any minor may give consent to his medical or dental care at the time such care is sought if ... (v) he is living separate and apart from his parent or legal guardian, and is managing his own financial

[110] *See* Interview with David Clark, *supra* n. 76.

[111] Ala. Code § 22-8-4 (2002) (general consent to health care permitted at age 14).

[112] Ala. Code § 22-8-4 (2002) provides that a minor "...may give effective consent to any legally authorized medical, dental, health or *mental health services* for himself or herself, and the consent of no other person shall be necessary" (emphasis added).

[113] Minn. Stat. § 144.341 (2002) provides that a minor "may give effective consent to personal medical, dental, *mental* and other health services, and the consent of no other person is required" (emphasis added).

affairs." This language contains ambiguity, as well as restriction. This text can be clarified so that homeless and at-risk youth are able to receive greater health care access.[114] For example, removing the term "and is managing his own financial affairs" would leave the statute less restrictive. It would also remove the ambiguity of the procedures required to address this language, if any in fact exist, by which a health care provider must determine whether or not services may be provided to the minor. At the same time, removal of these words would allow a service provider to administer health care to a homeless or at-risk minor, so long as the minor lives apart from her parents. Given that the terminology "he is living separate and apart from his parent or legal guardian" would remain intact, all minors would not be reached by this change, alleviating concerns that parental rights with respect to health care decisions may be thwarted. This phrasing option, similar to Minnesota[115] and California,[116] does not define a time period for "living apart." It may still leave health care providers in a position of having to ascertain the veracity of a minor's claim of living apart from her parent(s) or guardian. However, the vagueness of this proposed term expansion may actually benefit homeless and at-risk minors' ability to obtain services by creating "wiggle room" within the statute by which health care providers can utilize discretion to administer services to this population.

Implicit in our recommendation to broaden the MMR in Massachusetts is precise language that allows for clear and consistent application. If being a homeless minor were no longer considered a status crime, Massachusetts could take direction from Arizona, which specifically defines and provides for homeless youth. To provide for the best interests of Massachusetts youth, it would be prudent for the legislature to precisely define homeless youth

[114] *See* Interview with David Clark, *supra* n. 76.

[115] Minn. Stat. § 144.341 (2002) which allows general health care "Notwithstanding any other provision of law, any minor who is living separate and apart from parents or legal guardian, whether *with or without the consent of a parent or guardian* and *regardless of the duration of such separate residence*, and who is managing personal financial affairs, *regardless of the source or extent of the minor's income*, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required" (emphasis added).

[116] Cal. Fam. Code § 6922 (2002) provides that "A minor may consent to the minor's medical care or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older ... (2) The minor is living separate and apart from the minor's parents or guardian, whether with or without the consent of a parent or guardian and *regardless of the duration of the separate residence*" (emphasis added).

so that providers could be clear on whom they may treat.[117] However, as homelessness is still considered a status crime, legislators could look to Alabama and other states that have implimented a bright line age requirement for health care consent. Legislators could also look to Alabama as a model for its statutory inclusion of high school graduates among those that automatically obtain the right to consent to their health care.

Finally, the term "medical," in Mass. Gen. Laws ch. 112, § 12F (2002), is not defined as to which type of services are and are not covered. Specifically, it is unclear if all non-abortive surgeries are included as the statute is presently written.[118] However, if definition is sought, then the benefit of ambiguity is lost. On the other hand, defining the term "medical" as it pertains to this statute may serve as a prophylactic to litigation during a minor's illness - litigation which may serve to delay treatment.

Active Educational Measures

MMR in Massachusetts should be broadened both in scope as well as in application. The statute(s) are only as good as they are applied. Therefore, irrespective of any substantive changes in the current provisions, education of youth workers and medical professionals is paramount to the health of Massachusetts youth. Currently many health care providers and homeless youth may not know about the consent statutes and mental health regulation. They may be unaware of care for which they are currently eligible as minors.[119] Additionally, those youth who are aware of their access to medical care often have to skirt the law or blatently lie to medical professionals.[120]

If the MMR is expanded, then providers are likely to be a homeless youth's first source of knowledge and first advocate. Day programs for at-risk and homeless youth are an integral site at which providers can educate homeless youth on their right to access medical care. In addition to counseling youth who utilize these programs, written material, which may be picked up by youth, outlining their right to consent would be an effective means of

[117] Ariz. Rev. Stat. Ann. §44-132 (West 2002).

[118] It is clear that Massachusetts, in enacting Mass. Gen. Laws ch. 112, § 12S (2002), wished to address the issue of abortion separately as it pertains to the consent of minors.

[119] *See* Interview with Genny Price, *supra* n. 75.

[120] *See* Interview with David Clark, *supra*, n. 79.

reaching the target population. Effectively and efficiently disseminating current statutory information, as well as new statutory amendments, is crucial in educating providers and youth so that the statute benefits JRI's target population.

What Standards Should Be Used to Determine if a Minor is Mature Enough to Access Health Care without Parental Consent?

While the LO recommends implementing more of a bright-line age system, another option is a maturity standard. One consideration is that the American Academy of Pediatrics Task Force grants informed consent based on the patient's age, disease, severity, prognosis, risks, proposed benefits, level of intelligence, reasoning, emotional state, and cultural perspective.[121] In addition, studies have shown that teens can make informed choices just as well as adults with regard to issues such as diabetes, epilepsy, and depression.[122]

A clear and concise statutory definition of "mature minor" could help youths gain accessibility to needed health care. For example, Alabama provides a concrete definition of a mature minor as, "[a]ny minor, who is age 14 or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services, and the consent of no other person shall be necessary."[123] While Massachusetts may use this model as a guide, it should be modified to include even more precise language stipulating those who are eligible to consent for their own medical care. For example, is graduation from high school necessary, or is it sufficient for a student to study for, and obtain, her GED? Massachusetts should take these indications into consideration when drafting legislation, but may wish to use indicators such as "financial independence," "job procurement," and "school attendance."

Overall, the Massachusetts consent statutes[124] provide a very positive basis from which JRI may seek to expand minors' rights to consent to general health care. The above discus-

[121]Report of LO#1, 2000-2001, Appendix #9, p. 9, citing Christin Hanisco, *Acknowledging the Hypocrisy: Granting Minors the Right to Choose*, 16 N.Y.L. Sch. J. Hum. Rts. 899 (summer 2000).
[122]Report of LO#1, 2000-2001, Appendix #10, 4, citing Shoshanna Ehrlich, *Minors as Medical Decision Makers*, 7 Mich. J. Gender & L. 65 at 71-72 (2000).
[123]Ala. Code § 22-8-4 (2001).
[124]Mass. Gen. Laws ch. 112, § 12F, § 12S (2002).

sion, along with the summary of recommendations,[125] will hopefully move JRI and the next LO toward their goal of expanding the current MMR.

In view of the Massachusetts analysis, it may be useful to consider and analyze the bigger-picture context of minors' consent to health care in terms of how other states deal with the MMR and issues of consent to health care.

3.4 MMR State Chart

The following chart, adapted from research conducted by The Alan Guttmacher Institute,[126] represents minors' access to various forms of non-abortive medical services in the respective states, with exclusions and limitations notated in parenthesis (see key).[127] This chart may be useful in considering statutory schemes for Massachusetts with the goal of expanding health care access for minors (or, alternatively, homeless minors). Since this chart reflects research conducted in July of 2000 by The Alan Guttmacher Institute, and that conducted in January, February, and March of 2002 by the Law Office, the authors encourage readers to seek current information in conjunction with utilizing this chart. The research was not aimed at examining whether the actual practice of health care in each state is consistent with, or diverges from, the common or statutory law as it is written. For that reason, this

[125] *See* Recommendations section, *infra*.

[126] The Alan Guttmacher Institute, *Minors and the Right to Consent to Health Care* <www.agi-usa.org/pub/ib_minors_00.html> (last updated Jan. 24, 2002).

[127] According to The Alan Guttmacher Institute, it "has periodically reviewed state laws pertaining to minor's authority to consent to medical care and to make other important decisions without their parents' knowledge or permission." In July of 2000, "its review was expanded to also take into account state court decisions and attorneys general opinions that affect young people's access to confidential services." The information provided by The Alan Guttmacher Institute does not identify if the minor's access to a particular heath care service is provided by statute or common law, and it is unclear to what extent those researchers specifically considered the issue of the "mature minor" doctrine as it applies to access to the various forms of non-abortive health care presented here. The Law Office's research, utilizing research from The Alan Guttmacher Institute, was conducted during the months of January, February, and March of 2002, and captures statutes and case law in effect during that time. The Law Office was unable to verify all of the information contained in the research of The Alan Guttmacher Institute; however, spot verification did reveal some discrepancies (see, e.g., Minn. Stat. § (14)4.34(1) (2002), which provides that a minor living apart from parents and managing his or her financial affairs can consent to mental health services), which may have resulted from changes in laws since the time of their research. Such discrepancies, when discovered, were corrected on this chart. Since the Law Office is focusing on the states of Arizona, Alabama, California, Michigan, Minnesota and Washington, each of those states was thoroughly verified with respect to the above-described health services, and the applicable statutes of those states are presented in Appendix B.

chart must be read with that consideration in mind. Finally, since the research was aimed at capturing specific material from state statutes or case law, and additional information located elsewhere may bear on the issue of minors' access to health care depending upon how the inquiry is framed, the authors encourage readers to consider additional sources of information.

MINORS' ACCESS TO HEALTH CARE

IN THE UNITED STATES[a]

STATE	GENERAL MEDICAL HEALTH[b]	MENTAL HEALTH	SUBSTANCE ABUSE[c]	COMMUNIC-ABLE DISEASES[d]	CONTRA-CEPTIVES	PRENATAL CARE
ALABAMA	✔(8)	✔	✔	✔(1), (7)		✔
ALASKA	✔(9)			✔	✔	✔
ARIZONA			✔(1)	✔	✔	
ARKANSAS	✔(15)			✔(7), (13)	✔	✔(12), (13)
CALIFORNIA		✔(1), (7)	✔(1), (7)	✔(1)	✔	✔(12)
COLORADO		✔(4), (7)	✔	✔	✔(11), (19)	

[a] The age of majority in the 50 states and the District of Columbia is 18, with the exception of Alabama and Nevada, in which it is 19; Pennsylvania, in which it is 21; and Mississippi, in which it is 21, aside from consent for general health care, for which the age of majority is 18.

[b] The Alan Guttmacher Institute did not define the term "general medical health care." However, Minn. Stat. § 144.341 (LEXIS L. Publg. 2001), "Living apart from parents and managing financial affairs, consent for self," provides that "Notwithstanding any other provision of law, any minor who is living separate and apart from parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required," while Ala. Code § 22-8-4 (LEXIS L. Publg. 2001), "Minors; consent for self," provides that "Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary." Thus, this term suggests that statutes indicated provide broad language covering medical, dental, mental, and possibly other, health services.

[c] Statutes typically encompass the board terms "alcohol" and "drugs."

[d] Includes HIV testing and treatment, with the restriction of testing only in California, New Mexico, and Ohio.

STATE	GENERAL MEDICAL HEALTH	MENTAL HEALTH	SUBSTANCE ABUSE	COMMUNIC-ABLE DISEASES	CONTRA-CEPTIVES	PRENATAL CARE
CONNECTICUT		✔	✔	✔		
DELAWARE	✔(10)		✔(1)	✔(1), (7), (13)	✔(1), (7)	✔(1), (7), (12), (13)
DIST. OF COLUMBIA		✔	✔	✔	✔	✔
FLORIDA		✔(2)	✔	✔	✔(11), (17)	✔(13)
GEORGIA			✔(7)	✔(7), (13)	✔	✔(12)
HAWAII			✔(7)	✔(3), (7), (14)	✔(3), (7), (14)	✔(3), (7), (12), (14)
IDAHO	✔		✔	✔(3)	✔	
ILLINOIS	✔(11), (13)	✔(1), (7)	✔(1), (7)	✔(1), (7)	✔(9), (18)	✔(13), (18)
INDIANA			✔	✔		
IOWA			✔	✔(20)		
KANSAS	✔(13), (21)		✔	✔(7)	✔(15)	✔(13), (22)
KENTUCKY	✔(7), (10)	✔(5), (7)	✔(7)	✔(7)	✔(7)	✔(7), (12)
LOUISIANA	✔(7), (13)		✔(7)	✔(7)		
MAINE			✔(7)	✔(7)	✔(10), (17)	
MARYLAND	✔(7), (10)	✔(5), (7)	✔(7)	✔(7)	✔(7)	✔(7)
MASSACHUSETTS	✔(11)	✔(5)	✔(1), (23)	✔	✔	✔(12)
MICHIGAN		✔(3)	✔(7)	✔(7)	✔(27)	✔(7)
MINNESOTA	✔(7), (10)	✔	✔(7)	✔(7)	✔(7)	✔(7)

STATE	GENERAL MEDICAL HEALTH	MENTAL HEALTH	SUBSTANCE ABUSE	COMMUNIC-ABLE DISEASES	CONTRA-CEPTIVES	PRENATAL CARE
MISSISSIPPI			✔(4), (7)	✔	✔(10), (19)	✔(13)
MISSOURI	✔(10), (13)		✔(7), (13)	✔(7), (13)		✔(7), (12), (13)
MONTANA	✔(7), (11), (13)	✔(5)	✔(7), (13)	✔(7), (13)	✔(7)	✔(7), (13)
NEBRASKA			✔	✔		
NEVADA	✔(10), (15), (17)		✔	✔		
NEW HAMPSHIRE	✔(15)		✔(1)	✔(3)		
NEW JERSEY	✔(11)		✔(7)	✔(7), (13)		✔(7), (13)
NEW MEXICO		✔		✔	✔	✔(24)
NEW YORK	✔(11)	✔(7)	✔(7)	✔	✔	✔
NORTH CAROLINA	✔(21)	✔	✔	✔	✔	✔(12)
NORTH DAKOTA			✔(3)	✔(3)		
OHIO		✔(3)	✔	✔		
OKLAHOMA	✔(7), (11)		✔(7)	✔(7)	✔(7), (25)	✔(7), (12)
OREGON	✔(4), (7), (13)	✔(3), (7)	✔(3), (7)	✔(13)	✔(7)	
PENNSYLVANIA	✔(8)		✔(7)	✔		✔
RHODE ISLAND			✔	✔		

STATE	GENERAL MEDICAL HEALTH	MENTAL HEALTH	SUBSTANCE ABUSE	COMMUNIC-ABLE DISEASES	CONTRA-CEPTIVES	PRENATAL CARE
SOUTH CAROLINA	✔(5), (26)	✔(26)	✔(26)	✔(26)	✔(26)	✔(26)
SOUTH DAKOTA	✔(21)		✔	✔		
TENNESSEE		✔(5)	✔(7)	✔	✔	✔
TEXAS		✔	✔(7)	✔(7), (13)	✔	✔(7), (12), (13)
UTAH				✔	✔(7), (16)	✔
VERMONT			✔(1)	✔(1)		
VIRGINIA	✔(21)	✔	✔	✔	✔	✔
WASHINGTON		✔(2)	✔(2)	✔(3), (13)	✔	✔
WEST VIRGINIA			✔	✔		
WISCONSIN			✔(1)	✔		
WYOMING				✔	✔	
N=	25	23	46	51	33	31
%	49%	45%	90%	100%	65%	60%

EXCLUSIONS AND LIMITATIONS KEY	
(1)	The minor must be at least 12 years old.
(2)	The minor must be at least 13 years old.
(3)	The minor must be at least 14 years old.
(4)	The minor must be at least 15 years old.
(5)	The minor must be at least 16 years old.
(6)	The minor must be at least 17 years old.
(7)	The heath care provider may notify parents.
(8)	The minor must be a high school graduate, married, pregnant, or a parent.
(9)	Minor may consent if a parent.
(10)	Minor may consent if a parent or if married.
(11)	Minor may consent if a parent, married, or pregnant.
(12)	Excludes abortive services.
(13)	Includes surgical care.
(14)	Excludes surgical care.
(15)	Minor must be able to understand the nature and consequences of medical or surgical treatment proposed.
(16)	Utah Code Ann. § 76-7-325 (LEXIS L. Publg. 2001), "Notice to parent or guardian of minor requesting contraceptive -- Definition of contraceptives -- Penalty for violation," stating "(1) Any person before providing contraceptives to a minor shall notify, whenever possible, the minor's parents or guardian of the service requested to be provided to such minor. Contraceptives shall be defined as appliances (including but not limited to intrauterine devices), drugs, or medicinal preparations intended or having special utility for prevention of conception. (2) Any person in violation of this section shall be guilty of a class C misdemeanor," was ruled unconstitutional by *Planned Parenthood Ass'n v. Matheson*, 582 F. Supp. 1001, 1983 U.S. Dist. LEXIS 10330 (D. Utah 1983) with respect to its failure to "provide a procedure whereby a mature minor or a minor who can demonstrate that his or her best interests are contrary to parental notification can obtain contraceptives confidentially." However, the court also noted that it "does not intend to imply by this decision that a law which provided a means for minors to demonstrate maturity or best interests contrary to parental involvement would be constitutional. All that the court has decided is that due to the failure to provide such a process, H.B. 343 goes beyond the constitutionally permissible point of regulating the right of minors to make independent decisions concerning whether to bear or to beget children."
(17)	If minor is a parent, or provider believes minor will suffer probable health hazard if services withheld.
(18)	If minor is a parent, or is referred by a doctor, clergy, or Planned Parenthood clinic.
(19)	If minor is a parent, or is referred by a doctor, clergy, family planning clinic, school of higher education, or state agency.
(20)	Parental notification required for positive outcome on HIV test.
(21)	If parent or guardian is not "immediately available."
(22)	If parent is not "available."
(23)	Requires diagnosis of two health care providers, and excludes methadone treatment.
(24)	Limited to pregnancy testing and diagnosis.
(25)	Females can consent if they have ever been pregnant.
(26)	Minors of any age when health care provider believes services are necessary; minors at least (16) years old may consent. to all health services excluding operations.
(27)	Under Mich. Comp. Laws § 400.14b (LEXIS L. Publg. 2001), "Family planning services; notice; referrals; furnishing drugs and appliances," minors may obtain contraceptive services (*See Doe v Irwin* (1977, WD Mich) 441 F Supp 1247, revd on other grounds (1980, CA6 Mich) 615 F2d 1162, cert den (1980) 449 US 829, 66 L Ed 2d 33, 101 S Ct 95, "Existence, if any, of fundamental civil right among minors to obtain prescriptive contraceptives need not exist to total exclusion of any rights of minor child's parents"; *Doe v Irwin* (1980, CA6 Mich) 615 F2d 1162, cert den (1980) 449 US 829, 66 L Ed 2d 33, 101 S Ct 95, "State-run clinic which distributed contraceptive devices and medication to unemancipated children without knowledge and consent of parents did not infringe parents' constitutional right to care, custody and nurture of their children.")

