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Involvement of Minors in Special Educational Decision-Making

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Introduction

Although there is no longer any doubt that children possess fundamental rights and enjoy constitutional interests shared by adults,[1] the Supreme Court has declined to consider the impact of these rights and interests on "the totality of the relationship of the juvenile and the state."[2] The Court has, instead, continued to maintain that although "[m]inors, as well as adults, are protected by the Constitution and possess constitutional rights,"[3] the state retains greater power to restrict the rights of children.[4] While the Court has made it generally clear that the rights of children and adults are not co-extensive, it has created confusion by continuing to determine the scope of children's rights on a case-by-case basis without constructing a practical, comprehensive framework for analysis.[5]

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[1] *See, e.g.,* In re Gault, 387 U.S. 1 (1967), which established minors' rights to counsel, notice, confrontation and cross-examination in juvenile court proceedings and Tinker v. Des Moines Indep. Comm. School Dist., 393 U.S. 503 (1969), holding that first amendment guarantees of free speech and expression applied to children in school settings. The Court also has recognized that minors have at least limited rights in a variety of other areas. *See, e.g.,* Planned Parenthood v. Danforth, 428 U.S. 52 (1976) (privacy in obtaining abortions); Goss v. Lopez, 419 U.S. 565 (1975) (due process protections prior to suspension from school); Carey v. Population Services International, 431 U.S. 678 (1977) (access to contraceptives).

[2] *Gault,* 387 U.S. at 13.

[3] Planned Parenthood v. Danforth, 428 U.S. at 74.

[4] For example, the Court has held that a state may legally create different obscenity standards for children and adults, Ginsberg v. New York, 390 U.S. 629, 638-39 (1969), and that a minor's right of privacy is not necessarily violated by a statute requiring a doctor to notify a minor's parents before performing an abortion on her, Planned Parenthood v. Danforth at 74. In its recent rulings, the Court has reinforced its differential view of the constitutional rights of minors with respect to school searches, *see* New Jersey v. T.L.O., 469 U.S. 325 (1985), and the regulation of speech in public schools, Bethel School District No. 403 v. Fraser, 106 S.Ct. 3159 (1986).

[5] *See* Note, *Assessing the Scope of Minor's Fundamental Rights: Juvenile Curfews and the Constitution,* 97 HARV.L.REV. 1163, 1168 (1984). The tension between state interests and the rights of

This article discusses judicial and statutory interpretations of children's rights to be informed, consent and object to assessment and placement related to special education programs in the public schools. It is the position of the authors that, although many children have a relatively high amount of first-hand knowledge about the impact of various special educational options, their rights to participate in relevant decision-making are practically nonexistent.[6] The article concludes by discussing research on children's abilities to give informed consent and by examining two models which allow children increased rights of assent or consent.

Provision of a wide range of special educational programming for handicapped children was made possible for most school districts by the enactment of the Education of All Handicapped Children's Act of 1975[7] (EAHCA), whose primary purpose was to "assure that all handicapped children have available to them . . . free, appropriate public education."[8] The Act is primarily funding legislation containing extensive regulatory conditions governing a state's acceptance of federal financial assistance.[9] To qualify for such assistance, a state must have, in effect, approved policies, plans and procedures designed to provide appropriate education to handicapped students.[10] At the heart of the statute are the procedural safeguards required of each local school district in its development of a variety of special educational placements and its identification of students qualifying for remedial treatment.

The sections of the Act and its accompanying regulations related to consent have the intent of increasing parental involvement in the special educational process of decision-making. Under the Act, parents have power to refer their children for evaluation, accept or reject the placement recommendations made by the school, and, if the child is found to have a handicapping condition, to participate in planning the educational program the child is to receive.[11] When a child first becomes the focus of an

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the "child as person" reflects conflicting and unclear visions of the role of government in the lives of its minor citizens. Restrictions on children's rights are often justified by reference to unique developmental traits and needs of children, even though such assumptions recently have been challenged. *See, e.g.,* Weithorn, *Informed Consent to Treatment: An Empirical Study of Children's Capacities,* 53 CHILD DEV. 413 (1982).

