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MORE THERAPEUTIC, LESS COLLABORATIVE? ASSERTING THE PSYCHOTHERAPIST-PATIENT PRIVILEGE ON BEHALF OF MATURE MINORS

Bernard P. Perlmutter*

“We conclude our pact then with the neurotics: complete candor on one side, strict discretion on the other.”¹

I. INTRODUCTION

Do children have a right to assert the psychotherapist-patient privilege in divorce or custody proceedings? Can a foster child invoke the privilege to prevent her guardian *ad litem* (GAL) from gaining access to her therapist’s notes in a dependency case? Can the GAL use a blanket court order to access these records in dependency proceedings? What are the benefits to the child of protecting her right to “complete candor” in the psychotherapist-patient relationship by mandating “strict discretion” from the therapist?

In three decisions, issued from 2001 to 2004, Florida’s Fourth District Court of Appeal robustly opined that “mature minors” have statutory rights to assert the psychotherapist-patient privilege and to prohibit parents and guardians *ad litem* from gaining access to their psychologists’ treatment records in family and juvenile court proceedings.² This triptych of decisions rendered by one Florida appellate court recognizes an adolescent’s capacity to make decisions about her own medical care and to maintain confidential relationships with health care professionals, which neither parents nor guardians (nor the state) can breach.³

The three cases thus articulate a “child-centered” jurisprudence, elevating the child’s need for confidential medical treatment over the competing claims of parents or guardians *ad litem* for access to the child’s confidential mental health

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1. SIGMUND FREUD, AN OUTLINE OF PSYCHOANALYSIS 64 (James Strachey trans., 1949).

2. *E.C. v. Guardian ad Litem*, 867 So. 2d 1193 (Fla. Dist. Ct. App. 2004); *S.C. v. Guardian ad Litem*, 845 So. 2d 953 (Fla. Dist. Ct. App. 2003); *Attorney ad Litem for D.K. v. Parents of D.K.*, 780 So. 2d 301 (Fla. Dist. Ct. App. 2001).

3. This trend runs counter to the “general rule . . . that children under eighteen are not permitted to consent to or refuse medical treatment without their parents’ consent. In fact, only the parents’ consent matters: the parents’ decision trumps even if the child disagrees.” Jennifer L. Rosato, *Let’s Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decisionmaking*, 51 DEPAUL L. REV. 769, 771 (2002); see generally Parham v. J.R., 442 U.S. 584 (1979) (parents retain plenary authority to seek mental health treatment for their children, subject to a physician’s independent examination and medical judgment).

treatment records.⁴ By privileging the child's health care privacy interests over those of the adults, the cases exemplify the child-centered approach championed by Professor Barbara Bennett Woodhouse and other scholars and practitioners. It thus serves as a counter-narrative to the traditional and prevalent narrative of parental and adult dominion over children:

Law adopts and advances views of children's nature that tend to justify adult dominion and silence children. Thus, children are not denied the right to testify by inhospitable rules of evidence, they are simply characterized as incompetent or unreliable witnesses. Children are not denied due process in foster care, custody, or commitment proceedings. Their interests are simply subsumed in the unity of family life and are presumptively one with those of their parents. Research has shown children to be remarkably distinct individuals even in infancy. However, children are often conceptualized by law as empty vessels for adults to fill and reempty at will, as if they have no religious, moral, or spiritual lives outside those of their parents. Anyone who takes children seriously (parents as well as professionals) is aware of the integrity, power, and individuality of children's spiritual lives, and the strength of their wills.⁵

This article's central trope is that the child has a bundle of interests in access to confidential medical treatment in general and psychotherapy in particular, that neither the parents nor court-appointed guardians *ad litem* (nor the state) can take away.⁶ The three decisions discussed in this article give the child a seat at the table in the courtroom, with court-appointed counsel zealously advocating for the child's

4. See Daniel W. Shuman, *Troxel v. Granville and the Boundaries of Therapeutic Jurisprudence*, 41 FAM. CT. REV. 67 (2003) ("At least by the last third of the 20th century, legal scholars and mental health professionals had agreed that the legal rule addressing child custody and visitation should incorporate a child-centered therapeutic perspective." (citing Barbara A. Babb, *Fashioning an Interdisciplinary Framework for Court Reform in Family Law: A Blueprint to Construct a Unified Family Court*, 71 S. CAL. L. REV. 469 (1998)).

5. Barbara Bennett Woodhouse, *Hatching the Egg: A Child-Centered Perspective on Parents' Rights*, 14 CARDOZO L. REV. 1747, 1838–39 (1993) (citations omitted); see also Katherine Hunt Federle, *The Ethics of Empowerment: Rethinking the Role of Lawyers in Interviewing and Counseling the Child Client*, 64 FORDHAM L. REV. 1655 (1996); Catherine J. Ross, *A Place at the Table: Creating Presence and Voice for Teenagers in Dependency Proceedings*, 6 NEV. L.J. 1362 (2006); Miriam Aroni Krinsky & Jennifer Rodriguez, *Giving a Voice to the Voiceless: Enhancing Youth Participation in Court Proceedings*, 6 NEV. L.J. 1302 (2006); Miriam Aroni Krinsky, *The Effect of Youth Presence in Dependency Court Proceedings*, JUV. & FAM. JUST. TODAY 16 (2006); Andrea Khoury, *Seen and Heard: Involving Children in Dependency Court*, 25 A.B.A. CHILD LAW PRACTICE 145 (Dec. 2006).