Of the 50 states and the District of Columbia analyzed, 49% allow minors some form of access to general medical care. Of these states, Oregon requires that the minor be at least 15 years of age, while South Carolina requires the minor to be at least 16 years of age. Seven states[128] provide that the health care provider may notify the parents following the rendering of general health care services to the minor. Alabama and Pennsylvania require that the minor must be a high school graduate, married, pregnant, or a parent in order to give consent; Alaska allows the minor to consent if he is a parent; six states[129] allow the minor to consent if she is married or a parent; six[130] allow the minor to consent if she is a parent, married, or pregnant; and Nevada allows a minor general health care access if she is a parent, or if the provider believes the minor will suffer a probable health hazard if she is not treated. Six states[131] allow surgical care under "general health care" services. Arkansas, Nevada, and New Hampshire require that the minor must be able to understand the nature and consequences of the medical or surgical treatment proposed. Four states[132] allow minors health care access only when the parent "is not immediately available." Finally, South Carolina allows minors of any age general health care access if the provider believes the services are necessary, with the exception that all minors at least 16 years of age may consent to all health care services with the exclusion of operations.

With respect to mental health care, 45% of the states allow minors some form of access. Of these states, California and Illinois require that the minor be at least 12 years of age; Florida and Washington require that the minor be at least 13 years of age; Michigan, Ohio, and Oregon require that the minor be at least 14 years of age; Colorado requires that the minor be at least 15 years of age; and five states[133] require the minor be at least 16 years of age. In seven states[134] the health care provider may inform the parents of the minor's

[128]Kentucky, Louisiana, Maryland, Minnesota, Montana, Oklahoma and Oregon.
[129]Delaware, Kentucky, Maryland, Minnesota, Missouri, and Nevada.
[130]Illinois, Massachusetts, Montana, New Jersey, New York, and Oklahoma.
[131]Illinois, Kansas, Louisiana, Missouri, Montana, and Oregon.
[132]Kansas, North Carolina, South Dakota, and Virginia.
[133]Kentucky, Maryland, Massachusetts, Montana, and Texas.
[134]California, Colorado, Illinois, Kentucky, Maryland, New York, and Oregon.

mental health treatment. Again, South Carolina allows minors of any age mental health care access if the provider believes the services are necessary, and full access to such services if the minor is at least 16 years of age.

Ninety percent of the states allow minors to seek treatment for substance abuse. Of these states, eight[135] require the minor be at least 12 years of age; Washington requires the minor to be at least 13 years of age; North Dakota and Oregon require the minor to be 14 years of age; and Mississippi requires that the minor be at least 15 years of age. In twenty[136] of the 45 states allowing minors access to substance abuse treatment, the health care provider may notify the parents that the minor has or is seeking such treatment. Missouri and Montana provide for incidental surgical care with substance abuse treatment without parental consent. Massachusetts requires that a substance abuse diagnosis be made by two health care providers prior to treatment, and specifically excludes methadone treatment. Finally, South Carolina allows minors of any age mental health care access if the provider believes the services are necessary, and full access to such services if the minor is at least 16 years of age.

All of the states allow minors access to care for communicable diseases (which may or may not include HIV care). In five states,[137] the minor must be at least 12 years of age to receive communicable disease treatment; while in five others,[138] the minor must be at least 14 years of age. Eighteen[139] of the 50 states[140] that permit minors access to communicable disease treatment allow that the health care provider may inform the parents as to the minor's request for this form of health care. Nine[141] of the states specifically allow the minor to consent to surgical care in connection with communicable disease treatment, while Hawaii specifically precludes surgical care incident to communicable diseases. The state of Iowa specifically calls for parental notification if the minor receives a position outcome on his or

[135] Arizona, California, Delaware, Illinois, Massachusetts, New Hampshire, Vermont, and Wisconsin.

[136] California, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Tennessee, and Texas.

[137] Alabama, California, Delaware, Illinois, and Vermont.

[138] Hawaii, Idaho, New Hampshire, North Dakota, and Washington.

[139] Alabama, Arkansas, Delaware, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, New Jersey, Oklahoma, and Texas.

[140] plus District of Columbia

[141] Arkansas, Delaware, Georgia, Missouri, Montana, New Jersey, Oregon, Texas, and Washington.

her HIV test. South Carolina allows minors of any age communicable disease care access if the provider believes the services are necessary, and full access to such services if the minor is at least 16 years of age.

With respect to contraceptive care, 65% of the states allow minors some form of access to these services. Delaware requires that the minor be at least 12 years of age, while Hawaii requires the minor be at least 14 years of age. Nine[142] states allow for a health care provider to notify the minor's parents upon a request for contraceptive services. Illinois allows a minor to consent only if she is a parent; Maine and Mississippi allow consent when the minor is a parent or is married; and Colorado and Florida allow a minor to receive contraceptives if the minor is a parent, married, or pregnant. Hawaii excludes surgical care in connection with contraceptives, Oklahoma allows female minors to consent if they have ever been pregnant, and South Carolina allows minors of any age contraceptive care access if the provider believes the services are necessary, and full access to such services if the minor is at least 16 years of age. Finally, Florida and Maine provide that contraceptive care may only be provided if the minor is a parent or a provider believes that the minor will suffer a probable heath hazard if the services are withheld; Illinois allows for minors to access contraceptive care if the minor is a parent, or is referred by a doctor, clergy, or Planned Parenthood clinic; and Colorado and Mississippi allow access to contraceptive care by minors when the minor is a parent, or is referred by a doctor, clergy, family planning clinic, school of higher education, or state agency.

Lastly, 61% of the states make provision for some access to prenatal care for minors. Of these states, Delaware requires the minor to be at least 12 years of age, while Hawaii requires the minor to be at least 14 years of age. Eleven states[143] allow the health care provider to inform the parents that services were or are being sought by the minor. Eleven states[144] also

[142]Delaware, Hawaii, Kentucky, Maryland, Minnesota, Montana, Oklahoma, Oregon, and Utah.

[143]Delaware, Hawaii, Kentucky, Maryland, Michigan, Minnesota, Missouri, Montana, New Jersey, Oklahoma, and Texas.

[144]Arkansas, California, Delaware, Georgia, Hawaii, Kentucky, Massachusetts, Missouri, North Carolina, Oklahoma, and Texas. Note: as is the case of Massachusetts, abortion services may be addressed and provided for in other statutes.

specifically exclude abortive services under their prenatal care statutes, while ten include "surgical care."[145] South Carolina allows minors of any age to consent to prenatal care if the provider believes the services are necessary, and full access to such services if the minor is at least 16 years of age. New Mexico limits prenatal care to pregnancy testing and diagnosis, while Hawaii excludes "surgical care."[146] Illinois allows for minors to access prenatal care if the minor is a parent, or is referred by a doctor, clergy, or Planned Parenthood clinic, while Kansas provides that minors can obtain prenatal care if the parent is "not available."

In summary, a broad range of access is allowed to minors across the 50 states and District of Columbia examined, coupled with a wide range of restrictions and limitations. Communicable disease care is the most commonly provided-for health care item for which minors may give consent, followed by substance abuse, contraceptive care, prenatal care, general medical health, and mental health. Overall, the District of Columbia, and Virginia appear to provide the most access to specified health care issues with the least restriction to health care services for minors, by allowing minors to consent to mental health, substance abuse, communicable disease, contraceptive, and prenatal care and, in the case of Virginia, general health care if the parent is not "immediately available." Alabama and South Carolina are also liberal in terms of allowing minors to consent to all forms of health care. However, in South Carolina, minors under the age of 16 must evidence to the health care provider that the services are necessary, while minors at least 16 years of age may consent to all health services, excluding operations.

Massachusetts presently provides for each form of health care herein considered, but general health care is restricted to minors who are parents, married, pregnant, in the armed forces, or living separate from their parents and managing their own finances; mental health care cannot be consented to before the age of 16; substance abuse treatment requires the diagnosis of two health care providers, and excludes methadone treatment and minors below

[145] It is unclear if this includes abortive services. Since the focus of the inquiry was not aimed at the issue of abortive services for minors, because Massachusetts provides for such services under Mass. Ann. Laws ch. 112, § 12S (2002), whether or not the term "surgical care" included abortive services in the respective states under prenatal care statutes was not investigated.

[146] *See id.*

the age of 12; and prenatal care of a minor younger than 12 years of age is unattainable on the minor's consent alone. The specific analysis of the consent statutes for the states of Alabama, Arizona, California, Michigan, Minnesota, and Washington are discussed further in the State Research section of this report.

4 Legal Access

4.1 Legal Access: Ability of Minors to Access the Legal System

Introduction

As the LO has outlined in previous sections of this report, there are certain areas of services to which a parent can help a minor gain access, and that anyone can access once she has reached the designated age of majority. A minor who no longer lives with a parent or guardian is disadvantaged in these areas, which become somewhat off-limits to them. One of those areas, considered by most to be an important part of being an adult in modern society, is access to the legal system.

In general, minors cannot access the legal system without the aid of a parent, a guardian ad litem (GAL), or a next friend. This creates a barrier for those minors, such as homeless youth, who no longer have the benefit of a parent or guardian. Those minors must rely on a GAL or next friend to help them assert their legal rights. The role of a GAL can be slightly different from jurisdiction to jurisdiction, however, one consistency is that the GAL is court-appointed and her role is to represent the best interests of the minor to the court. The issue of "best interest" is discussed in-depth in the emancipation section of the report. As that discussion indicates, the recommendations put forth by a GAL may not encompass what the minor wants. It is often difficult to determine what exactly is in the best interest of the minor, particularly when the minor is not in agreement with the determinations made by the GAL. This presents a problem for minors who feel that their interests are not being represented, as, in many states, minors cannot have their interests brought forward in a court

case unless an adult finds it to be in their best interest. In addition to a GAL, a "next friend" can also help a minor access the legal system. The concept of a next friend is defined by Black's Law Dictionary as: "A person who appears in a lawsuit on behalf of an incompetent or minor plaintiff, but who is not a party to the lawsuit and is not appointed as a guardian."[147] What exactly constitutes a next friend, and who can be one, seems to vary dependant on jurisdiction. In Massachusetts, the distinction between the GAL and next friend has been virtually eliminated. A next friend is chosen from among those court-approved to be GALs. The two terms are used synonymously.

Definition

The phrase "Legal Access" is somewhat self-explanatory, essentially meaning the ability to utilize legal services, and more specifically, the court system. In determining what legal access is currently available to minors, the LO examined the statutes, court rules, secondary sources such as law review articles, and case law in Massachusetts and in the comparison states. These sources spell out the rights and the abilities of a minor to access the legal system through the courts.

4.2 Questions Presented

- In what ways, in any, does the federal government restrict access to the legal system by minors?
- How can a minor in MA access the legal system currently? Can a minor retain counsel without parental consent?
- What exactly are guardian ad litems and next friends? Who can be one?

[147] Black's Law Dictionary 1041-1042 (6th ed., West 1990).

4.3 Federal Analysis

The federal government has traditionally left family law to the discretion of the states. There are very few federal regulations pertaining to the age a citizen must be to initiate legal proceedings. The only clear age determination that the federal government regulates has to do with voting restrictions. The federal government allows all citizens over the age of eighteen to vote.[148] Other than voting laws, the federal government delineates age through the Federal Rules of Civil Procedure, stating "the capacity of an individual, other than one acting in a representative capacity, to sue or be sued shall be determined by the law of the individual's domicile."[149] It does seem from recent decisions that the United States Supreme Court may be leaning towards giving minors more legal rights, but so far the decisions have only affected state statutes regarding abortion.[150] One law review article does give the impression that "the question of whether a minor has standing to sue on his or her own behalf remains an open one."[151] However, given JRI's limited resources, it would be easier to leave the federal government to continue in its policy of leaving family issues to each specific state and work on changing Massachusetts laws directly.

4.4 Massachusetts Analysis

In Massachusetts, a minor has various options for gaining access to the state's legal system without parental support or consent, of which the assistance of GALs is the most common and practical. The Massachusetts Rule of Civil Procedure 17(b) states that the court shall appoint a guardian ad litem for an infant who is not otherwise represented in an action. GALs are appointed in record numbers in the state's Probate, Family, and Juvenile Courts. In evaluating child abuse, neglect, or child custody, particularly in conjunction with allegations of substance abuse, domestic violence, or sexual abuse of a child, the courts become involved

[148] U.S. Const. amend. XXVI § 1.
[149] Fed. R. Civ. P. 17(b) (Lexis 2001).
[150] *Bellotti v Baird*, 443 U.S. 622 (1979); *Curry v. Dempsey*, 701 F.2d 580 (1983)
[151] Jana Micek, *Rights of Children: The Childs Right to Access to the Courts,* 11 J. Contemp. Leg. Issues 656 (Lexis 2000).

in the investigation of complex family dynamics and social histories, and a skilled GAL renders invaluable assistance to the trial court in making these assessments.[152]

Attorneys appointed as GALs have traditionally served in the capacity of "next friend" to represent the interests of a minor involved in juvenile or probate litigation.[153]

> In the past, courts distinguished between the terms "next friend" and "guardian ad litem." A "next friend" was a person other than a guardian who brought an action on behalf of an infant or incompetent person. [] A "guardian ad litem" described a person appointed to defend or prosecute a suit on behalf of an incompetent person otherwise unrepresented. [] The distinction was only formal and the functions of the two representatives were really the same. [] Today we use guardian ad litem and next friend interchangeably.[154]

Appointment of counsel or a "next friend" GAL for a child is discretionary in the probate courts, unless the "Probate Court judge contemplates an award of custody of a minor child to [the Department of Social Services] under Mass. Gen. Laws ch. 199 § 23(c) (2001)." However, "[w]here DSS is not a candidate for custody – the child is not entitled to counsel."[155] Discretion is usually exercised in favor of the appointment of a legal representative only in particular circumstances.[156] For instance, in *Benson v. Benson*, 422 Mass. 698, 700 (1996), the Massachusetts Supreme Judicial Court affirmed that "[m]inor children of divorcing parents should be represented by counsel or a Guardian ad Litem when said parties enter into [a] surviving agreement that is essentially non-modifiable–."