[6] *See* BERSOFF, CHILDREN AS PARTICIPANTS IN PSYCHOLOGICAL ASSESSMENT IN CHILDREN'S COMPETENCE TO CONSENT 149, 151 (G. Melton, ed., 1983), which notes that children are typically enrolled as test takers by proxies, usually parents, who consent for them.

[7] 20 U.S.C. §§ 1400-1462 (1982).

[8] 20 U.S.C. § 1400(e).

[9] A comprehensive review of the terms of the Act can be found in Colley, *Education for All Handicapped Children's Act (EHA): A Statutory and Legal Analysis* 10 J.L. EDUC. 137 (1981).

[10] 20 U.S.C. § 1412.

[11] For example, 34 C.F.R. § 300.S04 (1983) specifies EAHCA due process procedures which extend only to parents:

assessment the outcome of which may be to recommend placement in a special education program, the parents must be informed of the school district's intent and give their consent before any of the proposed procedures may occur. Implementing regulations clearly specify procedures required to ensure that the parental consent is valid.[12] If parents refuse to consent on the basis of seemingly arbitrary or unreasonable grounds, the regulations permit the schools to act as child advocates and challenge parental refusal.[13] Under the federal system, therefore, children do not particiapte in the consent process and are represented only through the "putative benefactors"[14] of parents and school.

> 300.504 Prior notice; parent consent.
>
> (a) Notice. Written notice which meets the requirements under § 300.505 must be given to the parents of a handicapped child a reasonable time before the public agency:
>
> (1) Proposes to initiate or change the identification, evaulation or educational placement of the child or the provision of a free appropriate public education to the child, or
>
> (2) Refuses to initiate or change the identification, evaluation, or educational placement of the child or the provision of a free appropriate public education to the child.
>
> (b) Consent. (1) Parental consent must be obtained before:
>
> (i) Conducting a replacement evaluation; and
>
> (ii) Initial placement of a handicapped child in a program providing special education and related services.

[12] Consent is defined solely in terms of informing parents and requiring their approval. Implementing regulations provide that: As used in this part: "Consent" means that:

> (a) the parent has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language, or other mode of communication;
>
> (b) the parent understands and agrees in writing to the carrying out of the activity for which his or her consent is sought, and the consent describes that activity and lists the records (if any) which will be released and to whom; and
>
> (c) the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

34 C.F.R. § 300.500.

[13] 34 C.F.R. § 300.504 specifies:

> . . . (c) Procedures where parent refuses to consent. (1) Where State law requires parental consent before a handicapped child is evaluated or initially provided special education and related services, State procedures govern the public agency in overriding a parent's refusal to consent.
>
> (2)(i) Where there is no State law requiring consent before a handicapped child is evaluated or initially provided special education and related services, the public agency may use the hearing procedures in §§ 300.508 to determine if the child may be evaluated or initially provided special education and related services without parental consent.
>
> (ii) If the hearing officer upholds the agency, the agency may evaluate or initially provide special education and related services to the child without the parent's consent, subject to the parent's rights under §§ 300.513.

[14] *See* Bersoff, *supra* note 6 at 153.

In theory, following assessment and parental consent to placement, children may have somewhat greater involvement, in the drafting of their individualized educational programs. At this stage of planning, the Act requires the attendance of teachers, parents and "school system representatives" and permits the child to attend "where appropriate."[15] The Department of Education's suggested guidelines for determining appropriateness allow the parent to decide what is appropriate, a system which preserves parental power to act on behalf of children.[16]

Children typically fare no better under state laws because, as with the federal system, they are given no personal rights to consent, assent or object to proposed special education assessments and placements. For example, the Minnesota statute describing procedures for identification and placement of handicapped students lists as an overall goal ensuring that: "Handicapped children and their parents or guardians are guaranteed procedural safeguards and the right to participate in decisions involving identification, assessment and educational placement of handicapped children,"[17] yet only the parents are guaranteed rights to written notice,

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[15] Participating in meetings.

(a) General. The public agency shall insure that each meeting includes the following participants:

(1) A representative of the public agency, other than the child's teacher, who is qualified to provide, or supervise the provision of, special education.

(2) The child's teacher.

(3) One or both of the child's parents, subject to § 300.345.