6. While courts in child custody and visitation cases regard the child's interests as important, the child's interests typically occupy second tier status below those of parents and the state, and the child's perspective is relegated to the dissenting judge. See, e.g., *Troxel v. Granville*, 530 U.S. 57, 86 (2000) (Stevens, J., dissenting) ("Cases like this do not present a bipolar struggle between the parents and the State over who has final authority to determine what is in a child's best interests. There is at a minimum a third individual, whose interests are implicated in every case to which the statute applies—the child.").

articulated wishes and legal interests.⁷ With counsel at the child's side, the child's voice in court is amplified, reflecting her distinct "integrity, power, and individuality," and the competing arguments of the parent or guardian are brushed aside by the court.⁸

In upholding the child's right to assert the psychotherapist-patient privilege, the decisions promote the child's right to a confidential relationship with her therapist unimpeded by parental assertion or waiver of the privilege. But the cases posit a paradox that reflects a larger tension over who speaks for the child in court proceedings involving the child's "best interests" and specifically the child's health care interests. In each case, the child asserts the right through independent, court-appointed counsel in an adversarial proceeding that pits the child (and her attorneys) against those persons closest to the child who are presumed to have the child's best interests at heart. Indeed, the court's analysis allows the child to usurp the parents' claimed interest in asserting this privilege on behalf of the child.

This article examines these issues in light of different bodies of Florida and federal law and policy, public health policy and medical ethics, developmental psychology, and through the dual lenses of procedural justice and therapeutic jurisprudence.⁹ It argues that appointing counsel to advocate for the child's private therapeutic interests is pivotal to the analysis of the three decisions, which all promote the child's rights as a key and privileged stakeholder in the proceeding. This argument dovetails with a central purpose of therapeutic jurisprudence, to promote positive therapeutic outcomes for participants in legal proceedings, which necessarily includes zealous legal advocacy for a patient's articulated interest in unimpeded access to psychotherapy.¹⁰

7. Providing children court-appointed counsel in dependency and family court proceedings is the exception rather than the rule in Florida. See generally Michael J. Dale & Louis M. Reidenberg, *Providing Attorneys for Children in Dependency and Termination of Parental Rights Proceedings in Florida: The Issue Updated*, 35 NOVA. L. REV. 305, 338–40 (2011).

A recent study published by Florida's Children First and the University of Florida Levin College of Law's Center on Children and Families reports that "[f]ewer than 10% of Florida's neglected, abused and abandoned children have access to attorneys to represent them in the courtrooms where their fundamental rights are at stake." CENTER ON CHILDREN AND FAMILIES & FLORIDA'S CHILDREN FIRST, LEGAL REPRESENTATION OF DEPENDENT CHILDREN: A 2012 REPORT ON FLORIDA'S PATCHWORK SYSTEM 1 (Feb. 2012), available at <http://www.floridaschildrenfirst.org/index.php?s=representation>). By contrast, in the 15th Judicial Circuit (Palm Beach County), where the three cases discussed in this article were litigated, 53% of children have access to counsel. *Id.* at 6.

8. Cf. Melissa L. Breger, *Against the Dilution of Children's Voices in Court*, 20 IND. INT'L & COMP. L. REV. 175, 192 (2010) ("Children's voices have been stifled, diluted or ignored in the court system, and this is partly due to the dominant paradigm in children's legal theory focusing upon 'best interests,' while often overlooking the voices of our youth. The dilution of children's voices in the courtroom is not only disempowering and disenfranchising to youth, but is also misguided.").

9. Of necessity, the article's focus on the confidentiality rights of children in the psychotherapist-patient relationship is narrower in scope than more sweeping treatments of confidentiality in the contexts of child welfare and juvenile court mental health proceedings. See, e.g., Matthew J. Fraidin, *Stories Told and Untold: Confidentiality Law and the Master Narrative of Child Welfare*, 63 ME. L. REV. 1 (2010); David R. Katner, *Confidentiality and Juvenile Mental Health Records in Dependency Proceedings*, 12 WM. & MARY BILL RTS. J. 511 (2004).

10. See DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE, INTRODUCTION xviii (1996) [hereinafter THERAPEUTIC KEY] ("Therapeutic jurisprudence proposes that we be sensitive to those consequences, and that we ask whether the law's antitherapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating

But at what cost? Is there a danger that upholding the child's right to assert the privilege will provoke collateral "anti-therapeutic" damage that deepens the parent-child conflicts rather than alleviates them? How do we define "therapeutic"?¹¹ Will the child and the parent be estranged and their relationship irreparably damaged? Is this "anti-therapeutic"? Will the guardian's relationship with the child be undermined? Is this "anti-therapeutic"? Will the ruptures in these important relationships, brought about by the stresses and disagreements in the course of a full-tilt adversarial litigation over access to the child's treatment records, harm the child or inhibit the child's healing process?¹² When assessing the lawyers' advocacy in these three cases, can we envision less adversarial ways to represent the children's privacy interests while at the same time serving the clients' personal interests as their "healing agents"?¹³

In rewinding the three cases, this article proposes a more collaborative paradigm for resolution of disputes over parental or guardian *ad litem* access to the child's private psychotherapy records. In reframing the three decisions, the article argues that the family court and juvenile court process should, without question, promote the law as a healing agent that protects children's therapeutic interests and respects their right to maintain privileged, confidential relationships with

due process and other justice values."); see also Bruce J. Winick & Ginger Lerner-Wren, *Do Juveniles Facing Civil Commitment Have a Right to Counsel?: A Therapeutic Jurisprudence Brief*, 71 U. CIN. L. REV. 115 (2002); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37 (1999).

11. As several critics have argued, the term "therapeutic" has indeterminate and protean meanings. See, e.g., Susan L. Brooks, *Using Therapeutic Jurisprudence to Build Effective Relationships With Students, Clients and Communities*, 13 CLINICAL L. REV. 213, 216 n.11 (2006) ("Until now, therapeutic jurisprudence has neither embraced nor rejected any particular theoretical approach. . . . Because therapeutic jurisprudence does not prescribe a particular normative framework, there is a genuine danger that many misguided ideas and programs will be passed off as 'therapeutic.'"); Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193, 201 (1995) ("Whereas the words therapeutic and well-being may be specific enough to help differentiate T[herapeutic]J[urisprudence] from other perspectives, they are still extremely vague.").