Attorneys may also be appointed as investigator-GALs if the scope of the appointment is primarily a fact-finding mission or if there are legal issues intertwined with the "best interest" determination that are better addressed by an attorney with knowledge of the rules of evidence, including relevance, admissibility and hearsay.[157] Such an attorney/GAL might

[152]Marcia M. Boumil, *Ethical Issues in Guardian Ad Litem Practice*, 86 Mass. L. Rev. 8, 8 (2001).
[153]*Id.* at 9.
[154]*Judge Rotenberg Edu. Ctr., Inc. v. Commissioner of the Dept. of Mental Retardation*, 424 Mass. 476, 477 n.3 (internal citation omitted).
[155]*D.O. v. B.O.*, 49 Mass. App. Ct. 1119, 1120 (2000).
[156]Boumil, *supra* n. 152, at 10.
[157]Boumil, *supra* n. 152, at 10.

also initiate legal action on behalf of the child.[158] For example, in *Matter of Walter*, 408 Mass. 584, 584-585 (1990), the GAL attempted to bring a paternity action on behalf of the child to disprove the paternity of the mother's husband. The court ultimately denied the petition, not because it exceeded the scope of the GAL's authority, but because such a petition was found contrary to the best interest of the child.[159]

With the new Supreme Judicial Court guidelines in place, courts generally specify the issues to be addressed by the GAL. Individuals who serve as GALs have a variety of qualifications and the trial judge will select a GAL with expertise that meets the needs of the individual case.[160] GALs may be lawyers, psychologists, or social workers, and some have training in more than one field.[161] In many cases, the GAL plays an interdisciplinary role and is expected to generate a comprehensive investigative report that is both legally admissible and clinically defensible.[162] As for confidentiality of GAL reports, the courts remain sensitive to the parties' need for privacy, and although "the information in the [GAL] report is based primarily on documents which are not impounded and are part of the record,"[163] it does not become a public document.[164]

Like in Washington, the new guidelines require Massachusetts courts to make the GAL appointments from a rotating list.[165] In the context of attorneys accepting assignments to represent indigent clients, this practice ostensibly ensures equal access to cases by certified advocates and minimizes the appearance of judges favoring certain practitioners.[166] In the context of GALs conducting custody evaluations, however, the need for particular qualifications of the GAL will doubtless result in judges departing from the rotating list in order to select GALs that meet the needs of individual cases.[167] The parties' agreement as to a

[158] *Id.*
[159] *Id.* at 589.
[160] Boumil, *supra* n. 152, at 10.
[161] *Id.*
[162] *Id.*
[163] *Giacchino v. Johnson*, 49 Mass. App. Ct. 1114, 1114 at n. 4 (2000).
[164] *Kendall v. Kendall*, 426 Mass. 238, 253 at n. 17 (1997).
[165] *See* Mass. Gen. Laws ch. 215 (2000); Uniform Practices Xa, Xb.
[166] Boumil, *supra* n. 152, at 11.
[167] *Id.*

particular GAL is also likely to be honored, resulting in deviation from the rotating list.[168]

In sum, Massachusetts' GAL system is fairly well thought out. However, in the absence of concrete codification of the procedures involving minor litigants, it inevitably becomes susceptible to various legal and social challenges.

5 Shelter Restriction

5.1 Introduction

Shelter restriction statutes are intended to support a larger legislative aim of accounting for homeless youth and to ensure that some form of administrative action be taken once they are homeless, whether by a local law enforcement agency, state social service agency, or other appropriate administrative body. For example, the Massachusetts shelter restriction statute demands that a minor's presence be reported to The Department of Social Services within 72 hours after shelter staff receives knowledge of the minor's presence at the shelter.

Even though state legislatures may have intended otherwise, shelter restriction statutes make it harder for minors to access services in the short term. Mandatory reporting at shelters discourages homeless youth from seeking shelter services. The risk of being reported often makes youths hesitant to volunteer information about themselves, their situation, or their needs for fear that staff will report them. In addition, an extra burden is put on shelter staff to report minors, thereby decreasing the amount of homeless youth willing to enter shelters for services, or to find a way to provide services to minors without soliciting age or situation specific information from them. Some states have sanctions written into the statute itself for shelters that fail to report the minors. At the very least, shelters that fail to report minors at their facility are at risk of losing their licensing or funding.

[168] *Id.*

5.2 Definition

The term "shelter restriction" refers to state statutes that restrict homeless youths' access to shelters by stipulating that minors' presence be reported by shelter staff. Shelter restriction statutes vary by state in terms of the length of time the shelter staff has to report the location of the child, what body or group receives the report, and the method of reporting.

5.3 Questions Presented

- Are there federal laws that regulate shelter restrictions?
- What was the Massachusetts statute intended to do? Is it meeting that goal?
- Are there other states that have similar shelter restriction statutes? Are there any with completely open access to shelters for minors?

5.4 Federal Analysis

The federal statute 42 U.S.C.S. § 5712 (LEXIS L. Publg. 2002), enables the states and private service providers funding for youth centers, temporary shelters, and counseling services. The legislative intent of the statute suggests that Congress was seeking ways to control juvenile delinquency. A common problem surrounding juvenile delinquency is homelessness and lack of supervision. The statute seeks to define homeless youth, and it advances the importance of at-risk youth receiving necessary services. The statute also outlines the criteria a service provider must meet in order to gain access to funding. The statute is very specific in that it leaves the administration of the actual services to providers who qualify under this Act within the complete control of the states. The federal government explicitly states in the statute that all qualifying groups must provide appropriate plans to develop adequate contact between the runaway youths, their parents, and/or the appropriate state officials. The federal government does not refer however, to specifics regarding shelter restrictions.

The statute empowers the states to enact any regulations or restrictions in regard to shelters and other treatment services.[169]

The federal rules state that shelters must notify parents within 24 to 72 hours of the minor's admission. Different states have come up with different ways of dealing with this requirement. For example, the Tennessee statute requires that shelters make a "good faith" attempt to contact a youth's parents. Maine requires that a shelter contact the Department of Human Services, but does not require parental notification. In Alaska, Louisiana, and New York, no contact is necessary where compelling reasons are shown against it.[170] There is not a great deal of analysis regarding this issue. It is clear that Congress wants to provide services to runaways, but wants them to receive such services under supervised conditions.[171]

To bring about change at the federal level is a daunting task. JRI should pursue collaborations with other organizations, both at the local and national level, who are opposed to strenuous shelter restrictions. The necessary resources needed to generate the appropriate change at the national level can only be realized if the sum of organizations against shelter restrictions pool resources to meet their desired objectives. In the event that the client tries to seek federal change it could focus on the federal government to require loose shelter restrictions in the statutes funding criteria. If desired, the federal government could amend the funding qualifications regarding shelters, and could increase the time period for mandatory reporting. The remaining analysis and challenges regarding shelter restrictions are on the state level.

5.5 Massachusetts Analysis

In Massachusetts, a temporary shelter may only provide shelter for a period of seventy-two hours. This is stated in Mass. Gen. Laws ch. 119 §23 (2002):

> "A temporary shelter care facility program or a group care facility, licensed under the provisions of chapter twenty-eight A, may, for a seventy-two hour period,

[169] 42 U.S.C.S. § 5712 (LEXIS L. Publg. 2002).
[170] Paradise and Horowitz, *supra* n. 12, at 4.
[171] 42 U.S.C.S. § 5712 (LEXIS L. Publg. 2002).

> provide temporary shelter to a child under eighteen without parental consent, provided that the child's welfare would be endangered if such shelter were not immediately provided. At the expiration of such seventy-two-hour period, the licensee shall (1) secure the consent of parent or guardian to continued custody and care, (2) refer the child to the department for custody and care, or (3) refuse to provide continued care and custody to said child."

This law, while simple in nature, has far reaching effects that have shaped the way that services are provided to homeless youth. Originally this law was passed as part of the 1974 legislative agenda of the Office for Children.[172] The intention of the Amendment to Ch. 119 was to "remove the cloud of civil or criminal liability for appropriately licensed facilities able to satisfy the emergency needs of runaways."[173] The main goal of the legislative proposals were as follows;

> (1) to recognize that children are entitled to similar rights and social benefits as other citizens; (2) to adequately provide the community-based, preventive services that are critical to strengthening family life; (3) to give a greater voice to communities in planning the development of these local services; and (4) to increase our commitment of resources to services for children, Massachusetts' most precious resource.[174]

The Office for Children intended to open up services to runaway children and not restrict their access to shelter and services. In fact, the law was meant to clarify that despite the fact that statutes against aiding and abetting runaways exist, this does not apply to shelters as long as they stay within the federal guidelines of only providing shelter to a youth for seventy-two hours. Although the bill was titled "An Act Providing a Temporary Shelter Program for Children," the Office for Children recognized that "(t)his law is mislabeled. It really gives the

[172] Letter to the Massachusetts Senate and House from David S. Liederman, Director, Massachusetts Office for Children.
[173] Cost Estimates, Explanations of Proposed Office of Children Legislation.
[174] *Id.*

Office for Children authority to license and regulate temporary shelter facilities."[175] While the law allowed for temporary shelter of minors in adult shelters, unfortunately, runaways often see homeless shelters as more dangerous than the streets, and so they choose not to stay. Another result is that there are far too few shelters that house only youth, as they are seen to be taken care of by the temporary shelters. When youth become homeless, it is often not because they do not have a home. They may have a place to live that is temporary or sporadic and so do not fit into the population that DSS serves, namely youth in need of foster care. This population is in desperate need of temporary shelter. Unfortunately, while they are legally able to seek temporary shelter for up to seventy-two hours, they almost always feel that the streets are a safer alternative.[176] The regular population in homeless shelters sees homeless youth as vulnerable. Youth are therefore often targeted and become victims of crimes against person and property. Genny Price, the Clinical Director at Bridge Over Troubled Waters, a drop-in center for homeless minors, comments that minors "don't belong in the adult shelters. They are really designed for an older, chronically homeless population. And so you don't want ... even 18 and 19 year olds in there getting comfortable, never mind kids under 18."[177] What Massachusetts General Laws ch. 119 §23 (2002) does is take away the possibility of providing homeless shelters designated for youth. It effectively makes the youth's situation more dangerous. Runaway youth are forced to live in camps, live in dangerous shelter conditions, or trade sexual favors for shelter.[178] In making recommendations for possible changes to the shelter restriction statute in Massachusetts, the LO has accounted for JRI's position as a small organization with limited resources. Therefore, our recommendations focus on state shelter restriction advocacy positions that are feasible for JRI. In sum, while the massachusetts' statute is meant to clarify the meaning of the Federal reporting regulation for Massachusetts' shelters, it has actually made it difficult for youths to access service. Therefore, in our recommendations, we will focus on how some

[175] *Id.*
[176] *See* Interview with Genny Price, *supra* n. 75.
[177] *Id.*
[178] *See* Interview with Dave Clark, *supra*, n. 79.

States have dealt with the Federal reporting regulation while still providing adequate shelter services for runaways.

6 The States Chosen

This year's LO chose to focus its state comparison research on six states: Alabama, Arizona, California, Michigan, Minnesota, and Washington. These states were chosen because of their strengths or weaknesses in providing services to minors. The LO continued the research on Arizona, California, Minnesota, and Michigan's various services for at-risk youth, focusing on emancipation, the mature minor rule, legal access, and shelter restrictions that was begun by past LOs. Alabama was added to the state analysis as it has a good model for minors' consent to health care, while Washington was added because of its shelter restriction statute.

7 Alabama

7.1 Emancipation

First enacted in 1876, Alabama's statute frames emancipation as relieving minors from the disabilities of non-age.[179] The statute allows juvenile courts to relieve minors from disability of non-age who over the age of 18 years, provided it is in the minors best interest.[180] Since the age of majority in Alabama is 19, one may assume that Alabama wants to limit the duration of time that minors can be emancipated before they reach the age of majority.

Obtaining relief from this disability is difficult for most minors in this state. The first section of the statute provides a detailed description of who can petition the court for emancipation, with only one provision allowing the minor, herself, to petition without the consent of another.[181] The minor may only petition alone if there is "no father, mother or guardian," or

[179] Ala. Code § 26-13-1 (2001).
[180] *Id.*
[181] *Id.*

if the parents exist but are "insane" or have "abandoned said minor for one year" or more.[182] Also, of the two other provisions, the first allows parents to petition for emancipation, seemingly without the minor's consent[183] and the other requires that the minor have a guardian who agrees with the petition.[184] The petition must be filed in the county of residence of the petitioning party.[185] Once emancipated, the minor may contract and has the ability to buy and sell real estate, and all other such things she could legally do "if 19 years of age."[186]

The Alabama statute does not set out specific criteria that must be met in order for a minor to become emancipated prior to reaching the age of majority. However, some criteria was cited in *Boykin v. Collins*, a case in which the Supreme Court of Alabama affirmed the city court's decision and held that the petition need not allege that the removal from disability of non-age will be in the best interest of the minor.[187] Boykin, who was over the age of 18 years, was relieved from the disability of non-age by the city court after a review of the petition and the affidavits of two persons (relationship to plaintiff unspecified in the case) stating that it would be in the best interest of Boykin to be relieved of said disability of non-age and that Boykin was "of discreet and mature judgment and competent to manage his own property and business."[188]

The dearth of case law specific to the removal of disability of non-age, makes a review of existing case law on matters of child support and custody necessary to glean how the court determines whether a minor is emancipated. In a child support case, *Anderson v. Loper*, the father was attempting to prove that his daughter was emancipated, therefore terminating his support obligations.[189] The trial court's determination was based upon the best interest standard since: "[t]he best interest standard affords freedom for the trial court to consider numerous and varied factors ... A multitude of facts are proper for consideration and there

[182] *Id.*
[183] *Id.* § 26-13-1(1).
[184] *Id.* § 26-13-1(3).
[185] *Id.* § 26-13-5.
[186] *Id.* § 26-13-5.
[187] *Boykin v. Collins,* 40 Ala. 407, 37 So. 248 (1904).
[188] *Id.* at 408.
[189] *Anderson v. Loper*, 689 S.2d 118, (Ala. Civ. App. 1996).

are no specific rules or guidelines that will control every case."[190] After hearing testimony and observing the demeanor of the father, mother, minor, and other witnesses, the trial court held that although the daughter was 18 years of age, a high-school graduate currently living with her boyfriend and his family, attending college full-time and working part-time, she was not emancipated.[191] Since the daughter was not emancipated and free from parental control, nor self-supporting, her father was responsible for her support.[192] The appellate court affirmed, stating that since there was no finding that the trial court was plainly and palpably wrong, the trial court is the ultimate decision-maker.[193]

The best interest standard gives courts wide latitude in determining whether or not emancipation will be granted because it allows them to base all of their decisions, whether to the benefit or detriment of the minor, on this ambiguous and broad standard. This statute also allows the court to restrict and qualify the rights of a minor who have been emancipated by the court. However, these restrictions must be included in the judgment relieving the minor of the disability of non-age.[194] It appears that Alabama recognizes the need and ability for some minors to be on their own but is not quite comfortable with giving minors total rights as courts do in other jurisdictions.

Once a minor becomes emancipated, the trial court generally has no jurisdiction to require a parent to provide support for the minor.[195] However, support of an adult child may be ordered by the trial court in very limited exceptions, including for a mentally or physically disabled child who is unable to support herself, or for college expenses of a child who has reached the age of majority.[196]

Overall the statute makes it difficult not only to qualify for emancipation but also to garner all of its benefits when it is actually granted. If Massachusetts were to begin formulating

[190] *Id.* at 120, citing *Hodge v. Hovey,* 679 So. 2d 1145, 1148 (Ala. Civ. App. 1993).
[191] *Id.* at 119, 120.
[192] *Id.* at 120.
[193] *Id.*
[194] *Id.* § 26-13-6.
[195] *B.A. and E.A. v. State Department of Human Resources ex rel. R.A.*, 640 So. 2d 961 (Ala. Civ. App. 1994).
[196] *Id.* at 962.

an emancipation statute, this would not be the model to follow.

7.2 Mature Minor

Alabama maintains very broad statutes pertaining to the ability of minors to consent to general health care without needing additional parental consent. In Alabama "any minor who is age 14 or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services, and the consent of no other person shall be necessary."[197]

Passed in 1975, this statute places Alabama at the forefront of children's rights as pertaining to health care access.[198] By allowing minors age 14 or older the unfettered right to consent to general health, dental, and mental health services, it appears that Alabama, in effect, recognizes that many minors have the experience and judgment to make fully informed decisions.[199] By not requiring the minor to be financially independent or live separately from her parents or legal guardian, this statute acknowledges the importance of minors' privacy rights. In effect, it shows that parents do not have an absolute right to make health care decisions for their children, even though they are living in the same household. In addition, since age acts as the bright line rule determining ability to consent to general health care, Alabama effectively rids its laws of inconsistencies in determining which health care issues are worthy of minor consent alone, as well as inconsistencies in dealing with a vague maturity standard for those at least 14 years old.

Moreover, by including high school graduates among those with the right to consent to health services, Alabama acknowledges the potential difficulty that this group of minors may face. The inequitable reality for some high school graduates may be that they are independent from their parents and yet, traditionally, still cannot consent to their own health care since they have not reached the legal age of majority - even if only a few months

[197] Ala. Code § 22-8-4 (2001).

[198] *See* The Alan Gutmacher Institute, *supra* n. 126; South Carolina also maintains a broad medical consent statute whereby any minor 16 years of age or over may consent to health services other than operations. S.C. Code Ann. § 20-7-280 (2001).