(4) The child, where appropriate.

(5) Other individuals at the discretion of the parent or agency.

(b) Evaluation personnel. For a handicapped child who has been evaluated for the first time, the public agency shall insure:

(1) That a member of the evaluation team participates in the meeting; or

(2) That the representative of the public agency, the child's teacher, or some other person is present at the meeting, who is knowledgeable about the evaluation procedures used with the child and is familiar with the results of the evaluation.

34 C.F.R. § 300.344.

[16] The guidelines are written in question and answer form and specify:

> 21. When may a handicapped child attend an IEP meeting? Generally, a handicapped child should attend the IEP meeting whenever the parent decides that it is appropriate for the child to do so. Whenever possible, the agency and parents should discuss the appropriateness of the child's participation before a decision is made, in order to help the parents decide whether or not the child's attendance will be (1) helpful in developing the IEP and/or (2) directly beneficial to the child. The agency should inform the parents before each IEP meeting — as part of the "notice of meeting" required under at § 300.345(b) — that they may invite their child to participate.
>
> Note — the parents and agency should encourage older handicapped children (particularly those at the secondary school level) to participate in their IEP meetings.

46 Fed. Reg. 12, 5467 (1981).

[17] Min. Stat. § 120.7 (Supp. 1983) provides:

> Subd. 3a. School district obligations. Every district shall insure that:

participation in decision-making, denial of consent, and request for hearings to appeal decisions.[18] California's statute specifies that meetings at which special educational program planning is to occur should include the individual with exceptional needs "when appropriate," yet allows only parents to have the rights of notice, consent and the ability to request a meeting to consider a change in placement.[19] Other states make no mention of participation of children in either their statements of purpose or descriptions of requirements for meetings.[20]

> (a) All handicapped children are provided the special instruction and services which are appropriate to their needs;
>
> (b) Handicapped children and their parents or guardians are guaranteed procedural safeguards and the right to participate in decisions involving identification, assessment and educational placement of handicapped children;
>
> (c) The rights of the child are protected when the parents or guardians are not known or not available, or the child is a ward of the state.

[18] Subd. 3b. Procedures for decisions. Every district shall utilize at least the following procedures for decisions involving identification, assessment and educational placement of handicapped children:

> (a) Parents and guardians shall receive prior written notice of:
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> (1) any proposed formal educational assessment or proposed denial of a formal educational assessment of their child;
>
> (2) a proposed placement of their child in, transfer from or to, or denial of placement in a special education program; or
>
> (3) the proposed provision, addition, denial or removal of special education services for their child.
>
> (b) The district shall not proceed with the initial formal assessment of a child, the initial placement of a child in a special education program or the initial provision of special education services for a child without the prior written consent of the child's parent or guardian.

[19] CAL. EDUC. CODE § 56341 (West 1983) states:

> (b) The individualized education program team shall include the following:
>
> (1) A representative . . . who may be an administrator, program specialist, or other specialist who is knowledgeable of the program options. . . .
>
> (2) The pupil's present teacher. . . .
>
> (c) When appropriate, the team shall also include:
>
> (1) The individual with exceptional needs.
>
> (f) The parent shall have the right to present information to the individualized education program team in person and the right to participate in meetings relating to eligibility for special education and related services, recommendations and program planning.

See also CAL. EDUC. CODE § 56346 (West 1983). Parental notice of program and plan; consent to individualized education program; due process hearing.

No pupil shall be required to participate in all or part of any special education program unless the parent is first informed, in writing, of the facts which make participation in the program necessary or desirable and of the contents of the individualized education plan, and after such notice, consents in writing, to all or part of the individualized education program. . . . The parent may withdraw consent at any time after consultation with a member of the individualized education program team and after he or she has submitted written notification to an administrator.

[20] *See, e.g.*, N.J. STAT. ANNOT. 18A: 46-8 (1984).