These criticisms have been sensibly answered by one of the co-founders of the movement, who argues that "[a]s a mere lens or heuristic for better seeing and understanding the law, however, I think therapeutic jurisprudence has quite rightly opted not to provide a tight definition of the term, thereby allowing commentators to roam within the intuitive and common sense contours of the concept." David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL. PUB. POL'Y & L. 220, 221 (1995).

12. The often deleterious and unpleasant outcomes of litigation suggest that lawyers should try to "reframe the problem as resolving a dispute rather than winning a lawsuit." Bruce J. Winick, *A Legal Autopsy of the Lawyering in Schiavo: A Therapeutic Jurisprudence/Preventive Law Rewind Exercise*, 61 U. MIAMI L. REV. 595, 643 (2007) [hereinafter Winick, *A Legal Autopsy*]. As Winick shows in his detailed rewinding of the many different scorched-earth lawsuits in *Schindler v. Schiavo* that destroyed family relationships and embittered all of the parties:

The litigation and their mutual animosity took over their lives and will forever haunt their memories and the way they are remembered by others. As the Schindlers put it, 'our lives—psychological, professional, philosophical, emotional—would be transformed forever.' In view of the high personal, emotional, and reputational costs that this most public of controversies imposed, it is likely that if somehow given the opportunity to turn back the clock, they would have chosen to resolve their conflict privately and would have moved on.

Id. at 620–21.

13. See generally Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407 (2000) ("The idea of the law as a healing agent might sound bizarre to many. How can a system that prides itself on adversariness heal?").

therapists and other health care professionals. The legal process should also be mindful of the child's important attachments to family members and other trusted adults, which are at least of equal importance to the professional relationship safeguarded by the psychotherapist-patient privilege.¹⁴

This article examines these tensions through three rubrics that evaluate the legal arguments and the character of the lawyering for the three children involved in the litigation. Part II evaluates the lawyer's role as a zealous advocate for the child's *access* to treatment. Part III evaluates the role of counsel in ensuring that the child's *voice* is heard in the courtroom to protect her right to therapy. Finally, Part IV rewinds the cases to consider the child's lawyer's role as a collaborator and "healing agent," facilitating the child's *connections* to significant adults.¹⁵

II. D.K., S.C., AND E.C.: THREE STORIES OF ZEALOUS ADVOCACY TO ENSURE ACCESS TO PSYCHOTHERAPY

A. D.K. v. Parents

Styled *Attorney ad Litem for D.K., a minor, Petitioner v. The Parents of D.K.*, D.K.'s case is the story of a teenager with an extensive treatment history for various mental health disorders that played a pivotal role in her parents' divorce.¹⁶ Her court-appointed counsel was charged with accomplishing one specific task for his client: to "protect any privilege the minor child might have."¹⁷

The privilege at issue was the psychotherapist-patient privilege,¹⁸ which encompassed an extensive mental health treatment history dating back to D.K.'s

14. See Barbara A. Babb, *An Interdisciplinary Approach to Family Law Jurisprudence: Application of an Ecological and Therapeutic Perspective*, 72 IND. L.J. 775, 808 (1997):

Family law decision-makers must embrace as a goal of family law jurisprudence the need to strengthen individuals and families and to enhance their functioning. This objective challenges decision-makers to examine the family holistically, identifying how family members interact with other aspects of the family ecology at the present time and over the course of time. Judges must know and understand the backgrounds and communities from which family law litigants and their legal issues emerge.

15. For other iterations of these terms in analogous contexts involving clients with diminished capacities and marginal status in the legal system. See, e.g., Peter Margulies, *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 FORDHAM L. REV. 1073, 1092-93 (1994); Peter Margulies, *Representation of Domestic Violence Survivors as a New Paradigm of Poverty Law: In Search of Access, Connection, and Voice*, 63 GEO. WASH. L. REV. 1071, 1076-80 (1995). The concepts are used to analyze the roles of lawyers for vulnerable populations such as incapacitated elders and domestic violence victims. In this article, the terms are used to reframe the role of counsel in advocating for the child's right to assert an important evidentiary privilege in family and juvenile court cases, and the impact of that advocacy on the child's broader family ecologies.

16. *D.K.*, 780 So. 2d. at 304 (The case was styled *Attorney for D.K. v. Parents of D.K.* to conform to the long-recognized procedural requirement that "[u]nless a child has a guardian or other like fiduciary, a child must sue by his next friend."); *Kingsley v. Kingsley*, 623 So. 2d 780, 784 (Fla. Dist. Ct. App. 1993); see also Rule 1.120(b), Fla. R. Civ. P. ("An infant or incompetent person who does not have a duly appointed representative may sue by next friend or by a guardian ad litem.").

17. *D.K.*, 780 So. 2d. at 304 n.1.