[199] *See* The Alan Gutmacher Institute, *supra*, n. 129.

shy of their 18th birthday. While Alabama's broad 14 year-old age status takes care of all high school graduates, this offers added protection and another option for Massachusetts to consider.

Further, Alabama acknowledges that any minor, even those under the age of 14, may have health care concerns dealing with traditionally sensitive and urgent issues, such as pregnancy, STDs, alcohol, or drug abuse.[200] Alabama Code § 22-8-6 gives "any minor," regardless of age, the ability to "give effective consent for any ... health services to determine the presence of, or to treat, pregnancy, venereal disease, drug dependency, alcohol toxicity, or any reportable disease." This statute respects minors' right to privacy, independent of age, when these specific health concerns surrounding issues of immediacy, confidentiality, and important policy implications are present.

While broadly supporting the rights of minors to consent to general health care, Alabama also protects health care providers from liability for treating a minor who is under the age of 14. Under Alabama Code § 22-8-7 (2000), "any physician or other person who has relied in good faith upon the representations" of a minor who misrepresents herself will not be held liable for not gaining proper consent.

In sum, Alabama's statutory scheme has remained unchanged since enactment in 1975, and there appears to be only one case citing the general health consent statute, which case deals with the issue of abortion and parental notification.[201] Without any amendments or oppositional case law, this suggests that Alabama has found the bright-line age test to work well. Therefore, Alabama's broad statutory scheme offers a good model for Massachusetts to follow in expanding its Mature Minor Rule, especially when considering a bright-line age recommendation for drafting expanded mature minor legislation.

[200] Ala. Code § 22-8-6 (2001).

[201] *See Arnold v. Board of Educ.*, 754 F.Supp. 853, 859 (S.D. Ala. 1990). This case mentions Ala. Code § 22-8-7 in the context of a 15-year-old minor who consented to an abortion without informing her parents and where the school officials also did not inform the parents or have a duty to notify. While the holding does not deal specifically with the statute, the court granted summary judgment for the defendant school officials, which lends support and credibility to the statute.

7.3 Legal Access

A minor in Alabama is defined as a person "who is under nineteen years of age and has not otherwise had the disability of minority removed."[202]

Alabama Rule of Civil Procedure 17(c) (2001) holds that whenever "a minor has a representative, such as a guardian or like fiduciary, the representative may sue in the name of the minor." If a minor defendant, however, does not have a duly appointed representative, the court shall appoint a guardian ad litem for her and may make any other orders it deems proper for the protection of the minor.[203] Moreover, if a minor is or should be made a party defendant, "the court may direct further process to bring the minor into court or appoint a guardian ad litem (GAL) for the minor without service upon the minor or upon anyone for the minor."[204]

Whenever a GAL is necessary for a minor, "the court in which the action is pending must appoint some person who is qualified to serve in that capacity to represent the minor in the capacity of an attorney or solicitor." In addition, the court must not "select or appoint any person who is related, either by blood or marriage within the fourth degree, to the plaintiff or the plaintiff's attorney, or to the judge or clerk of the court, or who is in any manner connected with such plaintiff or such plaintiff's attorney, or who has been suggested, nominated, or recommended by the plaintiff or the plaintiff's attorney or any person for the plaintiff."[205] If the GAL is appointed for the representation of a minor fourteen years of age or over, the minor may, "within thirty days after perfection of service upon the minor in such cause," have her choice of a GAL, but only if the minor's cause is "certified by an officer authorized to take acknowledgments." If the minor fails to nominate a GAL within that thirty day period, or before any hearing is scheduled on the matter, whichever is earlier, the court shall appoint the GAL previously provided.[206] Any action against a minor who has a

[202] Ala. Code § 26-2A-20(11) (2001).
[203] *Id.*
[204] *Id.*
[205] Ala. R. Civ. Proc. 17(d) (2001).
[206] *Id.*

general guardian will still require an appointment of a GAL.[207]

The power of the court to appoint GALs can be found in at least eight Alabama Code sections, which refer to the appointments of GALs in particular types of hearings including, but not limited to, appointment; compromise of debts; sales of property; accountings; settlements; and removal. For example, under Alabama Code § 26-2A-52 (2001), dealing with the appointments of GALs in guardianship and protective proceedings, "at any point in the proceeding, a court may appoint a GAL to represent the interest of a minor if the court determines that such representation of the interest otherwise would be inadequate." In its commentary to the aforementioned provision, Alabama legislators established that the court has very broad discretion in appointing a GAL for a minor, and such appointment can be made at any time and for virtually any reason.[208] Moreover, the court is not required to set out its reasons for appointing a GAL as a part of the record.[209]

However, in certain proceedings, appointment of a GAL is not mandated by the legislature, and a minor can explore other avenues in accessing the state legal system. For instance, in proceedings for a waiver of parental consent to performing an abortion on a minor, a minor who has not obtained "consent from either of her parents or legal guardian, may petition, on her own behalf, the juvenile court, or the court of equal standing, in the county in which the minor resides or in the county in which the abortion is to be performed for a waiver" of the parental consent requirement.[210] "Notice by the court to the minor's parents, parent or legal guardian [is not] required or permitted."[211] In addition, the requirements and procedures under the aforementioned statute apply and are available to minors whether or not they are residents of the state of Alabama.[212] The minor also may participate in court proceedings on her own behalf.[213] The court must advise "her that she has a right to be represented by an attorney and that if she is unable to pay for the services of an attorney one will be ap-

[207] *Id.* (Committee Comments on 1973 Adoption).
[208] Ala. Code § 26-2A-52(Comment)(2001).
[209] *Id.*
[210] Ala. Code § 26-21-4 (a)(2001).
[211] *Id.*
[212] *Id.*
[213] Ala. Code § 26-21-4 (b) (2001).

pointed for her."[214] If the minor chooses to self-represent, the pleadings, documents, and/or evidence she files with the court "are liberally construed by the court so as to do substantial justice," and any hearsay evidence she wishes to submit is admissible.[215] Moreover, during her proceedings, a court must insure that her identity is kept confidential.[216]

In sum, neither Alabama statutory law, nor its common law clearly elucidate exactly what options a minor in that state has with respect to accessing the legal system. The rules seem to differ depending on the nature of the proceedings in which a minor is a party.

7.4 Shelter Restrictions

In Alabama any person who takes a child into custody must, with all possible speed, make arrangements to release the child to their parents, the court, or an appropriate intake facility or agency.[217] If there is no parent, guardian, custodian, or suitable person willing and able to provide supervision for a runaway, the court has to make a determination if the child should continue to live in shelter care.

Alabama has a very vague statute regarding shelter restrictions because it requires runaways to be reported, but it does not specify what "all possible speed" means.[218] Under the all possible speed standard, a runaway could be reported at any time during the 24-72 hour period stipulated by the federal rules.[219] The open-ended nature of the statute provides a great deal of leeway to people who provide services to at risk youth populations. In Alabama, a minor can continue to receive shelter care if there is no person to actually take care of them, such as a parent or guardian.[220] The court determines if youth are eligible for shelter care, but it gives youths who truly need it access to shelters, regardless of restrictions. The court's intervention regarding shelter care gives runaway youths access to a hearing process,

[214] *Id.*
[215] *Id.*
[216] Ala. Code § 26-21-4 (c) (2001).
[217] Ala. Code § 12-15-58 (2001).
[218] *Id.*
[219] 45 C.F.R. § 1351.18 (2002).
[220] Ala. Code § 12-15-58 (2001).

and it allows their situation to be evaluated on an independent basis.[221] Alabama seems to focus on the population as a whole in its legislation, but it also attempted to include ways for people in special situations to gain access to needed services.

8 Arizona

8.1 Emancipation

Unlike many other states, Arizona does not have a statutory scheme outlining a procedure for emancipation. In accordance with common law, the state recognizes emancipation in cases only where the minor has been married or has enlisted in the armed forces.[222] Arizona courts seem to look at whether a minor is emancipated on a case-by-case basis, and places weight on the intent of the parents when deciding if emancipation exists. In *Tencza v. Aetna*, for example, the Court held that "actual emancipation is a question of fact" not of law, showing the reluctance of the court to supply a bright line test for determining emancipation status.[223] Although the court does conclude that a child who still lives at home may be considered legally emancipated, the court is not clear under what circumstances a minor may petition, or what may be required of the minor for the court to grant emancipation. The Court does say, however, that emancipation must be proven by a preponderance of evidence and the burden of proof is on the one asserting it. It is a possibility that Arizona does not have a statute governing emancipation because the legislature determined that there is no need, or because they have provided for such services as legal and medical access through other statutes, without resorting to the total freedom an emancipation statute would grant minors.

Due to the lack of specific procedures and statutes, this is obviously not a model Massachusetts should look to in crafting an emancipation statute for the Commonwealth.

[221] *Id.*
[222] *Tencza v. Aetna Casualty and Surety Co.*, 527 P.2d 97 (Ariz. 1974).
[223] *Id.* at 97.

8.2 Mature Minor

Unlike most other states, Arizona does not have particularized statutes that allow for minors' consent to general health care, drug abuse treatment, prenatal care, or access to contraceptive care. Under Arizona Revised Statute § 36-2024 (2001) (enacted 1972; amended 1986), however, a minor may specifically consent to her own treatment for alcohol abuse, and under Arizona Revised Statute § 44-132.01(2001), she can consent to treatment for sexually transmitted diseases. Since no age minimum age is specified, this may allow for a health care provider to widely interpret the age of a minor who may give consent for treatment, or alternatively, to narrowly interpret the statute's silence and refuse to treat minors based on an individual arbitrary motive.

Despite the absence of a statutory scheme, Arizona is nevertheless exceptional, in that it statutorily defines a homeless minor under Arizona Revised Statute § 44-132(C) (2001): a homeless minor may consent to the furnishing of hospital, medical and surgical care. Indeed, with § 44-132(C), Arizona uniquely provides for access to medical care for homeless youth under 18 years of age. An individual "under the age of eighteen years living apart from his parents and who lacks a fixed and regular nighttime residence or whose primary residence is either a supervised shelter designed to provide temporary accommodations, a halfway house or a place not designed for or ordinarily used for sleeping by humans is entitled to obtain hospital, medical and surgical care."[224] While no age minimum is specified, this could be a point of confusion for health care providers. However, a health care provider acting in reliance on the consent of a minor who has authority or apparent authority pursuant to this section to consent to health care is not subject to criminal and civil liability and professional disciplinary action on the ground that he or she failed to obtain consent of the minor's parent, parents or legal guardian.[225]

Finally, Arizona does not specify a minor's right to consent to outpatient mental health care, and is restrictive regarding a minor's access and consent to voluntary admission for

[224] *Id.*

[225] Ariz. Rev. Stat. § 44-132(B) (2001).

mental health services. Except in the case of an emergency, a minor may only be admitted if consent is given by a parent, or, if the child is in the custody of the court, a ward of the juvenile court, or is adjudicated delinquent or incorrigible unless approved by the court

However, Arizona does not specify a minor's right to consent to outpatient mental health care, and is restrictive regarding a minor's access and consent to voluntary admission for mental health services. Except in the case of an emergency, a minor may only be admitted if consent is given by a parent, or, if the child is in the custody of the court, a ward of the juvenile court, or is adjudicated delinquent or incorrigible unless approved by the court.[226]

In sum, the Arizona statute, which specifically provides a homeless minor to consent to medical care, is unique and may serve to provide the most liberal access to health care for youths, particularly the target population of JRI. Massachusetts legislators would be wise to inquire as to the implications of a similar provision in Massachusetts statutes.

8.3 Legal Access

Arizona sets out the legal rights given to minors in its statutes, court rules, and procedures. If a minor is an abuse victim, she may choose a parent or any immediate family member to exercise her rights, unless the delinquent act is alleged against that chosen representative.[227] A minor must be represented to initiate a court proceeding. However, any person interested in the welfare of the minor may petition the court for the appointment of a GAL that will represent the best interests of the minor.[228] The court may also appoint a GAL to protect the child's best interests if there is an allegation of abuse or neglect of the child, if the parents are continuously in conflict with one another, if there is a history of parental alienation, substance abuse by either parent, family violence, if there are serious concerns about the mental health or behavior of either parent, if the child in question is an infant or toddler, or if the child has special needs.[229]

[226] Ariz. Rev. Stat. § 36-518 (2001), enacted in 1971; ammended nine times since.
[227] Ariz. Rev. Stat. Ann. § 8-384 (West 2001).
[228] Ariz. Rev. Stat. Ann. § 14-5207 (West 2001).
[229] Ariz. Stat. Maricopa Super. Ct. Rule 6.13 (West 2001).

The GAL may be an attorney or court-appointed special advocate.[230] In appointing a GAL, the court will generally appoint one who would be in the best interests of the minor, such that the representative will be able to continue with the proceedings for as long as they last and will take a genuine interest in the outcome.[231] The minor may nominate someone if over the age of fourteen unless the nominee is found by the court to be contrary to the best interests of the minor.[232] In general, a minor has many rights that can be invoked. However, the minor must initiate the proceedings by retaining a lawyer or other such representative who can petition the court for a GAL to commence the proceedings.

8.4 Shelter Restrictions

In Arizona, by definition a homeless youth is one who "is an individual under the age of eighteen years living apart from his parents and who lacks a fixed and regular nighttime residence or whose primary residence is either a supervised shelter designed to provide temporary accommodations, a halfway house or a place not designed for or ordinarily used for sleeping by humans."[233] A youth who is homeless has the capacity to give consent in the same manner as a legally emancipated youth.[234]

9 California

9.1 Emancipation

California's current emancipation statute, effective January 1, 1979, resulted from dissatisfaction by public interest lawyers over what they viewed as unnecessary problems facing clients who had not reached the age of majority. Now, California's Emancipation of Minors Law enables a minor to petition the court and be granted emancipation with relative ease.

[230] Ariz. Stat. Juv. St. Rule 70 (West 2001).
[231] Ariz. Stat. Ann. § 14-5206 (West 2001).
[232] *Id.*
[233] Ariz. Rev. Stat. §44-132 (2001)(One area for further research will be if this translates into more shelters specifically designed for this population).
[234] *Id.*

When considering these petitions, the superior courts in California are authorized to grant emancipation to children who are at least 14 years of age, and under the age of 18, by authority of case law or Family Code statutes § 7000 and § 7120, the Emancipation of Minors Law.[235] Also, the court may recognize emancipation if the minor is validly married or on active duty with the armed forces.[236]

To begin the process of emancipation, a minor must file a petition with the court stating that they are at least 14 years of age and has the consent of her parent or guardian, is willing to live separate and apart from her parents or guardian, demonstrates to the court she is managing her own financial affairs, and must provide evidence that her income is not derived from criminal activity.[237] In addition, the minor must provide an affirmation that emancipation is not contrary to the minor's best interest.[238] Prior to the hearing of the emancipation petition, notice must be given to the parent, guardian, or other persons entitled to custody of the minor, as well as to the district attorney of the county where the petition is filed. Other than notifying the parent that an emancipation petition has been initiated by the minor, parental involvement is not required.[239] If the court is satisfied that emancipation will not be "contrary to the minor's best interest," the petition is sustained and the minor is emancipated.[240]

Once a minor is emancipated, she is entitled to consent to medical care, enter into binding contracts and real estate transactions, sue and be sued, enroll in school, establish her own residence, and apply for work permits.[241] Once granted, a declaration of emancipation may be voided upon a showing that it was obtained by fraud or misrepresentation of material information, or may be rescinded if the minor becomes indigent and has no means of support.[242] This option of rescission gives the court some degree of control over what happens to

[235]Cal. Fam. Code Ann. §§ 7000, 7120 (LEXIS L. Publg. 2001).
[236]*Id.*
[237]Cal. Fam. Code Ann. § 7121 (LEXIS L. Publg. 2001).
[238]Cal. Fam. Code Ann. § 7122 (LEXIS L. Publg. 2001).
[239]Sanger and Willemsen, *supra* n. 37 at 261.
[240]*Id.*
[241]Cal. Fam. Code Ann. § 7050 (LEXIS L. Publg. 2001).
[242]Cal. Fam. Code Ann. § 7130 (LEXIS L. Publg. 2001).

minors after they leave the courtroom, essentially granting the judiciary not only the power to confer emancipation but also the power to take it away.