The approach outlined in the Act and related state statutes appears to be supported by the holdings in Supreme Court cases establishing limits on state regulation of educational practice.[21] Further, in its only decision involving potentially conflicting parent and child interests in the diagnosis and placement of minors, the Supreme Court, in *Parham v. J.R.*[22] upheld a Georgia statute which permitted commitment of children to mental hospitals on application by their parents and approval by an admitting physician. Although it found that a child had substantial liberty interests in not being unnecessarily confined and in avoiding the effects of misclassification and improper diagnoses,[23] the Court concluded that giving parents sole discretion to make and authorize such placements was permissible because "pages of human experience" show that parents generally act in their child's best interests.[24] Since children were viewed as incompetent to make decisions concerning treatment,[25] recognizing a right to participation for them was viewed as both potentially interfering with treatment programs and disrupting to parent-child relationships.[26]

The Court's position in *Parham* and its education-related decisions assume both that the parent always speaks for the best interests of the child and that, as the child grows older, he will accept views congruent with those of his parents. Although this assumption may be generally correct, congruence between the interests of parents and children may not routinely exist.[27] In the context of special education, children may have

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[21] The cases establish the propositions that the States may not: require children to attend only public schools, Pierce v. Soc. of Sisters, 268 U.S. 510 (1925); require a flag salute, West Virginia Bd. of Educ. v. Barnette, 319 U.S. 624 (1943); allow prayer in public classrooms, School Dist. v. Schempp, 374 U.S. 203 (1963); complete education beyond the eighth grade for followers of the Old Order Amish Sect, Wisconsin v. Yoder, 406 U.S. 205 (1972); prohibit the teaching of foreign languages, Meyer v. Nebraska, 262 U.S. 390 (1923); ignore the first amendment rights of students, Tinker v. Des Moines Indep. Comm. School Dist., 393 U.S. 503, nor suspend students without providing some level of due process protection, Goss v. Lopez, 419 U.S. 565.

[22] Parham v. J.R., 442 U.S. 584 (1979).

[23] *Id.* at 601.

[24] *Id.* at 602. This assumption may be especially faulty in the context of a stressful decision to admit a child to a mental hospital. Often, the problems which lead parents to seek hospitalization of their child can be traced to family difficulties and not just the "illness" of an individual child. Concepts developed by theorists to explain breakdowns in family cohesiveness leading to a decision to commit a child include scapegoating, denial of true feelings family members have for each other and a desire to continue the appearance of family integrity. *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions* 62 CAL. L. REV. 840, 851-853 (1974).

[25] *Parham,* 442 U.S. at 603.

[26] *Id.* at 605.

[27] In his dissent in Wisconsin v. Yoder, 406 U.S. at 241, Justice Douglas argued that the wishes of the involved adolescent children, not exclusively those of their parents, must be considered in determining whether compulsory education laws should be enforced. Justice Douglas felt that, since school attendance most directly affected the future choices of the children, not those of their parents, the students should be given an opportunity to articulate their views.

interests, separate from those of their parents, in avoiding stigmatizing labels[28] and, for example, in remaining within a regular classroom environment.

Parents and school district officials, even though acting on good intentions, may not adequately represent the best long- and short-term interests of their children. Parents may view special education services as a way to obtain small group instruction, individualized planning and close monitoring of the educational progress of their children. Such interests may cause them to minimize the stigmatizing effect that labeling may have for a child. Many parents do not understand the issues involved in special education discussions, feel too intimidated to participate fully in meetings and readily agree to any recommendations the school officials make.[29] School district officials may be concerned about whether teachers with twenty-five regular classroom students can adequately individualize instruction for those students with atypical needs. Administrators are often additionally motivated by the need to publicly demonstrate that all students in regular classrooms are scoring well on standardized achievement tests. Labeling and removing problem students to nontraditional academic tracks superficially explains and justifies their failure to achieve. Given the potential infringement on children's interests created by adult decision-making, involving the students themselves in special education planning may make the due process guarantees of the Act more meaningful for children.