18. The operative sections of the privilege statute that the appellate court analyzed in *D.K.* provided:

high school years in the late 1990s, when she was admitted to two inpatient facilities to treat mental health and behavioral problems.¹⁹ After discharge, she received therapy from at least two mental health professionals.²⁰ Shortly after beginning her treatment with a psychotherapist, she revealed for the first time, to the therapist, that her father had sexually abused her between the ages of three and seven. This revelation prompted the mother's filing of a petition for divorce.²¹

D.K.'s father denied the allegations of sexual abuse, but her mother relied on them as the basis for her petition for sole custody of their daughter and her sibling.²² During the litigation, the parents agreed to the appointment of a "certified custody evaluator" and a psychologist to evaluate the entire family.²³ The parents agreed to provide both the evaluator and the psychologist with the family's complete medical records.²⁴ The father separately sought his daughter's medical records.²⁵

At the prompting of the mother, whose attorney had suggested to the father and the court "that the daughter might have a privilege in the records,"²⁶ the judge appointed an attorney *ad litem* who promptly "asserted a privilege on behalf of the daughter and opposed the production of the mental health records."²⁷ The attorney *ad litem*'s assertion of the privilege was made over the objection of the parents, who had each separately agreed to produce the child's records to the evaluators and who had each claimed that they could assert or waive the privilege on their daughter's behalf.²⁸ In response, D.K.'s court appointed attorney *ad litem* filed a motion for a protective order arguing that her disclosures were protected by the patient-psychotherapist privilege that she herself, through her counsel, could assert pursuant to Fla. Stat. § 90.503(3)(a).²⁹

At the hearing on the child's motion, the custody evaluator and court-appointed psychologist testified that "it was in the best interest of both children to obtain all

(2) A patient has a privilege to refuse to disclose, and to prevent any other person from disclosing confidential communications or records made for the purpose of diagnosis or treatment of the patient's mental or emotional condition, including alcoholism and other drug addiction, between the patient and the psychotherapist. . . .

(3) The privilege may be claimed by:

(a) The patient or the patient's attorney on the patient's behalf;

(b) A guardian or conservator of the patient.

Id. at 306 (citing FLA. STAT. § 90.503 (2000)).

19. *D.K.*, 780 So. 2d. at 304.

20. *Id.* at 303-04.

21. *Id.*

22. *Id.* at 303.

23. *Id.* at 304.

24. *Id.*

25. *Id.*

26. *D.K.*, 780 So. 2d. at 304.

27. *Id.*

28. *Id.*

29. *Id.*

of the records to evaluate the custody issues.”³⁰ The psychologist “recognized the need to protect the confidentiality of the minor child and that using what he saw in those records as a basis of his opinion would make him a conduit of privileged information and would not be in the best interests of the daughter.”³¹ Neither expert could articulate a specific reason for needing the reports, but both nevertheless felt that their opinions would not be complete without the “entire psychological picture” of the daughter, even though the two had already examined her and heard from her about the prior reported sexual abuse.³²

The trial court denied D.K.’s protective order, finding that while there was a confidential testamentary privilege between the child and her therapist, the parents had waived the privilege, and further, that the two forensic experts said they “needed” the information to complete their custody evaluations.³³ Through her court-appointed attorney *ad litem*, D.K. petitioned the District Court of Appeal to quash the trial court’s order denying her motion for protective order.³⁴

In an opinion written by Chief Judge Martha Warner, the appellate court held that D.K. had a right to assert the psychotherapist-patient privilege, that her parents had not waived the privilege, and that the court’s authority to decide child custody matters according to D.K.’s “best interests” did not override her independent right to assert the privilege.³⁵

In upholding D.K.’s right to assert the privilege, the court based its analysis on a review of a bundle of constitutional, legal, and medical decision-making rights accorded to children, independent of the decision-making authority vested in and exercised by parents.³⁶ The court then identified several statutory provisions “that appear to limit parents’ access to their child’s medical records.”³⁷ The court carefully unpacked the plain language of the psychotherapist-patient privilege statute, examined analogous authority from other jurisdictions, and concluded “that a child has a privilege in the confidentiality of her communications with her psychotherapist.”³⁸ The court carefully limited its holding to the unique facts presented in this case, finding that “the parents are engaged in litigation, and each has a personal interest in asserting the privilege that could be in conflict with the child’s interest in asserting the privilege.”³⁹

The court completed its analysis by elevating the child’s specific interest in asserting the privilege over the general “best interest of the child” standard

30. *Id.*

31. *Id.*

32. *Id.*

33. *D.K.*, 780 So. 2d. at 304.

34. *Id.*

35. *Id.* at 304–10.

36. *Id.* at 304–05 (noting that “not all decisions are removed from a minor,” including the decision to petition for the removal of the disability of non-age, the right to request psychological treatment, the right to seek an abortion, and the right to invoke and waive constitutional rights, without parental involvement).

37. *Id.* at 305 (noting that various Florida health care statutes, including several provisions of the Florida Mental Health Act, “favor confidentiality of psychiatric records, even a minor’s psychiatric records in some instances”).

38. *Id.* at 306–07.

39. *D.K.*, 780 So. 2d at 308.

prevalent in custody disputes.⁴⁰ The court predicated its holding that D.K.'s interest in preserving her "most private communications" with her therapist was more important than maintaining her "relationship with her father" as a means of ensuring her best interests.⁴¹ In granting the certiorari petition and quashing the lower court's order authorizing the release of D.K.'s records to the psychologist and evaluator, the court aptly summarized the tensions between children and their parents inherent in its decision to grant D.K. the right to claim a privilege in her disclosures to her therapist over her parents' objections:

We recognize the tension apparent in the law between the rights and responsibilities of parents and the rights of children. Certainly, to promote strong families, parents should be involved and active in the lives of their children, including their health care, for which the parents are held responsible. Unfortunately, sometimes the parents are the cause of abuse, both emotional and physical, of their children. Allowing parents complete access to their children's health care records under all circumstances may inhibit the child from seeking or succeeding in treatment. *The tension between the child's need for confidentiality and privacy to promote healing may conflict with the need of the court for information to inform its judgment as to the child's best interest.*⁴²

B. *S.C. v. Guardian ad Litem*

Whereas D.K.'s battle to protect her privilege was waged by her court-appointed lawyer against her parents, S.C.'s battle for mental health record privacy pitted her lawyers against her court-appointed guardian *ad litem* in a different forum and within a distinct legal and procedural framework.