Prior to the 1979 enactment, the common law meaning of emancipation and its consequences was haphazard, and no standards or statutory guidelines existed to determine when a minor was emancipated.[243] The proposed legislation sought to expand legal mechanisms to independent and self-supporting minors, to assist them in uncomplicating their lives, to remedy inadequacies of the existing law, and clarify the definitional limitations of common law emancipation, implement procedures, remove barriers, and allow minors themselves to petition for emancipation.[244] The new emancipation statute was not designed to benefit all youths, but rather those that are usually brighter, more self-sufficient, and industrious, and have matured "earlier than the arbitrary eighteen year designation which serves as the age of majority."[245] The legislators acknowledged that the statute would help not only minors who had good relations with their parents but also those who did not.[246] Also, proponents of this new legislation argued that emancipation might actually save the state money by removing mature and self-reliant minors from expensive foster care prior to reaching the age of majority.[247]

The California statute, like most other states' emancipation statutes, while greatly expanding the rights of minors, does not grant minors carte blanche every right an adult is entitled to. An emancipated minor in California still receives minority status for purposes of school attendance laws, certain child labor laws, voting laws, and laws that restrict the possession and purchase of alcohol.[248] In addition, the California juvenile courts retain jurisdiction over minors who are emancipated prior to reaching the age of majority.[249]

The level of detail within the statute evinces the intent of the legislators for the text to be straightforward and inclusive of all parties to whom the petition has an effect. Criticism

[243]Sanger and Willemsen, *supra* n. 37 at 251.
[244]*Id.* at 254.
[245]*Id.*
[246]*Id.* at 255.
[247]*Id.*
[248]*Id.* at 260.
[249]*Id.*

of this law does exist, however. But such criticisms are generally derived not from the procedural language itself, but rather from the inconsistent way that the courts seem to apply the standards within the text.

California's Emancipation Law has been the subject of numerous studies and criticisms because it seems to hinder emancipated minors from building independent lives.[250] Although the statute requires that emancipation must not be contrary to the best interest of the child, this is not always a paramount consideration for the court.[251] This is partially due to the fact that the requirements set forth in § 7120 are not always strictly adhered to. For example, judges tend to be lax in enforcing the requirement that the minor must be willing to live separate and apart from her parents or guardian.[252] While the court insists that a minor has legally derived income, the amount of income required is left unspecified.[253] Lastly, the "best interest" requirement is up to the discretion of the court and rarely is the emancipation petition denied on this ground.[254] The court generally looks at the harm that will come to the child if emancipation is granted and the judge relies on his or her own personal experiences when examining the totality of the circumstances surrounding the petition.[255]

In their emancipation study, Sanger and Willemsen found that early emancipation often has the unintended consequence of forcing minors to quit school so they can work.[256] Sanger and Willemsen also found that homelessness was another serious problem for emancipated minors.[257] This conclusion was strengthened by evidence from the state of Michigan, demonstrating that a large number of minors in the state's runaway shelters were emancipated minors. This finding in Michigan actually led that state to amend its emancipation statute to require proof of housing by the minor before emancipation is granted.[258] Lastly,

[250]Alexis A. Phocas, *Runaways and California's Juvenile Law: The Emancipation Option*, 19 J. Juv. L. 46 (1998).
[251]Sanger and Willemsen, *supra* n. 37.
[252]Alton, *supra* n. 21.
[253]*Id.* at 664.
[254]*Id.* at 664.
[255]*Id.* at 664-665.
[256]Sanger and Willemsen, *supra* n. 37 at 291.
[257]*Id. see also* Phocas, *supra* n. 250.
[258]*Id.* at 292.

Sanger and Willemsen found that many of the minors had second thoughts about emancipation, mostly attributed to the lack of understanding about what the rights, limitations, responsibilities, and consequences of their new status would entail.[259] The unintended consequences, coupled with the relative ease and speed with which an emancipation petition is granted, suggests that California's statute is flawed to the detriment of those it is intended to serve. This is due, in part, to the fact that judges, rather than making independent, best interest determinations, often use parental signatures on petitions to serve as a proxy for this determination.[260] Considering the deleterious effects that a grant of early emancipation has on many minors, the standard of "not contrary" to the youth's best interest, at times, seems to be ignored.

As a result of their research, Sanger and Willemsen offer modifications to California's statute that would reduce the negative consequences of emancipation. These recommendations include: (1) increasing the age requirement from 14 to 16 years; (2) appointment of counsel, whose chief obligation would be to educate the minor about emancipation; (3) inquiring about the current educational status of the minor, as well as future plans;[261] (4) requiring declarations similar to those required in Michigan;[262] (5) requiring more substantial proof of the minor's independence; (6) relegating emancipation determinations to family court judges; and (7) incorporating specific factors into the statute that will assist the judiciary in making "best interest" determinations.[263]

Although California's statute has been shown to have unintended results, it is still useful to JRI because it is of interest to many researchers. Therefore, there is a lot of useful information available. Furthermore, the recommendations offered by Sanger are just some of the criteria that should be explored by future law offices because they appear to be based on in-depth analysis of primary and secondary sources.

[259] *Id.* at 293.
[260] *Id.* at 316.
[261] For example, Montana grants emancipation only when the court finds that the youth will continue to diligently pursue graduation from High School or has already graduated, and Indiana requires that emancipated minors are still subject to compulsory school attendance.
[262] *see* discussion of Michigan's emancipation statute later in this paper.
[263] Sanger and Willemsen, *supra* n. 37, at 336-341 and 664-665.

9.2 Mature Minor

The statutory scheme in California that gives minors the right to consent to medical care is expansive, yet it retains vestiges of parental control over the minor. The age at which a minor may consent to medical care in California is 12 for most types of care, and 15 for generalized medical and dental care.[264] Most types of medical care are covered: mental health, drug and alcohol abuse counseling and treatment, pregnancy care, access to contraceptives, and generalized medical and dental care. These areas of coverage are more expansive than many other states, and yet, in specific instances statutory language provides that a health care provider may contact a minor's parent or guardian to apprise him or her of the care given or needed by the minor.[265]

California allows a minor to consent to medical treatment at the age of 12 if the minor has come into contact with a communicable disease. That disease is required by law to be reported to the local health officer or is a sexually transmitted disease, "as may be determined by the State Director of Health Services."[266] However, the first provision of this subsection, "an infectious, contagious, or communicable disease," is overly broad and vague. This may result in California health care providers interpreting the language too narrowly or too broadly. Similar to other states studied, California includes specific language designating a minor's right to consent to contraceptives, sterilization, care for a sexually transmitted disease, drug and alcohol counseling, and mental health care.[267] All of the above may be provided to a minor 12 years of age and over without a parent's consent or fiduciary responsibility.

California grants minors broad consent rights in that it provides minors 15 years of age and older to consent to their own general medical and dental care. As per §6922, a minor may

[264] Cal. Fam. Code Ann. §6922 (LEXIS L. Publg. 2001), enacted 1992; Cal. Fam. Code Ann. §6924 (LEXIS L. Publg. 2001), enacted 1992,ammended 1993 and 2000; Cal. Fam. Code Ann. §6925 (LEXIS L. Publg. 2001),enacted 1992, amended 1996; Cal. Fam. Code Ann. §6926 (LEXIS L. Publg. 2001), enacted 1992; Cal. Fam. Code Ann. §6929 (LEXIS L. Publg. 2001), enacted 1992.

[265] Cal. Fam. Code Ann. §6922 (LEXIS L. Publg. 2001).

[266] Cal. Fam. Code Ann. §6926 (LEXIS L. Publg. 2001).

[267] Cal. Fam. Code Ann. §6925 (LEXIS L. Publg 2001), Cal. Fam. Code Ann. §6926 (LEXIS L. Publg. 2001), Cal. Fam. Code Ann. §6929(LEXIS L. Publg. 2001), Cal. Fam. Code Ann. §6924 (LEXIS L. Publg. 2001).

give consent if they are 15 years of age or older, living separate and apart from their parent or guardian "whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence," and "the minor is managing the minor's own financial affairs, regardless of the source of the minor's income." However, subsection (c) provides that a physician, surgeon, or dentist "may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed ... if the physician ... has reason to know ... the whereabouts of the parent or guardian." This relic of parental power is mirrored in §6929 (f) which stipulates the state shall:

> "respect the right of a parent or legal guardian to seek medical care and counseling for a drug or alcohol-related problem of a minor child when the child does not consent to the medical care and counseling, and nothing in this section shall be construed to restrict or eliminate this right."[268]

The presence of the provision allowing a physician to contact a minor's parents without her consent seems indicative of the reluctance of states to fully allow minors rights normally afforded once the age of majority has been attained. Entwined with this may be the state's own deference to the "right" to parent, regardless of familial circumstance. Hence, California presents a comprehensive and liberal statutory scheme for minors seeking health care independent of their parent or guardian, and yet, vestiges of parental control are evinced within the same statutory provisions. However, the intricate duality of this system allows youth more liberal access to health care than in many other jurisdictions.

Inclusive or absent of the parent notification provision, the California statute which allows minors 15 years of age or older to consent to medical care is a decent framework with which Massachusetts may glean statutory language and effective goals.

[268] Cal. Fam. Code Ann. §6929(f)(LEXIS L. Publg. 2001).

9.3 Legal Access

California minors are granted an extensive set of legal access rights as set forth in the state's statutes and court procedures. In some circumstances, a minor can even appear in court without the use of a representative. A minor at least 12 years old may appear in court for the purpose of requesting or opposing an injunction or restraining order to prohibit harassment, violence, or the threat of violence in the workplace, or a protective order.[269] For all other proceedings, a guardian, conservator, or GAL must represent any unemancipated minor.[270] However, a minor may enforce rights in a civil action or other legal proceedings in the same manner as an adult, except that a guardian must conduct the action or proceedings.[271] The reason for this is that a minor cannot give a delegation of authority, make a contract relating to real property or any interest therein, or make a contract relating to any personal property not in the immediate possession or control of the minor.[272]

Unlike many states, a minor in California may institute her own proceedings as long as she has a representative.[273] The minor is fully entitled to petition the court for a GAL or next friend to be her representative. Furthermore, any interested party may file a petition to provide a GAL or next friend for the minor.[274] Generally, a parent of the minor is given preferential treatment for the appointment as GAL; however, the court is not bound in appointing a parent, and can listen to the wishes of the minor in choosing whom to appoint as representative.[275]

In all civil actions, a minor plaintiff 14 years of age or older must apply for a GAL before the summons is issued.[276] A plaintiff minor under 14 years of age must have a friend or relative apply.[277] A defendant minor 14 years of age or older may apply within ten days

[269] Cal. Civ. Pro. § 372 (West 2002).
[270] *Id.*
[271] Cal. Fam. Code Ann. § 6601 (West 2002).
[272] Cal. Fam. Code Ann. § 6701 (West 2002).
[273] *In Re Cahill*, 74 Cal. 52 (1887).
[274] Cal. Fam. Code Ann. § 7804 (West 2002).
[275] 2 Cal. Affirmative Def. § 18:3 (West 2002).
[276] Cal. Civ. Pro. § 373 (West 2002).
[277] *Id.*

after service of summons.[278] A defendant minor 14 years of age or older who neglected to apply or under 14 years old must have a friend, relative, any party to the action, or the court apply.[279] The court may also, on its own, or on the request of an interested person, appoint a GAL at any stage of the proceedings for a minor or group of minors if not precluded by a conflict of interest.[280] The reasonable expenses are paid by the estate, interested person(s), or other such funds as the court deems proper.[281] Even after the GAL is appointed, the minor must be represented by an attorney who's role would be to represent the wishes of the minor rather than the best interests of the minor.[282] The role of the attorney is to represent the wishes of his or her client, including that of a minor client.[283]

California makes every attempt to provide legal services for the minors of the state. Minors can initiate court proceedings and have extensive legal rights that can be enacted, at times, without the need for a representative. California would be a good state to look at for recommendations for increasing the legal rights of minors in Massachusetts.

9.4 Shelter Restrictions

In California, the Runaway Youth and Family Crisis Project attempts to provide long-term assistance and temporary shelter related services to runaway youth.[284] The program allows runaways to receive service for up to fourteen days.[285] The main objective of the program is to provide youths with necessary medical, emotional, and social services, so that they can return to a suitable living arrangement with their parents. The program also seeks to place youths in suitable living arrangements if reunification with their parents is not possible.[286] Though this program provides shelter services, the state of California does not have a specific

[278] *Id.*
[279] *Id.*
[280] Ca. Prob. Code Ann. § 1003 (West 2002).
[281] *Id.*
[282] Robyn-Marie Lyon, Comment: *Speaking for a Child: The Role of Independent Counsel for Minors*, 75 Calif. L. Rev. 681, 695 (1987).
[283] *Id.*
[284] Cal. Wel. & Inst. Code § 1788 (2001).
[285] *Id.*
[286] *Id.*

shelter restriction statute, and therefore follows all federal guidelines.

10 Michigan

10.1 Emancipation

Michigan's current emancipation statute began in 1968, and was most recently amended in January 1, 1998.[287] Emancipation is granted in Michigan by operation of law or pursuant to statute § 722.[288] Emancipation under operation of law occurs in limited circumstances including, but not limited to, when a minor reaches the age of 18 years, is validly married, or is on active duty with the armed forces.[289] Alternatively, a minor may petition the family division of circuit court in the county were they reside.[290] A minor must include in her petition a declaration that she is able to manage her financial, personal, and social affairs.[291] The petition must also include an affidavit by one of the named persons including, but not limited to, the minor's physician, a psychologist, a member of the clergy, a certified social worker, a teacher, or school administrator, or a law enforcement officer who states he or she has personal knowledge of the minor's circumstances and, given the circumstances, emancipation is in the minor's "best interest."[292] If the minor's custodial parent(s) is (are) providing support and does (do) not consent to emancipation, the court may dismiss the petition solely on that basis.[293] The court is able to investigate the allegations within the petition and appoint legal counsel for the minor and/or the parent(s) or guardian if the petition is opposed.[294]

Emancipation is granted by the court upon a finding that the minor is at least 16 years of age, has demonstrated her ability to manage her financial, social, and personal affairs, and has

[287] Mich. Stat. Ann. § 722.4 (LEXIS L. Publg. 2001).
[288] Mich. Stat. Ann. § 722 (LEXIS L. Publg. 2001).
[289] *Id.* § 722.4.
[290] *Id.* §§722.4(a)-(e).
[291] *Id.* § 722.4(a)(1).
[292] *Id.* § 722.4(a)(2).
[293] *Id.* § 722.4(b)
[294] *Id.*

proof of housing. The court also considers the parents' or guardians' lack of objection to the petition, and the fact that they are not supporting the minor financially. The minor must also understand the rights and responsibilities that come with her emancipated status.[295] The minor carries the burden of proof of showing, by a preponderance of evidence, that emancipation should be granted.[296] Similar to the California statute, the petition is voidable upon a showing that it was obtained fraudulently and can be rescinded if the emancipated minor becomes indigent and has no means of support.[297]

Once a minor is emancipated, she is entitled to all the rights and responsibilities that a person who has reached the age of majority is entitled to unless there are statutory or constitutional restrictions. These rights include the ability to enter into contracts; to sue and be sued; the right to earn a living; authorize health care; to register for school; and to retain her earnings.[298] Furthermore, under the statute, the parents or guardians are obligated to support the minor.[299]

This state's comprehensive statute is of particular interest to this year's Law Office, because its structure and requirements are such that the best interest of the minor standard is somewhat described, and judicial discretion is limited. Despite the lack of case law interpreting this statute, the statute itself is comprehensive and incorporates many features that researchers have suggested when studying other state statutes.[300]

Michigan's Emancipation of Minors Act can be considered "limited" or "partial" because, unlike California's statute, it does not terminate parental financial support.[301] This statutorily required parental obligation relieves financial stress to the minor and allows her to continue schooling. Similar to the California statute, Michigan allows only the child to petition for emancipation.[302] This is important because as studies indicate, many emancipation

[295] *Id.* § 722.4(c)(2).
[296] *Id.* §722.4(c)(3).
[297] *Id.* § 722.4(d)(3).
[298] *Id.* § 722.4(e).
[299] *Id.*
[300] *see* Sanger and Willemson, *supra* n. 37.
[301] *Id.* § 722.4 (e)(2).
[302] *Id.* § 722.4 (a).

petitions are filed by parents to abdicate their parental duties.[303] However, prior to the amendment of this statute, parents were able to legally abandon their children, and were not obligated to notify the child of their intent.[304] These features of Michigan's statute are of particular interest because Massachusetts legislators have expressed concerns and hesitation about emancipation terminating parental support obligations, and parents, for selfish reasons, emancipating their children.

From a best interest perspective, the Michigan statute requires the minor to provide specific and detailed information to the court prior to the grant of emancipation.[305] This information includes the minor's ability to manage her financial, personal, and social affairs; proof of employment; proof of housing; and proof that she understands her rights and responsibilities as an emancipated minor. These requirements address and rectify many of the unintended consequences of California's statute discussed above that were contrary to the minor's best interest. Michigan's statute also contains a provision that allows an emancipation order to be rescinded upon a finding that the minor is indigent and has no means of support.[306]

In addition to requiring continued parental support to the emancipated minor, perhaps one of the most exciting features of the Michigan statute is the requirement that the petition include an affidavit by at least one of 13 named professionals, stating that he or she has personal knowledge of the minor, and that emancipation is in her best interest.[307] This requirement allows the court to make informed decisions about the minor's best interest, qualifications, circumstances, and abilities, as viewed by a third-party professional.