Factors in Planning for the Involvement of Children in Special Education Decision Making

The argument for involving children in special education assessment and placement decisions is premised on research evidence indicating that

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[28] Assignment of disability levels to children has a negative impact on self-perception and frequently jeopardizes peer group acceptance. Cochran, *Perjorative Terms and Attitudinal Barriers,* 58 ARCHIVES OF PHYSICAL MED. AND REHABILITATION 499, 502 (1977); labels create the assumption of "handicappism" which promotes differential treatment of those labelled handicapped, Bogdan, *Handicappism* SOC. POL., 14, 16 (1977); labels may come to be used as referents, Burbach, *The Labelling Process: A Sociological Analysis* in HANDBOOK OF SPECIAL EDUCATION 249 (J. Kaufman ed., 1981); labels may maintain prejudice and stereotypic imagery of the handicapped. Foster, *I Wouldn't Have Seen It If I Hadn't Believed It,* 41 EXCEPTIONAL CHILDREN 469, 470 (1975).

[29] Parents often go along with decisions made by the school system for long periods oftentimes without actually having a substantive voice in educational decision-making. Strickland, *Parental Participation, School Accountability and Due Process,* 3 EXCEPTIONAL EDUC. Q. 9, 12 (1982). This situation indicates that parents may have neither the information nor the strategies to ensure equal status in decision-making. Many parents hesitate to make decisions actively because they do not feel qualified to help in developing an educational plan. *See, e.g.,* Yoshida, *Parental Involvement in the Special Education Pupil Planning Process: The School's Perspective,* 44 EXCEPTIONAL CHILDREN 531, 532 (1978).

allowing children to set goals and to plan the means for achieving those goals leads to their increased commitment toward goal attainment.[30] There is, however, some research literature warning of the risks and potential harms from involving students in decision-making. This latter research notes that some children may ultimately be harmed as a result of their participation in decision-making, if they deny themselves needed interventions, become increasingly aware of their diagnostic labels and limitations or experience confusing and anxiety from coping with the dilemmas of valid educational options.[31]

Any weighing of the potential risks and benefits of children's involvement in decision-making must take into account the specific type of decision to be made (e.g., placement in an out-of-school, residential treatment facility, provision of one hour a day of special teaching within the school setting) and the competencies of the child at issue. Research evidence on the impact of children's involvement in psychoeducational decision-making can assist practitioners in making situation-specific decisions. For example, one study of the effects of children's participation in psychoeducational decisions evaluated expectations and outcomes resulting from the involvement of thirty-two learning disabled and emotionally disabled students, ages 11 to 19 years, in decisions concerning their educational and treatment programs.[32] When the students were asked to choose whether to be involved, most were interested in participating, perceived themselves as competent to do so and expected no negative effects from their involvement. After their participation, the

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[30] For example, Weithorn, *Involving Children in Decisions Affecting Their Own Welfare,* in CHILDREN'S COMPETENCE TO CONSENT (Melton, ed., 1983), suggests that providing information to a child regarding his/her situation and alternatives may facilitate positive outcomes and provide an opportunity for parents and children to plan together and develop mutual respect. It also has been noted that involvement in treatment decision-making fosters a child's sense of responsibility with regard to changing behavior, clarifying problems to be solved, internalizing goal-directed behaviors and values, and avoiding learned helplessness. *See* Crogham, *Contracting with Children: A Therapeutic Tool* 14 PSYCHOTHERAPY: THEORY, RESEARCH AND PRACTICE 32, 36 (1977). Programs designed to increase children's sense of personal control and responsibility (e.g., through participation in decision-making) have been found to lead to increased academic achievement. *See* DECHARMS, ENHANCING MOTIVATION (1976). In a study of minors' participation in decisions to enter psychotherapy, a positive relationship was found between subjects' motivational readiness and treatment adjustment and outcomes. ADELMAN, *Competence of Minors to Understand, Evaluate and Communicate About Their Psychoeducational Problems* PROF. PSYCHOLOGY, 16, 426 (1985).

[31] *See* Miller, *Children's Rights on Entering Therapeutic Institutions,* 4 CHILD AND YOUTH SERVICES 89, 92-94 (1982); Melton, *Decision Making By Children: Psychological Risks and Benefits* in CHILDREN'S COMPETENCE TO CONSENT (Melton, ed. 1983).