One of the many features of the attorney's battle with the guardian in *S.C.* was the GAL Program's view that confidentiality does not attach to guardian-child communications.⁴³ Moreover, unlike the situation in *D.K.*, where parents sought to assert and abrogate the privilege, the guardian *ad litem* was claiming entitlement to the records. The GAL relied on a standard form order that it routinely submitted to the court, which allowed it *carte blanche* access to records "regardless of the confidentiality or classification status of said records or information."⁴⁴ Once in possession of this information, the guardian *ad litem* was under no legal or ethical duty to preserve its confidentiality.

40. *Id.* at 309–10.

41. *Id.* at 309.

42. *Id.* at 310 (emphasis added).

43. See STATE OF FLORIDA GUARDIAN AD LITEM PROGRAM, IN THE CHILDREN'S BEST INTERESTS: A MANUAL FOR PRO BONO ATTORNEYS WHO ASSIST GUARDIANS AD LITEM app. A (1991) [hereinafter GUARDIAN AD LITEM PROGRAM] ("Communications between a child and his guardian ad litem are not privileged in law, and a guardian ad litem shall not assure the confidentiality of such communications.").

44. *S.C.*, 845 So. 2d at 955.

By contrast, as a general proposition, the child's attorney is often statutorily and ethically bound to preserve most confidences of the client.⁴⁵ Furthermore, in keeping with the profession's "best practices," children's lawyers should respect client confidentiality, and whenever possible, should ask the child-client for permission to view and share confidential records.⁴⁶ There are, of course, boundaries within the confines of the attorney-child client relationship to the duty to preserve client confidences, such as the need to prevent "reasonably certain" death or substantial bodily harm.⁴⁷

This important distinction between the contrasting confidentiality obligations of the attorney and the guardian is thus particularly apropos in the context of the S.C. litigation. The GAL Program sought confidential and private information regarding its client's therapy in the absence of statutory or ethical limitations on the guardian's sharing of this information in or beyond the dependency courtroom.⁴⁸ For instance, the guardian could be subpoenaed to testify in dissolution, domestic violence, criminal, or other judicial proceedings about matters falling within the purview of the dependency proceeding. Because the guardian is prohibited from asserting the privilege of confidentiality, this highly confidential information about therapy can be volunteered or compelled in these court proceedings.⁴⁹

45. See, e.g., FLA. STAT. § 39.4086 (2001) (now repealed statute stipulating that attorney owes child same duties of advocacy, loyalty, confidentiality, and competent representation as is due an adult client); FLA. RULES OF PROF'L CONDUCT R. 4-1.6 (2011) (duty to preserve client confidences except to prevent client from committing a crime or to prevent a death or substantial bodily harm to another); AMERICAN BAR ASSOCIATION STANDARDS OF PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE AND NEGLECT CASES Standard B-4, commentary (1996) (child's lawyer must preserve child client's confidences, except in situations when child is in grave danger of serious injury or death, in which instance lawyer must ask court to appoint a guardian *ad litem* to represent the child's best interests and alert court to grave danger of serious injury or death facing child); cf. *People v. Gabriesheski*, 262 P. 2d 653, 658-60 (Colo. 2011) (child's statements to an attorney acting as a GAL in abuse and neglect proceedings are *not* protected by attorney-client privilege).

46. JEAN KOH PETERS, REPRESENTING CHILDREN IN CHILD PROTECTIVE PROCEEDINGS: ETHICAL AND PRACTICAL DIMENSIONS 97 (2d ed. 2001):

A primary duty area for the lawyer is keeping client confidentiality . . . The client must be reassured over and over again about the lawyer's strict understanding of the duty of confidentiality. The lawyer should explain the duty in initial discussions and also reinforce the child's understanding in many ways: when asking the child for permission to talk to different people, when asking for signed waivers for release of records, and when discussing with a client what the lawyer plans to tell other parties or the judge. The lawyer must put forth, concretely and specifically, the way in which he or she understands the confidentiality requirement, and stick by that understanding.

47. See generally Peter Margulies, *Lawyering for Children: Confidentiality Meets Context*, 81 ST. JOHN'S L. REV. 601, 612-13 (2007) ("While the duty of confidentiality requires that the lawyer generally decline to disclose any information relating to the representation of a client, that duty is not absolute.").

48. See generally FLA. STAT. § 39.201 (2009) and GUARDIAN AD LITEM PROGRAM, *supra* note 43 (duty not to disclose information relating to appointed case except in reports to the court).

49. See *In re* Report of the Family Court Steering Committee, 794 So. 2d 518, 522 (Fla. 2001) (recommending as a unified family court "guiding principle" that cases involving inter-related family law issues should be consolidated or coordinated to maximize use of court resources to avoid conflicting decisions and to minimize inconvenience to the families); cf. Roy T. Stuckey, *Guardians Ad Litem as Surrogate Parents: Implications for Role Definition and Confidentiality*, 64 FORDHAM L. REV. 1785 (1996) (proposing statutory recognition of an evidentiary privilege to permit guardians *ad litem* to refuse to repeat what their wards have told them, absent compelling circumstances).

Another distinguishing feature was that *D.K.* was a bipolar custody dispute between the child's parents and the child in which the child's privacy interests prevailed. In contrast, *S.C.*'s case involved a dispute between the child, her parents, and the guardian *ad litem*. In this tripartite struggle, the guardian was, of course, duty-bound to act in the child's best interests. As such, the guardian should arguably have been able to gain access to the child's confidential mental health records to conduct his or her factual investigation and make recommendations to the court about her treatment needs.