The Michigan statute is comprehensive, and although it relies on the subjective best interest standard, it limits discretion of the judiciary in several ways, including the high burden of proof placed upon the minor seeking emancipation. Requiring minors to prove that they have a source of income and housing, requiring that the minor understands their

[303]Report of LO #1, 2000-2001.
[304]*Id.* at 27.
[305]Mich. Stat. Ann. § 722.4(c)(2)(LEXIS L. Publg. 2001).
[306]*Id.* § 722.4(d)(3).
[307]*Id.* § 722.4(a)(2).

rights and obligations, and requiring an affidavit by an independent third party are some of the specific criteria this statute demands, thus giving guidance to the presiding judge and limiting her discretion.

10.2 Mature Minor

Michigan does not have a singular broad statute, or a statutory scheme, by which a minor may consent to her own general health care. However, statutes exist that authorize minors to consent to specific health care services, such as outpatient mental health care;[308] substance abuse;[309] communicable diseases;[310] , contraceptive services;[311] and prenatal and pregnancy related care.[312] The state passed these statutes in 1978, except for the mental health statutes enacted earlier in 1975, and the contraceptive care statute.[313] Since 1975, there have been minimal amendments, which have notes indicating the changes were not substantively significant,[314] and minimal case law implicating the authority of the statutes.[315] With no substantive statutory amendments and only one case discussing the substance abuse statute, this might indicate that the statutory scheme is working well for Michigan.

However, it is important to note that the scheme does not provide minors with the most empowering model. Not only are these Michigan consent statutes narrowly designed to authorize the minor to consent simply for specific health care needs, but most of the statutes

[308]Mich. Comp. Laws § 330.1707 (2001); Mich. Comp. Laws § 330.1498d. (2001).

[309]Mich. Comp. Laws § § 333.6121 (2001).

[310]Mich. Comp. Laws § 333.5127 (2001).

[311]Mich. Comp. Laws § 400.14b (2001), through case law interpretation. *See e.g.*, *Doe v. Irwin* (1977, WD Mich.) 441 F. Supp. 1247, rev'd on other grounds (1980, CA6 Mich.) 615 F2d 1162, cert. den. (1980) 449 US 829, 66 L.Ed. 2d 33, 101 S. Ct. 95, "Existence, if any, of fundamental civil right among minors to obtain prescriptive contraceptives need not exist to total exclusion of any rights of minor child's parents"; *Doe v. Irwin* (1980, CA6 Mich.) 615 F.2d 1162, cert. den. (1980) 449 US 829, 66 L.Ed. 2d 33, 101 S. Ct. 95, "State-run clinic which distributed contraceptive devices and medication to unemancipated children without knowledge and consent of parents did not infringe parents' constitutional right to care, custody and nurture of their children."

[312]Mich. Comp. Laws § 333.9132 (2001).

[313]Source: P.A.1939, No. 280, § 14b, added by P.A.1965, No. 302, § 1, Imd. Eff. July 22, 1965. C.L.1948, § 400.14b. P.A.1966, No. 248, § 1, Imd. Eff. July 11, 1966. C.L.1970, § 400.14b.

[314]For example the "Effect of amendment notes" for the mental health statute states: "The 1995 amendment in subsection (1), replaced "chemotherapy" with "psychotropic drugs"; deleted subsection (6); and made grammatical changes." Mich. Comp. Laws § 330.1707 (2001).

[315]*See Walling v. Allstate Ins. Co.*, 455 N.W.2d 736 (Mich. App. 1990).

in this category contain provisions permitting health care providers to inform the parent or guardian of services received by the minor, based on provider discretion.

Specifically, the mental health statute states that "a minor 14 years of age or older may request and receive mental health services ... on an outpatient basis ... without the consent or knowledge of the minor's parent."[316] However, the parent or guardian could be informed of the services received by the minor if the mental health professional determined "a *compelling need* for disclosure based on a substantial probability of harm to the minor or to another individual *and if the minor is notified of the intent to inform*"[317] (emphasis added). Since notification based on probability of harm to self or another person is customary with respect to disclosure standards in the mental health field,[318] this statute appears to grant minors similar confidentiality rights as are typically provided to adults with respect to mental health care needs. Requiring prior notification to the minor of intent to inform parents may demonstrate a general respect toward minors. It may also be a function of the general adherence to, and respect for the need for, strict confidentiality standards with regard to mental health matters.[319]

Unlike the mental health statute granting minors at least 14 years old the right to consent to services, a minor of any age may consent to treatment for substance abuse,[320] communicable diseases,[321] and pregnancy-related care.[322] This age inconsistency may reflect the reality of urgency and/or importance that individuals and society face, from a health and policy perspective, when dealing with these sensitive issues.[323] However, the sensitive nature of substance abuse, communicable diseases, and pregnancy-related care is not as restricted

[316]Mich. Comp. Laws § 330.1707 (2001).
[317]*Id.*
[318](*See e.g.*, *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 551 P.2d 334 (1976); *Berry v. Moench*, 8 Utah 2d 191, 331 P.2d 814 (1958); *Simonsen v. Swenson*, 104 Neb. 224, 177 N.W. 831 (1920); *MacDonald v. Clinger*, 84 A.D.2d 482, 446 N.Y.S.2d 801 (1982).
[319]*Id.*
[320]Mich. Comp. Laws § 333.6121 (2001).
[321]Mich. Comp. Laws § 333.5127 (2001)
[322]Mich. Comp. Laws § 333.9132 (2001).
[323]At the same time, mental health needs, in contrast to substance abuse, communicable diseases, and pregnancy-related care, may bring about symptomology that a minor under the age of 14 – particularly one with neurological problems requiring medications affecting the brain's functioning – may be viewed as an individual best seen and treated under the supervision of an adult.

as mental health care needs are with respect to confidentiality and minors' privacy rights.

Unlike the mental health statute, the provider is allowed to inform the parent or guardian without any statutory restrictions of compelling need or notification of intent to inform parents, but rather based solely on the provider's own judgment: "For medical reasons, [the health care provider] may, but is not obligated to inform the spouse, parent, guardian, or person in loco parentis as to the health care given or needed."[324] Although the statute points to "medical reasons" as the basis for informing others, in reality this allows the health care provider a large amount of discretion in deciding when to inform the parent. Indeed, even if the child requests confidentiality, the provider has the legal standing to inform the parent, despite the wishes of the minor. The statute states: "the information may be given to or withheld from these persons *without consent of the minor* and *notwithstanding the express refusal of the minor to the providing of the information*"[325] (emphasis added). In addition, with respect to pregnancy or prenatal care, the "putative father of the child" is added to the list of those potentially informed.[326] This does not indicate that providers will actually inform the parent (or putative father) against the will of the minor. However, with privacy rights in doubt, due to providers' legal permission to inform, this may deter minors from seeking needed treatment, even though they statutorily can consent to it.

In fact, the one case that implicates the substance abuse statute proves this point: in *Walling v. Allstate Ins. Co.*,[327] a hospital did not treat an intoxicated minor who came to the emergency room because she would not disclose her parent's phone number to the nurse.[328] The claim against the hospital alleged a duty to examine and treat the minor as matter of law,[329] and in part implicated the substance abuse statute, Michigan Compiled Laws § 333.6121. In interpreting the substance abuse statute, the court stated: "The purpose of the

[324]Mich. Comp. Laws § 333.6121 (substance abuse); Mich. Comp. Laws § 333.5127 (2001) (communicable diseases), and Mich. Comp. Laws § 333.9132 (2001) (pregnancy-related care).
[325]Mich. Comp. Laws 333.9132 (2001).
[326]*Id.*.
[327]455 N.W.2d 736 (Mich. App. 1990).
[328]The minor died later that night due to an unrelated fire and so plaintiffs sued the hospital, owners of a store, and family members of other minors who were with the decedent that night on different liability grounds.
[329]*Id.* at 735.

statute is to *permit* a hospital to provide medical treatment or care for substance abuse to a consenting minor without the prior consent of the minor's parents.[330] The statute does not *require* a hospital to provide treatment or care for substance abuse" (emphasis added).[331] The court reasoned that "[t]he record clearly establishes that, although decedent walked into defendant's emergency room with some difficulty, she did not require medical assistance while there. Decedent was conscious and coherent."[332] Since the minor's condition did not constitute an emergency, summary judgment in favor of the defendant hospital was affirmed. "Moreover, the trial court correctly ruled that defendant did not owe a statutory duty under MCL 333.6121, MSA 14.15(6121) to treat decedent."[333]

This case shows that Michigan courts support the discretionary nature of the statute which gives providers the power to inform a parent, even against the wishes of the minor. In this case, the minor chose to leave the hospital rather than disclose her parent's phone number.[334] This highlights the disempowered position of minors in Michigan's statutory scheme, supported by court interpretation, even where a sensitive issue like substance abuse is involved.

In summary, when focused on an analysis of constitutional privacy rights of minors, the current Michigan minor health and mental health care consent statutes, given their discretionary nature with respect to informing parents, guardians, and putative fathers by the health care provider, may be less supportive, *in toto*, of minors' rights than those currently in place in Massachusetts. Therefore, Michigan may not offer the best model for further expansion of Massachusetts minors' health and mental health consent statutes.

10.3 Legal Access

The state of Michigan identifies avenues for minors to access its legal system in its statutes and court rules. In any proceeding in the juvenile division of the probate court, the court

[330] *Id.*
[331] *Id.* at 737.
[332] *Id.* at 736.
[333] *Id.* at 738.
[334] Id. at 734.

may appoint a GAL for a minor if the court thinks that the welfare of the party requires it.[335] Outside of the juvenile division, a GAL can also be appointed. In fact, the court must appoint a GAL to "appear for and represent the interests of any person in any proceeding" where the law requires it.[336]

The GAL may be an attorney. However, in that case the GAL is not acting in the role of an attorney to the minor, in which he or she would represent the interests and desires of the child. Rather, a GAL is required to act in the best interests of the child, regardless of what the child may deem in her best interest.

In every case filed under the Child Protection Act in which judicial proceedings are necessary, the court must appoint a lawyer-guardian ad litem to represent the child. A lawyer-guardian ad litem represents the child's best interests in the child protection hearings.[337]

An important aspect of having an attorney appointed to be the GAL is that the appointment does not create an attorney-client relationship. Any information received by the GAL by any means, and any communications between that minor and the GAL, are not subject to the attorney-client privilege. This can cause a problem in getting a minor to trust their GAL. If the minor is aware that the relationship is not privileged, and that the GAL may share any information given to her with the court, the minor may not be as forthcoming, and this may therefore adversely affect her "best interests." The minor should be aware of this lack of privilege, as the GAL is required to inform the minor of this issue.[338]

However, if that attorney has his or her appointment as GAL terminated and the court later appoints that same individual as the minor's attorney, the appointment as attorney creates an attorney-client relationship. The attorney client privilege relates back to the date of the appointment of the GAL. That means that any information learned while the attorney was the minor's GAL will now be privileged.[339]

[335]Mich. R. Prob. Ct. 5.916 (West 2002).
[336]Mich. R. Prob. Ct. 5.121 (West 2002).
[337]Mich. Stat. Ann. § 25.248(10) (Lexis, 2001.)
[338]Mich. R. Prob. Ct. 5.121(E)(1) (West 2002).
[339]Mich. R. Prob. Ct. 5.121(E)(2) (West 2002).

In Michigan, minors can also bring suit and can be sued. They do this pursuant to Michigan Rule of Civil Procedure 2.201, which lays out the way in which any person in Michigan becomes a party to a suit. An emancipated minor may sue and be sued in the minor's own name without any adult representative bringing the suit for them.[340] If a non-emancipated minor has a conservator, actions may be brought and must be defended by the conservator on behalf of the minor.[341] If the minor does not have a conservator to represent her as plaintiff, the court shall appoint a competent and responsible person to appear as next friend on her behalf, and the next friend is responsible for the costs of the action.[342] If the minor does not have a conservator to represent her as defendant, the action may not proceed until the court appoints a GAL, who is not responsible for the costs of the action.[343]

If the minor is 14 years of age or older, the court can appoint a representative based on the minor's nomination and written consent of the person she wishes to be appointed.[344] If the minor is under 14 years of age the court can appoint a representative based on the nomination of the minor's next-of-kin or of another relative or friend the court deems suitable, and the written consent of the person to be appointed.[345]

In short, Michigan gives minors access to the legal system in much the same way that Massachusetts does, primarily through a GAL.

10.4 Shelter Restrictions

The State of Michigan's statutory provisions for youth separate those who are homeless from those who are in foster care. According to § 400.18d,[346] the Department of Social Welfare is authorized to set up temporary shelter for homeless dependent or neglected children. The Michigan courts have also held that sheltering homeless youth does not constitute aiding and abetting runaways. Often, federal rules that require temporary shelters to notify parents

[340] Mich. R. Civ. Pro. 2.201 (West 2002).
[341] *Id.*
[342] *Id.*
[343] *Id.* at (E)(1).
[344] *Id.*
[345] *Id.* at (E)(2).
[346] Mich. Comp. Laws § 400.18d (2002).

within 24-72 hours are seen as sufficient. Therefore, states rarely pass their own shelter restriction statutes. As a result, the shelter of runaways is often prosecuted under aiding and abetting runaway statutes. Michigan has such a statute. However, the Michigan Court of Appeals has ruled that these statutes do not apply to runaway shelters. According to *People v. Ison*,[347] the aiding and abetting statute is not meant to be read so broadly as to include homeless shelters and runaway hotlines. The only established laws on youth shelters in Michigan are federal.[348]

11 Minnesota

11.1 Emancipation

Minnesota does not have an emancipation statute, which essentially means that the status is conferred on a case-by-case basis. Emancipation is initiated by a parent, and may occur through a verbal or written agreement or may be implied from the conduct of the parties.[349] When a minor is emancipated in Minnesota, the parents' legal duty to support the minor terminates.[350] Due to the fact that Minnesota has no delineated statutory scheme, it would obviously not serve as a beneficial model for Massachusetts.

11.2 Mature Minor

Under the heading of "Consent of Minors for Health Services," Minnesota's statutory scheme[351] covers many aspects of consent without granting minors broad legal permission to consent to general health care. The eight statutes that comprise the statutory scheme were all passed in 1971, with the exception of the Hepatitis B vaccination statute,[352] enacted in 1993. In

[347] 346 N.W.2d 894 (Mich. App.1984).
[348] Paradise and Horowitz, *supra* n. 12.
[349] *In re Application of County of St. Louis to Determine Settlement of LaDean Fiihr. County of St. Louis v. County of Scott*, 289 Minn. 322, 184 N.W. 2d 22 (1971)(citing *Lufkin v. Harvey*, 131 Minn. 238, 240, 154 N.W. 1097, 1098 (1915)). (*See also In re Settlement of Horton,* 212 Minn. 7, 9, 2 N.W.2d 149, 150 (1942)).
[350] *Swenson v. Swenson,* 241 Mo. App. 21, 227 S.W.2d 103, 20 A.L.R.2d 1409 (1950).
[351] Minn. Stat. § 144.341 - 347 (2001).
[352] Minn. Stat. § 144.3441 (2001).

addition, this statutory scheme remains relatively unchanged, with minimal amendments. Three of the statutes, Emergency Treatment,[353] Information to Parents,[354] and Financial Responsibility,[355] remain unchanged since enactment in 1971. Three of the statutes, Living Apart from Parents and Managing Financial Affairs, Consent for Self,[356] Marriage or Giving Birth,[357] and Representations to Persons Rendering Service,[358] have undergone one amendment, occurring in 1986. Lastly, the statute covering pregnancy, STD, substance abuse, and abortion[359] has experienced four changes, with the last one occurring along with the others, *supra* in 1986. For a statutory scheme that includes all those sensitive issues, especially abortion, this reflects minimal changes. Certainly no recent legislative activity on these statutes may reflect that it has not been a "hot" topic in Minnesota or that currently no one is willing or able to advocate for change in Minnesota. This, however, does not indicate that Minnesota is a model that Massachusetts should look toward for further guidance in expanding the existing MMR. In fact, the two states' statutory schemes have many similarities.

Currently, Minnesota may suffer downfalls similar to those that Massachusetts experiences with respect to minors' rights to consent. Indeed, some of the Michigan provisions cover similar treatment as those found in Massachusetts statutes, including the right to consent to health care based on marriage or parent status, emergency treatment, pregnancy, substance abuse, abortion, living apart from parents and managing financial affairs, and addressing health care provider liability.

However, there are two statutes in the Minnesota scheme that Massachusetts should consider. First, in 1993, the legislature passed a specific statute granting the right to consent to a Hepatitis B vaccination. The assumption may be that Hepatitis B had become a highly publicized public health policy issue in the early 1990's. The legislature may have been responding to real concerns that youth are more likely to engage in unsafe sex and inject

[353]Minn. Stat. § 144.344.
[354]Minn. Stat. § 144.346.
[355]Minn. Stat. § 144.347.
[356]Minn. Stat. § 144.341.
[357]Minn. Stat. § 144.342.
[358]Minn. Stat. § 144.345.
[359]Minn. Stat. § 144.343.

drugs, thus increasing their risk of contracting the disease.[360] With the legal ability to consent to a vaccination, the legislature may have reasoned that at-risk youth, homeless or not, would be more likely to receive a vaccination if parental consent was not mandatory.