[32] Taylor, *Perspectives of Children Regarding Their Participation In Psychoeducational Decisions,* in PROFESSIONAL PSYCHOLOGY (1985). *See also* Taylor, *Attitudes Toward Involving Minors in Decisions,* 15 PROFESSIONAL PSYCHOLOGY, RESEARCH AND PRACTICE 436 (1984).

students followed through on a high percentage of their treatment choices and judged their involvement as effective. Only three of the students indicated that they were experiencing any negative effects. This research suggests that participation in psychoeducational planning should be routinely allowed, but that children who are displeased with their involvement should also be allowed to withdraw whenever they wish to do so.

Competence to participate is the second key issue involved in assessment of the risks and benefits of a minor's involvement in decision-making. Research studies consistently suggest that, by age 12, a substantial number of minors have attained adult-like reasoning capacities.[33] Other factors, such as social class[34] and personality style,[35] however, may alter the age at which an individual child may be considered competent to be involved in decision-making.

Particularly relevant for involvement in special education processes are the effects which various handicapping conditions, such as mental retardation and emotional disturbance, may have on the determination of competency to consent. Since the developmental studies of competency have chiefly focused on nonproblem populations of children with average and above-average intellectual ability,[36] the guidelines they provide may have limited relevance for special education populations. In a survey of children with psychoeducational problems and their parents, it was found that both groups proposed graduated ages for participation in decision-making, depending upon the topic to be decided and the handicapping conditions of the children.[37] While this intuition represents a common sense approach of case-by-case evaluation, the process may be difficult to implement within certain phases of the Act's procedures. For example, while educational and psychoeducational evaluators would have adequate

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[33] *See, e.g.*, Weithorn, *Informed Consent for Treatment: An Empirical Study of Children's Capacities*, 53 CHILD DEVELOPMENT 413 (1982). These capacities include the abilities to pay attention to the task at hand; to delay responses in order to reflect on issues; to weigh more than one alternative; to hypothesize as yet nonexistent risks and alternatives and to employ inductive and deductive forms of reasoning.

[34] Melton, *Children's Concepts of Their Rights*, J. OF CLINICAL CHILD PSYCHOLOGY 186 (1980).

[35] *See., e.g.*, Grisso, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOLOGY 412 (1978), who notes that, in early adolescence, the tendency to defer to adult wishes may be so great as to make independent decision-making impossible.

[36] *See* Miller and Melton, *supra* note 31 above.

[37] Taylor, *supra*, note 32. The overall mean ages suggested were 12.3 years for everyday activities, 15.1 years for health matters and 14.8 years for major life events. The children in the sample tended to propose ages for participation close to their own ages, suggesting that they felt themselves to be competent. Both groups proposed that children with behavior problems and those with limited intellectual ability attain higher ages before they are invited to participate, but this restriction did not extend to children with learning problems. Neither the adults nor the children thought that the age should be lowered for children in more positive groups, e.g., "gifted" or "student leader."

post-evaluation information to determine competency to participate in program-planning meetings, that information would be lacking for determination of competency to comment on the assessment itself. Preliminary questioning concerning competency might itself be viewed as an assessment for which permission was required. Further, such an individualized approach would require that same-aged children be treated differently. Such differential treatment could raise equal treatment arguments not easily refuted on the basis of ad-hoc "suspicions" of lack of competency to participate.

Models for Involvement of Children

Perhaps the most satisfying approach to involving minors in psychoeducational decisions assumes, first, that the desired goal is to create a joint adult-child decision-making process and, second, that a strict view of competency requirements may effectively bar most special education populations from participation. The consent may then be divided into the two developmental steps of "assent" and full "consent." Assent does not require a full comprehension of information provided and assumes the ability to express some preference concerning alternatives. In contrast, consent requires thorough comprehension of the problem and alternative solutions and the ability to clearly express a preference.[38] Assent, therefore, may be made a prerequisite for decision-making, even for children of very young ages, without involving the constraints imposed by consent until the children are able to demonstrate capacity. In such a system, for example, both child and parents could have an absolute right of refusal because the decision-making process is structured so that both the child's assent and the parent's permission are necessary conditions to assessment and placement. Conversely, however, neither the child's nor the parent's decision would be sufficient to determine a placement of the child.

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[38] "Consent is the express agreement of an individual to a . . . placement after having been informed of the purpose, nature and probable consequences of the proposed placement and other clinically appropriate alternatives. An individual is capable of providing informed consent if he or she comprehends the information provided to him or her regarding the proposed placement and alternatives, and is able to express a preference regarding the placement.