But the guardian's access begged the question of whether it was in the child's "best interests" for the guardian to breach the confines of *S.C.*'s psychotherapist-patient relationship any more than it was for the parents in the *D.K.* litigation. While the guardian speaks for the child's best interests, the guardian exerts less decision-making authority than the parent *vis-à-vis* the child, and the guardian clearly cannot usurp the parent's fundamental decision-making rights over the child.⁵⁰

Indeed, "[t]he importance of the familial relationship, to the individuals involved and to the society, stems from the emotional attachments that derive from the 'intimacy of daily association. . . .'"⁵¹ Even the most conscientious and caring guardian cannot claim the same "intimacy of daily association" with the child as even a less than exemplary parent (with intact parental rights) can assert.⁵²

Against this complex, multi-layered legal and ethical backdrop, the battle between *S.C.*'s lawyers and guardians unfolded. *S.C.* entered Florida's foster care system at the age of fourteen after the Department of Children and Families (DCF) alleged several acts of abuse by her parents.⁵³ DCF also charged the parents with neglect for being "unable to control or provide [her with] a safe environment."⁵⁴ Presumably, the parents' inability to control her behavior was inferred from the fact that *S.C.* "had also exhibited serious behavior constituting a threat to herself and others."⁵⁵ Indeed, she had been civilly committed to psychiatric programs several times under Florida's Baker Act⁵⁶ during the three years preceding the commencement of the dependency proceeding.⁵⁷

After DCF filed the petition seeking to shelter *S.C.*, the court appointed a guardian *ad litem* to represent her best interests.⁵⁸ The standard order of

50. See, e.g., *In the Interest of J.D.*, 510 So. 2d 623, 629 (Fla. Dist. Ct. App. 1987) (guardian *ad litem* may not usurp altogether parent's role in deciding child's educational placement as the "historical recognition that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment." (quoting *Santosky v. Kramer*, 455 U.S. 745, 753 (1982))).

51. *In re E.A.W.*, 658 So. 2d 961, 973 (Fla. 1995) (Kogan, J., concurring in part, dissenting in part) (quoting *Smith v. Org. of Foster Families for Equality & Reform*, 431 U.S. 816, 844 (1977)).

52. See *Santosky*, 455 U.S. at 753 ("The fundamental liberty interest of natural parents in the care, custody, and management of their child does not evaporate simply because they have not been model parents or have lost temporary custody of their child to the State.").

53. *S.C.*, 845 So. 2d. at 955.

54. *Id.*

55. *Id.*

56. FLA. STAT. § 394.467(1) (2006).

57. *S.C.*, 845 So. 2d at 955.

58. *Id.* at 953.

appointment contained broad boilerplate language granting the GAL Program automatic and unrestricted access to the child's records from a variety of agencies, hospitals, organizations, schools, and persons (including psychologists, psychiatrists, medical, and mental health professionals), regardless of the confidentiality status of the records and without the need for consent from the child, her caregivers, or her parents.⁵⁹ DCF filed a petition to adjudicate S.C. dependent, and the trial court appointed an attorney *ad litem* to represent her.⁶⁰

S.C.'s father consented to the petition, and she was adjudicated dependent as to him.⁶¹ In preparation for the mother's trial on the dependency allegations, DCF filed a motion to release all of S.C.'s records, including those of her former therapist.⁶² Through her attorneys, S.C. objected to the release of the records, arguing that they were privileged under the patient-psychotherapist privilege.⁶³ The court initially ordered that all records involving abuse, neglect, or abandonment be released to the parties.⁶⁴ However, on rehearing, the judge recognized that S.C. had not waived her privilege under § 90.503 and concluded that it would review the records *in camera* and release only those records related to her parents' statements in therapy, but not any of S.C.'s communications during her joint treatment sessions with her parents.⁶⁵ The trial court also agreed to release the dates that S.C. attended therapy.⁶⁶ Notably, however, the court's order "did not restrict access by the guardian *ad litem* to the confidential records."⁶⁷

This omission set the stage for the conflict between S.C. and her court-appointed guardian. Through her counsel, she moved to enjoin the GAL program and any individual guardian from "obtaining any confidential or privileged records pursuant to the initial appointment order without a formal petition and hearing as provided in Section 61.403(2), Fla. Stat."⁶⁸ She also sought injunctive relief to modify the standard GAL appointment order to preclude automatic production of those records, and to require a petition and hearing, pursuant to § 61.403(2) (Florida dissolution of marriage statute), before allowing the release of the therapy records.

After both DCF and the mother indicated their intention to call the former therapist as a witness, the plot thickened. S.C. filed a motion for protective order and a motion *in limine* to prohibit any party from calling the therapist as a witness.⁶⁹ After hearing from the parties, the trial judge concluded that it would permit the therapist to testify on a circumscribed basis, "limiting the testimony to:

59. S.C., 845 So. 2d at 955.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. S.C., 845 So. 2d at 955–56.

66. *Id.* at 956.

67. *Id.*

68. *Id.* at 956; FLA. STAT. § 61.403(2) (2011) (governing guardian records access procedures in dissolution proceedings, requiring the guardian to petition the court for an order, and "only after notice to all parties and hearing thereon" may the guardian inspect and copy any records or documents which relate to the child.).

69. S.C., 845 So. 2d at 956.

(1) whether the mother made therapy appointments for Petitioner; (2) the dates of the appointments; (3) whether Petitioner attended the appointments; (4) whether the mother was cooperative with the therapy schedule; and (5) whether the mother was a suitable custodian for Petitioner.⁷⁰ The judge directed the therapist not to rely on privileged information in her testimony.⁷¹ However, the court denied S.C.'s motion for injunctive relief with respect to the GAL's access to her therapy records.⁷² This denial was the subject of the interlocutory relief, the writ of certiorari that S.C. sought in the district court of appeal.⁷³

Relying upon *D.K.*, the court held that "Petitioner has a right to assert this privilege."⁷⁴ This court has recognized that a minor child has a privilege in the confidentiality of communications with a therapist.⁷⁵ The court considered S.C.'s "age and maturity" as reasons to "appoint an attorney *ad litem* to assert the *child's* position."⁷⁶ The court then turned to the question of whether the child could assert the psychotherapist-patient privilege against the guardian *ad litem*.⁷⁷ Discerning common interests to protect children in the family and juvenile court statutes, the court held that the requirements of § 61.403(2) were a "useful aid in reviewing the scope of the guardian *ad litem's* authority in chapter 39 proceedings."⁷⁸