However, this leads to the question of why the legislature enacted a separate statute, rather than amending another statute, such as the substance abuse statute. It also leads to a more substantive question about why the legislature seems to enact piecemeal legislation in response to high profile public health issues, rather than to enact a general consent statute that would be proactive rather than responsive to minors health care needs. This, of course, implicates the underlying issue of inconsistency with respect to what health care treatment services minors are deemed capable of offering consent to and why the "sexy" topics receive quick legislative attention and solution. In addition, this raises the fundamental argument between child versus parental rights to control minors' health care access and decisions. Again, this vaccination statute suggests that the legislature acknowledges a minor's ability to consent to her own health care, and yet wants to grant legal rights narrowly to minors in order to maintain parental control over at least some aspect of their youth's health care.

Second, Minnesota specifically addresses payment issues as the last statute within its statutory scheme. Titled "Financial Responsibility," Minn. Stat. § 144.347 states: "A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services." While JRI did not specifically request research on the payment issue, it should be put on the radar screen when expanding the mature minor consent statutes in Massachusetts, since payment concerns are often at the heart of gaining legislative support. As implied by this Minnesota payment statute, health care is not inexpensive and someone must bear the burden of those costs. Here, the legislature has put the burden on the minor who, through the statutory scheme, has been granted the right to consent to her own health care in certain circumstances. While this statutory snapshot does not give us the full picture of payment procedures and options in Minnesota, it does show that along with this right, the legislature seems to declare that there is a duty (of payment), as well.

[360] Immunization Action Coalition. Website: <www.immunize.org>.

Overall, Minnesota does not offer Massachusetts a model statutory scheme upon which to base an expansion effort. However, it does raise fundamental issues surrounding when the legislature is willing to consider amendments or new statutes in the face of high profile public health issues, but still not grant full rights for minors to consent to all health care. Possibly this information could be used to show the inconsistencies of piecemeal legislation that is reactive instead of proactive. In addition, the Minnesota payment statute may provide a basis for answering payment questions that this project will face in expanding the mature minor statutes in Massachusetts.[361]

11.3 Legal Access

The state of Minnesota has a long history of providing minors access to its legal system. In the 1960's when cases were coming before the United States Supreme Court regarding whether children had a constitutional right to counsel (particularly in delinquency proceedings), Minnesota was one of a few states that already gave a minor the right to counsel. Although the original focus of the nation's examination of rights of children to counsel was on delinquency, it led to a focus on procedural due process rights in other proceedings involving children, especially in child protection proceedings.[362]

Today in Minnesota, the primary way in which minors gain access to the legal system is through the GAL system. The GAL is appointed by the court to represent the "best interest" of the child. The responsibilities and obligations of the GAL are outlined in Minnesota General Practice Rule 908.01. These responsibilities can include: independent investigation and judgment, gathering information, participating in negotiations, and monitoring the case by reviewing documents; meeting with and observing the child and considering the child's wishes, as appropriate; and interviewing parents, caregivers, and others with knowledge

[361] Obviously, this exact Minnesota statute would not be helpful for our target homeless youth population since they are not financially solvent. However, it is important to note how other states handle the payment issue.

[362] Gail Chang Bohr, *Public Interest Law: Improving Access to Justice: Children's Access to Justice,* 28 Wm. Mitchell L. Rev. 229 (Lexis, 2001).

relevant to the case.[363] The GAL must make written and/or oral reports to the court regarding the best interests of the child, including conclusions, recommendations, and the facts of the case upon which they are based.[364]

GALs are appointed in several different instances. They can be appointed in cases of divorce where custody is an issue. In any proceeding for child custody or divorce in which an allegation of domestic child abuse or neglect has been made, the court must appoint a GAL to represent the child's best interest.[365]

In child protection cases, pursuant with Minnesota Statute Annotated § 260C.163, the minor has the right to effective assistance of counsel in connection with any proceeding in juvenile court. Also, if they desire counsel but are unable to employ it, the court will appoint counsel to represent the minor if it feels that such an appointment is appropriate. However, counsel for the minor cannot also act as the minor's GAL.[366] Often the minor has both an attorney and a GAL, with the attorney representing the minor's position and what the minor may feel is her best interest, and the GAL represents what she feels is the minor's best interest.[367] These two perspectives may not be the same.[368]

A GAL will also be appointed by the court to protect the interests of the minor if the minor is without a parent or guardian, if the minor's parent is a minor or incompetent, or if the parent or guardian is indifferent or hostile to the minor's interests.[369] The court may also use its discretion to appoint a GAL to protect the interests of the minor in any case where the court feels it is desirable. It is unclear what procedure minors have to go through in order to bring a case themselves, but since there appears to be no statute forbidding minors bringing cases, and Minnesota guarantees a minor's right to counsel and representation through a GAL, it is reasonable to infer that they can also bring cases with proper representation.

[363]Minn. Gen. Prac. R. 908.01 (Lexis 2001).
[364]*Id.*
[365]Minn. Stat. Ann. § 518.165 (Lexis 2001.)
[366]*Id.*
[367]*Id.*
[368]*Id.*
[369]Minn. Stat. Ann. § 260C.163 (Lexis 2001).

11.4 Shelter Restrictions

A search of the law in Minnesota reveals that there is no shelter restriction statute or regulations in that state. Therefore, the federal rules are the only ones in effect in Minnesota.

12 Washington

12.1 Emancipation

Washington's emancipation statute was implemented within the last decade. As such, there is little information by way of case law or law review articles on this statute. However, along with California and Michigan's statutes, it will provide guidance for an effective emancipation statute.

Washington's emancipation statute, effective January 1, 1994, is very focused on the minor as the important party rather than the parents. Under this statute, only a minor over the age of 16 years is eligible to petition the superior court.[370] The statute does not specifically state that parents cannot petition, although most states that allow parents to petition explicitly say so. Also, the statute requires the petition for emancipation to contain the present address and length of residence of the petitioner; the name and last known address of the parents, guardian, or custodian; and a declaration by the petitioner that indicates her ability to manage her own financial, social, personal, and educational affairs, including any supporting information.[371] After this information is considered by the court, emancipation is granted if the petitioner proves by clear and convincing evidence that she is at least 16 years of age, a resident of the state, and is able to manage her financial, educational, personal, and social affairs.[372] Furthermore, the court shall deny an emancipation petition, opposed by the minor's parent, guardian, custodian or department, "unless it finds, by clear and convincing evidence, that denial of the grant of emancipation would be detrimental to the interests of

[370] Wash. Rev. Code § 13.64.010 (2001).
[371] *Id.* § 13.64.020 (1)(a)-(f).
[372] *Id.* § 13.64.050 (1).

the minor."[373]

The statute is very specific in terms of service and procedure.[374] Procedurally, emancipation is granted after a hearing before a "judicial officer."[375] In 2001, this section was rewritten to expand the number of persons who are qualified to preside over emancipation hearings. Previous to this, the section provided that only a "judge" could preside over the hearing, sitting without a jury.[376] The minor must demonstrate to the judicial officer that she understands her rights and responsibilities, and the consequences of emancipation, prior to the granting of the petition.[377] Further, the allegations of the petition are investigated, and a report is filed with the court by a court-appointed GAL.[378] The appointment of a GAL is important here again not only because it is strong evidence that the statute is youth-oriented, but that it contains depth of thought and detail of the legislature.

After being granted emancipation, the minor is entitled to retain her own earnings, enter into contracts, and purchase real estate. Also, similar to the Michigan statute, Washington's statute identifies areas of the law where the minors, even though emancipated, will not be considered adults. These areas mostly encompass criminal law and statutory age requirements surrounding voting and alcohol consumption and purchase.[379]

The strength of Washington's statute is that it requires proof of the minor's ability to manage her own affairs, particularly financial, the court appoints a GAL, and allegations of the petition are investigated. Similar to the Michigan statute, these requirements help to ensure that the minor understands the rights and responsibilities and limitations of emancipation, and allows input from outside persons to assist the judiciary in making informed decisions about what is in the best interest of the child. The required ability to support oneself, coupled with evidence of emotional and social maturity, give the court a certain degree

[373] *Id.* § 13.64.050 (2).
[374] *Id.* § 13.64.030.
[375] "judicial officer" includes (a) A judge; (b) a superior court commissioner of a unified family court if the county operated a unified family court; or (c) any superior court commissioner if the county does not operate a unified family court. The term does not include a judge pro tempore. *Id.* § 13.64.040(2).
[376] *Id.* § 13.64.040(1)
[377] *Id.* § 13.64.040(1)(a).
[378] *Id.* § 13.64.040(1)(b)
[379] *Id.* § 13.64.060(2)(b)-(c).

of discretion when considering emancipation, but not so much that these criteria are rendered meaningless. These requirements serve two beneficial functions: first, they place limits on the court's discretionary latitude because these factors must be present for the minor to even petition. This is beneficial because the statute, and the resulting court order, are more likely to be able to withstand an attack because they are specific without being probative. Second, the prerequisites filter out minors who may be trying to emancipate themselves but yet are not ready to handle the responsibilities of the status. The last above-stated status seems to serve this function as well, in that it appears to be a test of maturity.

Unfortunately, the statute explicitly states that the minor has no access to child support once emancipated, which evinces the nationwide opinion that once minors are emancipated they should be able to support themselves financially. In other words, if parents' control over their children is effectively destroyed by the court, parents should then also be financially free of their obligations of support.

Few emancipation statutes provide this level of detail. There are several provisions and general goals that should serve as a model for Massachusetts were it to consider formulating an emancipation statute. Since this statute is less than 10 years old, a search of legislative history and intent by next year's Law Office would be beneficial.

12.2 Mature Minor

Washington's statutory scheme is akin to the average statutory schemes of most states in that it does not broadly allow a minor to consent to general medical or dental care. However, Washington does have provisions under which a minor can consent to the specific mental health, substance abuse, communicable disease, contraceptive, and prenatal forms of health care.

In Washington, the age at which a minor may consent to treatment for an STD is 14.[380] The STD statute sets contains specific language that the age of minority may not serve as a disaffirmance of consent. Similar to California, parents are not fiduciarily responsible for

[380]Wash. Rev. Code Ann. § 70.24.110 (West 2002), enacted in 1969, amended in 1988.

treatment provided under this statute. Additionally, a minor may consent to outpatient treatment for alcohol and substance abuse treatment at the age of 13.[381] In-patient treatment requires parental consent except in narrow circumstances defined by the state in § 13.32A.030(4)(c).[382]

With regard to prenatal and contraceptive care, the state of Washington has enacted broad statutes in which reproductive rights and concern for low birth rates in the state are recognized, and has promulgated programs to address the health care needs of expectant mothers and their anticipated children. Under Wash. Rev. Code Ann. § 9.02.100 (West 2002) (enacted in 1988, without revision), "Reproductive privacy – Public policy," Washington broadly provides for contraceptive choices for women by providing: "The sovereign people hereby declare that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions. Accordingly, it is the public policy of the state of Washington that: (1) Every individual has the fundamental right to choose or refuse birth control." Under Title 74, "Public Assistance," Chapter 74.09, "Medical Care, Maternity Access Program," the state has stated, in Wash. Rev. Code Ann. § 74.09.770 (West 2002) (enacted in 1989, without revision), that the purpose in enacting legislation with respect to prenatal care is "to provide, consistent with appropriated funds, maternity care necessary to ensure healthy birth outcomes for low-income families," and has, to this end, established a maternity health care access system. Under this system, minors may seek prenatal care through Wash. Rev. Code. Ann. § 74.09.790 (West 2002) (enacted in 1989, without revision), where it defines an "at-risk eligible person" as one who is an "eligible person determined by the department to need special assistance in applying for and obtaining maternity care, including pregnant women who are substance abusers, pregnant and parenting adolescents, pregnant minority women, and other eligible persons who need special assistance in gaining access to the maternity care system."

Mental health services are available to minors 13 years of age or older, and in-patient

[381] Wash. Rev. Code Ann. § 70.96A.095 (West 2002), enacted 1989, amended 1991, 1995, 1996, 1998.
[382] Wash. Rev. Code. Ann. § 70.96A.235 (West 2002), enacted 1998, amended 2000.

treatment is available without parental consent.[383] Section 71.34.042, similar to the specific language in § 70.24.110 ("a minor's consent to treatment of STDs is not disaffirmed because of minority"), sets forth a minor's right of self-determination and autonomy. A minor has the right to admit herself for in-patient mental health treatment without parental consent, and once voluntarily admitted, may give notice to leave at any time, and the appropriate mental health professional will "discharge the minor from the facility upon the receipt of the minor's notice of intent to leave." However, health professionals still retain the right to contact a minor's parents to notify them of the service requested by the minor.[384] Again, this evinces the state's willingness to afford minors a right to consent to their own treatment, yet still retains an authoritative parental role in hopes of protecting unwise choices by immature minors.

In summary, the state of Washington provides many forms of health care services to minors on their consent alone. While Washington may not have a general health care statute, the state does not remain silent on a minor's affirmative right of self-determination and consent.

12.3 Legal Access

In the state of Washington, any person 18 years of age or older may sue or be sued in a state court.[385] A younger person may sue or be sued, but only through a duly-appointed GAL.[386]

While appointment of a GAL is mandatory, it is not jurisdictional; rather, the rule is

[383]Wash. Rev. Code Ann. § 71.34.030 (West 2002), enacted 1998; Wash. Rev. Code Ann. § 71.34.042 (West 2002), enacted 1998.

[384]Wash. Rev. Code Ann. § 71.34.230 (West 2002), enacted 1998 (Any provider of outpatient treatment who provides outpatient treatment to a minor thirteen years of age or older shall provide notice of the minor's request for treatment to the minor's parents if ... the treatment program director determines that the minor lacks capacity to make a rational choice regarding consenting to disclosure. The notice shall be made within seven days of the request for treatment, excluding Saturdays, Sundays, and holidays, and shall contain the name, location, and telephone number of the facility providing treatment, and the name of a professional person on the staff of the facility providing treatment who is designated to discuss the minor's need for treatment with the parent).

[385]Wash. Rev. Code § 26.28.015 (2002).

[386]Wash. Rev. Code § 4.08.050 (2002)(minor as a plaintiff/defendant in superior court); Wash. Rev. Code § 12.04.140 (2002)(minor as a plaintiff in a district court); Wash. Rev. Code § 12.04.150 (2002)(minor as a defendant in a district court).

that a minor must be represented by a GAL, or judgments against her may be voidable at her option. Whether the minor will be allowed to avoid judgments or whether judgments are allowed to stand depends upon whether the court finds that the minor's interests were protected to the same extent as if a GAL had been appointed at the time the action was instituted.[387]

Revised Code of Washington § 4.08.050 (2002) provides that if an infant party has no guardian, or if the court considers that the guardian is an improper person, the court shall appoint a GAL. An infant plaintiff of 14 years of age or over may herself apply to the court for such a guardian. If she is under 14 years of age, a relative or friend may make the application. An infant defendant of 14 years of age or over may likewise apply to the court for a GAL, if she applies within thirty days after the service of the summons; if she is under 14 years old, or neglects to apply, then any other party to the action, or a relative or friend of the infant, may make the application.

With respect to actions brought by minors, the applicable statutes of limitations do not begin to run until the plaintiff reaches the age of 18.[388] For instance, the statute of limitations is tolled until the age of 18 in an action in which a minor claims childhood sexual abuse[389] or a violation of the common law duty of parental support.[390]

In both juvenile and family court settings, persons serving as GALs must complete a training program approved by the Office of the Administrator for the Courts. Each judicial district in Washington must compile and maintain a rotational registry of persons qualified to serve as GALs.[391] The counties must contain background information on their GALs, including matters such as education and criminal history. A potential GAL must make the required information available as a condition of appointment. Upon appointment, the GAL or the GAL program must provide this information to the parties or their attorneys.[392]

[387] *See Newell v. Ayers*, 23 Wash. App. 767, 598 P.2d 3 (1979).
[388] Wash. Rev. Code § 4.16.190 (2002).
[389] Wash. Rev. Code 4.16.340 (2002).
[390] *See e.g.*, *Nettles v. Beckley*, 32 Wash. App. 606, 648 P.2d 508 (1982).
[391] Wash Rev. Code 26.12.177 (2002); Wash. Rev. Code 13.34.102 (2002).
[392] Wash. Rev. Code 26.12.175(3) (2002); Wash. Rev. Code 13.34.100(3) (2002).