"Assent also is the express agreement of an individual to a . . . placement after having been informed of the purpose, nature and probable consequences of the proposed placement and other clinically appropriate alternatives, but, unlike consent, the individual need not fully comprehend the information provided. Rather, assent requires only a very rudimentary understanding of the information provided and the capacity to express a preference regarding the placements. Mere absence of objection shall not be interpreted as assent."

Report, Task Force on the Comment Statutes concerning the Psychiatric Hospitaliziation of Minors, Commonwealth of Virginia, Department of Mental Health and Mental Retardation (1984).

Two applications of this type of system will illustrate its potential benefits for special education placements. In its recommendations relating to research involving children, the National Commission for the Protection of Human Subject of Biomedical and Behavioral Research developed different standards for decisions on research proposals which involved (a) minimal versus nonminimal risks to subjects, and (b) variations in the direct benefits from participation. Under this system, an Independent Review Board must first make decisions concerning risks, benefits and the commensality of the research experience to situations already familiar to the child.[39] The board must then determine that adequate provisions are made for soliciting the child's assent and parental permission for participation. The guidelines further indicate that a child's refusal of permission should be binding in all but a few, limited situations. Children ages 7 and older are judged to be competent to give assent.[40] Procedures for resolving disagreements between parents and children are also specified.

Another paradigm for involving children in decision-making was developed by the Virginia Task Force on Commitment Statutes Concerning Psychiatric Hospitalization of Minors. The Task Force was appointed by the State Human Rights Committee and the Department of Mental Health and Mental Retardation of Virginia to review present commitment statutes and proposed needed recommendations. Their report[41] recognizes the differential capacities of minors of various ages and proposes procedures for the voluntary commitment of minors (a) under age 7; (b) ages 7 through 13; and (c) age 14 and older. Informed parental consent is alone sufficient to place a child under the age of seven. The collateral assent of the minor and the consent of the parent are required to place a child age 7 through 13, while the consent of both groups is required for minors age 14 and older.[42] Task Force proposals for civil commitment and involuntary admissions procedures similarly acknowledge the desirability of differential levels of children's participation at different ages and recommend that

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[39] "The requirement of commensality of experience should assist children who can assent to make a knowledgeable decision about their participation in research, based on some familiarity with the intervention or procedure and its effects. More generally, commensality is intended to assure that participation in research will be closer to the ordinary experience of the subjects. The use of procedures that are familiar or similar to those used in treatment of the subject should not, however, be used as a major justification for their participation. . . ."

Recommendations for Research Involving Children, National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1983).

[40] Parental or guardian permission normally will be required for the participation of children in research. In addition, assent of the children should be required when they are seven years of age or older. *Id.* at 13.

[41] *See* Report, *supra,* note 38.

[42] *Id.*

the state employ differential procedures to override the failure of a minor to agree to placement, depending upon the capacity of the minor for exercising autonomy.[43]

Portions of the recommendations in both reports are appropriate models for involving minors in the special educational decision-making process. The proposals specified by the Virginia task force are relevant to placement decisions involving a major infringement on the child's liberty, for example, a placement in a residential treatment facility or a special day school totally separate from the regular educational program. In permitting a preliminary weighing of risks and benefits from the child's participation, the procedures proposed by the biomedical research report group may be relevant to the range of less intrusive special education decisions, for example those ranging from special resource help one hour a day to those calling for placement in special educational classes within the school setting.

CONCLUSION

Allowing children to participate in special educational decision-making only at the discretion of their parents and the school system often denies them any meaningful involvement and deprives the adult decision makers from hearing the special concerns of children. The availability of models for involving children in decision making and research suggesting that children have the competencies requisite to effective participation in decision making make it possible for many school districts to design, and justify, plans for allowing students more meaningful roles in planning their educational programs. Such increased involvement would represent a step toward treating children like persons with their own interests and rights and may have the additional benefit of increasing student motivation to learn new skills.