Applying a Florida constitutional privacy analysis to the consideration of the child's and guardian *ad litem's* conflicting interests under the statutes at issue, the court concluded that the invasion of the privilege by the guardian "should be restricted to using the least intrusive means of obtaining information about the child's treatment."⁷⁹ The court held that:

Patently, the least intrusive means for such purpose dictates that to the extent the court may have authority to invade the minor's privilege, its exercise must, at a minimum, include notice to the minor and an opportunity to be heard. Submitting the issue to the trial court for resolution *in camera* and giving the minor the opportunity to be heard is the least restrictive or intrusive means of furthering a compelling state interest in acquiring the privileged information.⁸⁰

70. S.C., 845 So. 2d at 956.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.* at 957.

75. *Id.* (citing Attorney ad Litem for D.K., 780 So. 2d at 307).

76. S.C., 845 So. 2d at 957 (emphasis in original); see *infra* Part III.H. ("However, empirical research in developmental psychology demonstrates that children even as young as nine have limited medical decision-making capabilities.").

77. S.C., 845 So. 2d at 957.

78. *Id.* at 959 ("Although, here, we are dealing with a statutory, not a constitutional, privacy issue, there is no reason not to apply the same reasoning, particularly where the minor asserts the application of section 61.403(2).").

79. *Id.*

80. *Id.*

While acknowledging the guardian's "interest in inquiring into the child's progress in therapy,"⁸¹ the court saw the child's interest in record privacy as the paramount interest. Accordingly, the court held that the GAL program's standard form order departed from the essential requirements of the law, granted the writ, and quashed the trial court's order allowing the guardian unrestricted access to the records of S.C.'s treating therapist.⁸²

This ruling *should* have set the stage for repeal and amendment of GAL program protocols for inspecting and copying children's privileged mental health treatment records. But as the saying goes, *plus ça change, plus c'est la même chose*. The GAL Program's form order was not altered, and the issue was revisited in the case of S.C.'s foster care compatriot and sibling E.C.

C. S.C. v. Guardian Redux: E.C. v. Guardian ad Litem

Through the same team of lawyers at the Legal Aid Society of Palm Beach County, seventeen-year-old E.C. challenged identical boilerplate language in the same standard form order, signed by the circuit court, granting the GAL Program automatic and unrestricted access to the records of the child's psychologists and psychiatrists.⁸³ As in *S.C.*, the order allowed the guardian *ad litem* blanket access to the child's "most private communications" with therapists without the child's knowledge or consent.⁸⁴ Through court-appointed counsel, the child sued to quash the orders "tacitly approving the form order."⁸⁵

A different panel of the same district court (including Judge Warner) took a careful, albeit impatient, look at the order in question and held that "[it] does not provide that the guardian's right to obtain privileged information must be preceded by a noticed in camera hearing, where the minor may assert the privilege."⁸⁶ The court granted the petition for writ of certiorari and quashed the orders of appointment containing the language that the same appellate court had earlier found overbroad and violative of S.C.'s privileged interests.⁸⁷

D. Coda: Guardian ad Litem Practices in the Aftermath of S.C. & E.C. v. GAL

The current practice regime in the Florida Guardian *ad Litem* Program articulates both the programmatic need for access to a child's mental health records (when dictated by the child's best interests), and the child's personal interest in

81. *S.C.*, 845 So. 2d at 960.

82. *Id.*

83. *E.C.*, 867 So. 2d at 1194.

84. *Id.*

85. *Id.*

86. *Id.* at 1194–95.

87. *Id.* at 1195.

maintaining a confidential relationship of trust with his or her therapist.⁸⁸ While proclaiming a fidelity to protecting the child's confidentiality interests,⁸⁹ the protocol attempts to balance these competing interests by using the following test. However, the balance appears to tip in favor of the program's right to acquire records without first obtaining a court order or even consent from the child:

The Program shall balance the need for therapy records with the risk to the therapeutic benefits. If the child's mental health service provider indicates disclosure to the GAL will adversely affect the child's therapy, the Program shall evaluate the need for the information obtained from mental health records against the potential harm that may be caused by violating the trust established in the confidential relationship between the child and his or her therapist. If the child has the capacity to consent as described in subsection 5(a), the Program shall discuss the need for the therapy records with [the] child and consider the child's preferences in the decision to review therapy records. If the Program determines the need for the records outweighs the potential harm the Program may acquire the records.⁹⁰

Under these guidelines, the GAL Program, without first petitioning the court or giving prior notice to the child, unilaterally determines whether the child has the "capacity to consent" based on such factors as the "child's age, level of maturity, experience, education, background, and intelligence."⁹¹ Any child fourteen and older is presumed to have capacity to consent.⁹²

The protocol conspicuously omits mention of the due process requirements for confidential record access, including submitting the issue to the trial court for resolution *in camera* and giving the minor the opportunity to be heard, as laid out by the Fourth District Court of Appeal in *S.C.* and *E.C.* Thus, the Program arrogates to itself the right to determine when and how to gain access to children's therapy records, without notifying the child, or giving the child a right to be heard by the court prior to inspecting or copying those records.⁹³

The sole reference to the child's attorney *ad litem* (AAL) appears in the context of the Program's disclosure of already acquired therapy records:

88. STATEWIDE GUARDIAN AD LITEM OFFICE, STANDARDS OF OPERATION, Children's Mental Health Records, Standard 4.2 (2006), available at <http://www.guardianadlitem.org/documents/GALStandardsofOperationFINAL3106.doc>.