Various statutes and court rules seek to protect a minor's interest in pending litigation, or to more fully define the relationship between the minor and GAL in specific kinds of cases. For instance, in family law proceedings, the family court statutes provide that the role of a guardian ad litem is to "represent the interests of a minor or dependent child."[393] Another statute, specifically applicable to the dissolution of marriage proceedings, adds that the GAL may also function as an independent investigator and fact-finder, and may be directed to make a formal written report to the court.[394]

In the domestic violence prevention proceedings, governed by the Revised Code of Washington 26.50.020 (2002), a person under 18 years of age, who is 16 years of age or older, may act as a petitioner or respondent without representation by a GAL or next friend.[395] However, the court may, if it deems necessary, appoint a GAL for a petitioner or respondent, who is a party to a domestic violence action.[396] Moreover, for the purposes of a child dependency hearing involving allegations of child abuse and an unfit home environment, the juvenile court may, in its discretion, appoint a GAL to represent the child even though his parents are present.[397] It is noteworthy that under the Revised Code of Washington 26.50.020 (6)-(7) (2002), a person's right to petition for relief is not affected by her leaving from the residence or household to avoid abuse, and such action may be brought in the county or municipality of the person's new household or residence.

In sum, recent legislation in Washington has greatly expanded minors' access to the legal system, and, in particular, the role of the GAL in the litigation involving minors. Washington's approach would present a solid foundation for expanding minors' rights in Massachusetts.

[393] Wash. Rev. Code 26.12.175 (2002).
[394] Wash. Rev. Code 26.09.220 (2002).
[395] Although not clearly elucidated, the analysis of Washington's statutory and common law suggests somewhat interchangeable use of the terms "guardian ad litem" and "next friend.
[396] Wash. Rev. Code 26.50.020 (4) (2002).
[397] *See e.g.*, *In re Dunagan*, 74 Wash. 2d 807, 447 P.2d 87 (1968).

12.4 Shelter Restrictions

Washington's shelter restriction statute is RCW 13.32A.082 which states that:

> (1) Any person who, without legal authorization, provides shelter to a minor and who knows at the time of providing the shelter that the minor is away from the parent's home without the permission of the parent, or other lawfully proscribed residence, shall promptly report the location of the child to the parent, the law enforcement agency of the jurisdiction in which the person lives, or the department. The report may be made by telephone or any other reasonable means.
>
> (2) unless the context clearly requires otherwise, the definitions in this subsection apply throughout the subsection.
>
> (a) "shelter" means the person's home or any structure over which the person has any control.
>
> (b) "Promptly report" means to report within eight hours after the person has knowledge that the minor is away from a lawfully prescribed residence or home without parental permission.
>
> (3) When the department receives a report under subsection (1) of this section, it shall make a good faith attempt to notify the parent that a report has been received and offer services designed to resolve the conflict and accomplish a reunification of the family.[398]

The regulation from Washington's Department of Social and Health Services that specifically refers to shelters is as follows:

> (1) Within eight hours of learning that a youth staying at a shelter does not have parental permission to be there, shelter staff must report the location of the youth to:

[398] Wash. Rev. Code 13.32A.082 (2002).

(a) the parent;

(b) the law enforcement agency having jurisdiction in the shelter's area; or

(c) the department.

(2) The shelter staff must:

(a) Make the report by telephone or any other reasonable means; and

(b) Document the report in writing in the youth's file.[399]

Interpreting the statute and the regulation together, several things are clear about shelter restriction laws in Washington. First, the original statute seems to have been written broadly enough to include within its scope individual citizens who are providing shelter to minors. The statute refers to "an individual," and specifies that that individual report the location of the child to "the law enforcement agency of the jurisdiction in which the person lives."[400] Obviously, the legislature gave Washington's Department of Social and Health Services the discretion to write a regulation that governs shelters' reporting of homeless youth.

While homeless people under age 18 are referred to in the statute as "minors," the regulation uses the term "youth," but leaves it undefined.[401] The agency may have decided to change this language in order to broaden the scope of the statute. If "youth" can be broadly defined by shelter staff as any young person, without mandatory knowledge of legal minority status, more homeless young people could be reported by the staff. This could make it more difficult for shelter staff to simply plead innocence to a young person's age. This change in the term may allow shelter staff to further the legislative goal of accounting for homeless youth and funneling them into the system.

Another restrictive feature of this regulation is that the report must be made within eight hours of learning that the youth staying at the shelter does not have parental permission to

[399] Wash. Admin. Code 388-160-0265 (2002).
[400] Wash. Rev. Code 13.32A.082 (2002).
[401] Wash. Admin. Code 388-160-0265 (2002).

be there.[402] This negatively affects homeless youth in that they could feel forced to stay at a shelter for less than eight hours or risk being reported. If, for example, the young person wanted to sleep in the shelter, she would have to time her arrival so that she could get a night's rest and safety, and then leave without being reported. In addition, many shelters have rules that specify times to enter and exit the premises that may interfere with a young person's ability to evade getting reported.

All of this is not to suggest that homeless youth should try to evade the system. To the contrary, a realistic exploration of the legal hurdles homeless youth face in gaining access to resources must include an analysis of the practical barriers shelter restriction statutes and regulations impose on teenagers looking for shelter and nourishment. Any homeless youth interested in staying at a shelter would have to risk being reported to the social services agency, the local law enforcement agency, or her parents. For some, that may be a greater risk than sleeping on the street.

In addition, if by allowing the shelter staff to choose to report the location of the youth to her parents in an attempt at some kind of reconciliation, an eight hour limit on that report seems so brief as to actually discourage any possibility of a reconciliation. A newly homeless young person may need time and distance from a dysfunctional situation she chose to leave. Eight hours may not be enough time for that child to gain enough perspective to move forward and make choices about the future. In addition, a young person often leaves home after a fight with a family member, and this relative may not have had adequate time to find perspective, or even ensure that a youth's return would be safe and welcome.

Finally, the regulation allows for the shelter staff to have a choice in terms of who or what agency they notify.[403] Shelter staff's discretion in terms of reporting will probably benefit the child in the sense that the staff person can talk with the child and make an appropriate choice. If the young person needs to be reconciled with the parents, then a staff person's choice to not include an agency in the reporting could preclude unnecessary agency

[402] *Id.*
[403] *Id.*

involvement. If, however, the household is in need of resources to help resolve conflict and instability, shelter staff could help provide connections.

13 Recommendations And Solutions

13.1 Emancipation

One of the goals of this LO is to give recommendations on a standard that is more narrowly tailored than the current "best interest" standard used by Massachusetts' judges. Since the "best interest" standard is used in virtually every jurisdication, it is unlikely that a new standard would be implemented into a proposed emancipation statute. However, by analyzing how other state's emancipation laws are designed, it is apparant that inclusion of guidelines and requirements for both the judiciary and the petitioning minor can limit discretion and avoid many of the unintended consequences of other state's statutes.

Based on analysis of California, Michigan, and Washington's emancipation statutes, a proposal for a Massachusetts statute can be drafted in a manner that will be in the child's best interest. A thoughtfully drafted proposal will limit judicial discretion when making a best interest determination. Although this is not an exclusive list, an emancipation proposal should require: (1) parental support despite emancipation;[404] (2) that the minor is educated[405] and understands her rights, limitations, and obligations of emancipation;[406] (3) that maturity level of the minor, and not an arbitrarily picked age, should be a determining factor;[407] (4) completion of at least a high school education is mandatory;[408] (5) that the minor currently has housing;[409] (6) assign emancipation determinations to juvenile court;[410] and (7) require an affidavit from an independent third party who has personal knowledge of

[404]Report of LO #9, 1998-1999, p. 47.
[405]this may also include appointment of counsel or a GAL who's main purpose would be to educate the minor about emancipation.
[406]Sanger and Willemsen, *supra* n. 37, at 338.
[407]Hafen and Hafen, *supra* n. 26, at 464-465; Robyn-Marie Lyon, *supra* n. 282, at 698-700.
[408]Hafen and Hafen, *supra* n. 26, at 483.
[409]Sanger and Willemsen, *supra* n. 37, at 340.
[410]*Id.* at 341.

the minor that states whether emancipation is in the minor's best interest.[411]

Unfortunately, past LOs have come to one unified conclusion concerning emancipation and its future in Massachusetts: it won't happen. This sentiment has been echoed by service providers and other parties interviewed by this year's law office for reasons ranging from expressing concerns that it is more of a detriment to the youth than a benefit to them, to the idea that all of the services that an emancipation statute would provide are already afforded youths through other statutory mechanisms, such as the mature minor doctrine.[412] Through the LO's comprehensive research concerning this issue, we have formulated several recommendations for JRI were they to pursue the passage of an emancipation statute in Massachusetts.

In response to one of JRI's main concerns, LO #2 recommends that they look to Michigan's statute for a model of inclusion of a child support provision. The statute is relatively new but has so far gone unchallenged at least as far as this provision is concerned. LO #2 believes that it is helpful to look at this statute because it is the only one of the six states focused on which contains such a provision. It is apparent from this statute that the Michigan Legislature and Courts recognize the necessity of emancipation for some minors, yet still understand that certain realities exist that would make it difficult to survive without the continued support the minor is owed by one or both parent(s). In terms of the administering of a child support protocol, it would be beneficial to research the federal guidelines and understand what exists in Massachusetts in order to ensure that this part of the statute is strong and will really be beneficial to the minors. It would be extremely helpful to JRI for next year's LO to delve more deeply into the child support issue when they are looking at legislative intent to see if there are opinions from legislators not only on the state level, but also the federal, to reinforce the recommendations made to the Massachusetts legislature.

Second, a great majority of statutes utilize the "best interests of the child" standard when guiding the court's discretion. This standard is neither good nor bad, just as judicial

[411] *Id.* at 340.
[412] *See* Interview with Genny Price, *supra* n. 75.

discretion is neither good nor bad. Fortunately, this standard is seldom the only criteria relied upon. Many statutes ask the court to evaluate the maturity of the minor, including her ability to financially support herself and provide shelter for herself. These are very practical considerations for the court and seem to provide valuable guidance, while at the same time reigning in discretionary powers. Again, Michigan's statute is a very helpful example of the interplay between the common law "best interest" standard and the more practical concerns outlined above.

Finally, there is always the tension when formulating a new statute between wanting to allow discretion for individual circumstances and formulating narrow guidelines which provide direction for both courts and parties bringing suit. A comparison of Michigan and California's statutes is illustrative of this tension. California's statute regarding emancipation is extremely broad and, based on information from past LOs, somewhat useless because of the extreme amount of discretionary power allowed to the courts. Michigan's statute, on the other hand, is considered narrowly tailored and comprehensive, giving the court specific guidelines with which to work when deciding if a minor should be emancipated. A fine balance must be struck by the legislature when formulating a new statute, especially when that statute will affect such a large and vulnerable population. Contrasting the statutes from Michigan, California, and Washington will be extremely helpful in guiding the legislature concerning this balance, as well as researching appropriate legislative intent.

13.2 Mature Minor Rule

As recommended by last years LO, we have deepened the analysis on the Mature Minor rule in other jurisdictions, focusing on jurisdictions with broad consent rules to act as potential models for Massachusetts. In addition, through research and interviews, we have further analyzed the current Massachusetts Mature Minor Rule, including research on mental health regulations, payment, and legislative history. From this research on other jurisdictions as well as more in depth research on the current Massachusetts Mature Minor Rule we offer the following summary of recommendations:

1. Continue researching the Legislative History

It might be helpful for the next LO to look further into the legislative history by doing the following:[413]

i) Go to State Archives to see if there is any pertinent information:

a. Legislative Package

b. Governor's Legislative Files

ii) Go to State House Library:

a. Slip laws: Look at the slip law for the 1970 statute to see how it differs from the current version, which passed by Amendment in 1975. This may lead to understanding intent or concerns the legislators had that prompted them to change the original statute.[414] In turn, this may provide insight into future opposition to expanded legislation as well as possible answers.

b. State House News Service on microfiche (SHNS) provides daily accounts of House/Senate sessions, news stories, and synopsis of activity in State House. This may provide a background for legislative issues concerning the original statute while it was in the enactment process.

The next LO will have to decide if continuing the legislative history will be a priority or if background information provided in this report is sufficient.

2. In an effort to gain information on the larger picture of homeless youth in Massachusetts, LO #2 spoke with individuals at The Joe Budd Youth Services and Assessment Center in Springfield, Massachusetts. The LO learned that The Joe Budd Youth Services

[413] see Appendix A for information on conducting legislative history.

[414] However, we do know that "The 1975 amendment rewrote the section, adding hospitals and dentists as exempt persons, and adding five paragraphs relative to minors' consent to medical or dental care." Mass. Ann. Laws ch. 112, § 12F, Lexis Editorial Note (2002).

and Assessment Center, in conjunction with the Springfield Police Department and other agencies, has a series of procedures – including a 67-item questionnaire designed to assess how a minor can best be helped by which the problem of homeless and at-risk youth is addressed in Springfield, Massachusetts by both city and state officials. Further LOs may wish to contact this agency, as well as others across the state, to gather further information on state-wide agencies, services, and procedures available to address the issues surrounding homeless youth.

3. Create a legislative guide to educate legislators on the important issues discussed in this report.

4. Write and carry out a survey of youth for statistical data which would be helpful for a legislative guide.

5. Interview youth (homeless, at-risk, possibly a group of high school students who will be only 17 when they graduate)- learn their stories, concerns, and find out any perceived constraints stemming from the current MMR. This will be especially important in order to present personal accounts to legislators.

6. Continue payment research, if client requests.

7. Continue verification of research performed by the Alan Guttmacher Institute, or compile a 50-state and District of Columbia analysis of health care available to minors.

8. Create a guide for health care providers and possibly a pamphlet for homeless or at-risk youth. Create a dissemination strategy.

9. Publicize to providers and youth clause (v) of the Mass. Gen. Laws ch. 112, § 12S about living separate from parent(s) and managing own financial affairs as a current way to legally provide services to the target homeless and at-risk youth population.

10. Publicize the mental health regulation, 104 CMR 25.04., to providers and youth.

13.3 Legal Access

The research of past LOs and this year's LO, including various interviews with youth providers, indicates that the current legal system adequately addresses problems faced by

at-risk youth in Massachusetts. Future research should contain interviews with youth themselves to determine if there are legal concerns that providers are not currently aware of. Barring that, JRI should attempt to educate at-risk youth of the current manner in which they can access the legal system.

13.4 Shelter Restrictions

In comparing the Massachusetts shelter restriction statute to those of other states, Massachusetts' use of the phrase "child under eighteen" is beneficial to the state's homeless youth and should not be changed during any future statute revisions. The phrase provides strength in that it requires shelter staff to have official knowledge that the youth in question is under eighteen before any person or agency can be contacted or before the youth can be denied shelter.

Shelter staff often gather crucial information about the young person in the conversations that lead up to a minor revealing her age.[415] In the process of determining minority status, the shelter staff can, and usually does, ascertain the young person's health, background, and living situation. These details, usually only revealed in these conversation with the minor, can be crucial in helping staff to match appropriate services and resources to these young clients. A positive aspect of the 72-hour restriction is that these beneficial conversations will generally happen in that time period.[416]

Massachusetts should also look at the Tennessee version of a shelter restriction statute, which states that shelter staff must make a "good faith" effort to notify the runaway's parents.[417] This would provide a remedy in situations where notifying parents is difficult. Once the good faith effort was made, shelter could then be provided regardless of the success of the attempted contact. It would also allow shelter staff, who have significant contact with the youth, to make discretionary determinations. This would leave the decision in the hands of dedicated professionals. If the intent of the law is to provide services for children, it makes

[415] *See* Interview with Genny Price, *supra* n. 75.
[416] *Id.*
[417] Paradise and Horowitz, *supra* n. 12, at 4.

sense to give discretion to the professionals providing those services.

Massachusetts could adopt a statute specifying that notification need not be made where compelling reasons argue against it. These statutes have been enacted in Alaska, Louisiana, and New York, and are a response to the Federal notification rules.[418] These laws leave some discretion to the shelter workers in terms of who must be reported.

In conclusion, Massachusetts must figure out a way to give the shelter staff discretion despite the plain language of the Federal rules. One way of doing this is by giving shelter staff the power to decide how much effort needs to be put into contacting parents before shelter is provided, or to allow shelter staff to decide who should be reported, and who should not. The clear intent of this legislation when was passed in 1974 was to provide services for children. This statute may have the opposite effect of not allowing children to get one of the most necessary services, long-term shelter. JRI could show legislators the effects of the 1974 laws, and express the need for these amendments to the statute that have already been adopted in New York, Maine, Alaska, and Louisiana.

14 Conclusion

14.1 Conclusion

Law Office #2 made significant progress this year in meeting the goals put forth by the Justice Resource Institute. However, future LOs will need to further the research by including an exploration of legislative intent and interview youth. These recommendations should be taken with an eye toward potentially drafting legislation in the areas of emancipation, the mature minor rule, legal access, and shelter restriction.

[418] Paradise and Horowitz, *supra* n.12, at 4.