APPENDIX

RECOMMENDATIONS REGARDING VOLUNTARY PLACEMENT AND PARENTAL ADMISSION PROCEDURES

Recommendation II

The Task Force recommends that the informed consent requirements for voluntary placement of minors differ depending upon the age of the minor needing treatment. In recognition of the differential capacities of

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[43] *Id.*

minors of various ages to participate in personal placement and admission decisions, we have developed procedures for minors in the following three age groups: (a) under age 7; (b) age 7 through 13; (c) age 14 and older.

a) Parental admission of minors under age 7. Parental consent alone is sufficient to admit a child to a psychiatric facility or other placement. The consent of the parent will be considered valid only after the parent has been fully informed, pursuant to Recommendation I above. Although minors do not have decision-making authority under the age of 7, such minor shall be provided with information pursuant to Recommendation I in a manner commensurate with the minor's ability to comprehend that information.

b) Voluntary admission of minors age 7 through 13. The collateral assent of the minor and consent of the parent are required for voluntary admission of the child in a psychiatric facility or other placement. The assent of the minor and the consent of the parent shall be considered valid only after the minor and parent have been fully informed, pursuant to Recommendation I above.

If the minor should withdraw, such assent after admission, the admitting facility may detain the minor for up to 96 hours if the director deems it clinically appropriate. The parent or guardian must be notified of the minor's request for discharge, and disposition must be made within the 96-hour period for either continued treatment or discharge.

c) Voluntary admission of minors age 14 and older. The collateral comment of the minor and the parent are required for voluntary admission of the child in a psychiatric facility or other placement. The consent of the minor and parent shall be considered valid only after the minor and parent have been fully informed, pursuant to Recommendation I.

If the minor should withdraw such consent after admission, the admitting facility may detain the minor for up to 96 hours if the director deems it clinically appropriate. The parent or guardian must be notified of the minor's request for discharge, and disposition must be made within the 96-hour period for either continued treatment or discharge.

RECOMMENDATIONS REGARDING CIVIL COMMITMENT AND INVOLUNTARY ADMISSIONS PROCEDURES

Recommendation IV

The Task Force recommends that the procedures for involuntary placement of minors reflect both the differential capacities for exercising autonomy of minors of various ages, and the differential responsibilities of parents and state in exercising authority over minors of various ages. In recognition of these differences, we have developed recommendations for different involuntary placement procedures for minors in the following three age groups: (a) under age 7; (b) age 7 through 13; (c) age 14 and older, as follows:

(a) Civil commitment of minors under age 7. If the parent alone refuses admission or placement or is unable to provide comment after being informed of the clinically appropriate alternatives pursuant to Recommendation I, any responsible party may petition for the child's placement outside the home by a civil commitment. The Court shall consider the appropriateness of the placement by applying the commitment criteria specified in Recommendation III above, and may order the proposed placement, an alternative placement or no placement.

(b) Civil commitment of minor age 7 through 13. (i) If a *parent* alone refuses admission or placement or is unable to provide consent after being informed of the clinically appropriate alternatives pursuant to Recommendation I, any responsible party may petition for the child's placement outside the home by a civil commitment. The court shall consider the appropriateness of the placement by applying the commitment criteria specified in Recommendation III above, and may order the proposed placement, an alternative placement or no placement. (ii) If the *minor* alone fails to provide assent to the placement after being informed of the clinically appropriate alternatives pursuant to Recommendation I, and the parent or some other responsible party chooses to petition for the child's placement, a judicial hearing must be held in order to admit the minor. In this instance, the sole purpose of the hearing shall be for the Court to determine if the proposed placement is both clinically appropriate and the least restrictive alternative. The civil commitment criteria shall not be applied by the Court.

(c) Civil commitment of minors age 14 and older. If a *parent* or *minor* fails to consent to a placement after both have been informed of clinically appropriate alternatives pursuant to Recommendation I, the parents or some other responsible party, as the case may be, may petition for the child's placement outside the home by a civil commitment. The court shall consider the appropriateness of the placement by applying the commitment criteria specified in Recommendation III above, and may order the proposed placement, an alternative placement, or no placement. This civil commitment procedure shall also apply if the parent or minor is deemed to be incapable of providing fully informed consent for the minor's placement, or someone petitions for the child's placement.