89. *Id.* § 4.2(4)(b) ("The Program shall zealously guard the confidential relationship between and his or her psychotherapist established in § 90.503, Florida Statutes. If the Program is in possession of therapy records the Program shall review the information to determine the need for disclosure in the judicial proceedings.")

90. *Id.* § 4.2(3)(d).

91. *Id.*

92. *Id.* § 4.2(5)(a).

93. As Professor Michael Dale and Louis Reidenberg point out in their recently published critique of the existing system for representation of children in Florida juvenile court proceedings, "The GAL Program has staff attorneys who appear in court, but they represent the GAL Program, not the child." Dale & Reidenberg, *supra* note 7, at 327.

If the child objects to disclosure of the therapy records and has an AAL, the program attorney shall inform the AAL of the child's objection. If the child objects to disclosure of the records and does not have an AAL, the Program shall request appointment of an AAL, if available, to represent the child.⁹⁴

Under this administrative regime, which on its face appears to flout the prior holdings of the Fourth District Court of Appeal in *S.C.* and *E.C.*, if there is no attorney available to represent the child, or if the court declines for any reason to appoint counsel, it is safe to assume that the child's objections are not heard by the court.⁹⁵

III. HEARING THE CHILD'S VOICE IN COURT: THE IMPORTANCE OF PROTECTING ADOLESCENTS' CONFIDENTIALITY IN MEDICAL TREATMENT

A. The Importance of Confidentiality

The three decisions reflect the legal and policy arguments concerning the importance of assuring confidentiality in treating the child's emotional and physical needs. The children's attorneys had a rich font of legal and constitutional authority to support their arguments. Legislative and judicial recognition of the public interest in the psychotherapist-patient privilege of confidentiality is universal in the U.S. legal system. All fifty states and the District of Columbia have enacted into law some form of psychotherapist-patient privilege.⁹⁶ The U.S. Supreme Court characterizes the privilege as "rooted in the imperative need for confidence and trust" in the physician-patient relationship, noting that "the physician must know all that a patient can articulate in order to identify and to treat disease; barriers to full disclosure would impair diagnosis and treatment."⁹⁷

The need for confidentiality is greater in psychotherapy. As the United States Supreme Court held in *Jaffee v. Redmond*, "[t]he mere possibility of disclosure may impede development of the confidential relationship necessary for successful

94. STATEWIDE GUARDIAN AD LITEM OFFICE, STANDARDS OF OPERATION, Children's Mental Health Records, Standard 4.2(5)(b)(iii) (2006).

95. See Dale & Reidenberg, *supra* note 7, at 315 ("An 'attorney ad litem' (AAL) may only be appointed at the discretion of the court, to represent the child's legal interests . . . *children are rarely appointed an attorney.*") (emphasis added) (citation omitted).

96. *Jaffee v. Redmond*, 518 U.S. 1, 12 (1996); see also Anne D. Lamkin, *Should Psychotherapist-Patient Privilege Be Recognized?*, 18 AM. J. TRIAL ADVOC. 721, 723-25 (1995) (The majority of states and the District of Columbia have recognized the psychotherapist-patient privilege in some form); see, e.g., FLA. STAT. § 90.503 (2010). For a comprehensive overview of state privilege statutes, see *Jaffee*, 518 U.S. at 12 n.11.

97. *Trammel v. United States*, 445 U.S. 40, 51 (1980).

treatment.”⁹⁸ The Court’s opinion explicitly incorporated a “therapeutic” perspective⁹⁹ into its rationale:

A psychiatrist’s ability to help her patients “is completely dependent upon [the patient’s] willingness and ability to talk freely. This makes it difficult if not impossible for [a psychiatrist] to function without being able to assure . . . patients of confidentiality . . . Where there may be exceptions to this general rule . . . there is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment.”¹⁰⁰

The Court accordingly recognized the privilege, under the Federal Rules of Evidence, based on its utilitarian view that the public good of recognizing the privilege transcended the typically “predominant principle of utilizing all rational means for ascertaining truth.”¹⁰¹ It agreed with the judgments of fifty state legislatures that “[t]he psychotherapist privilege serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem. The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”¹⁰²

B. The “Transcendent Importance” for Children of the Psychotherapist-Patient Privilege

Children are particularly vulnerable to psychological damage, high-risk behaviors, abuse, and other physical and emotional health risks. An estimated one in five children ages nine to seventeen, has a mental, emotional, or behavioral disorder.¹⁰³ Suicide is the third leading cause of death for adolescents.¹⁰⁴ In 2003, 900,000 children nationally were found to be abused or neglected, increasing their risk for other psychosocial problems.¹⁰⁵

Even youth without a formal diagnosis or traumatic event experience emotional crises serious enough to warrant counseling. Among the 20.6% (or about 5.1 million) of adolescents who reported receiving “treatment or counseling for

98. *Jaffee*, 518 U.S. at 10.

99. See Shuman, *supra* note 4, at 72 (“The Court’s willingness to rely on a therapeutic basis for a decision in *Jaffee* indicates that it is willing to address the therapeutic implications of legal rules in certain circumstances.”).

100. *Jaffee*, 518 U.S. at 10–11 (citing Advisory Committee’s Notes to Proposed Rules, 56 F.R.D. 183, 242 (1972) (quoting Group for Advancement of Psychiatry, Report No. 45, Confidentiality and Privileged Communication in the Practice of Psychiatry 92 (June 1960)).

101. *Trammel*, 445 U.S. at 50.

102. *Jaffee*, 518 U.S. at 11.

103. U.S. DEPT. OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 124 (1999).

104. ELIZABETH M. OZER, M. JANE PARK, TINA PAUL, CLAIRE D. BRINDIS & CHARLES E. IRWIN, JR., NAT’L ADOLESCENT HEALTH INFO. CTR, AMERICA’S ADOLESCENTS: ARE THEY HEALTHY? 21, 23 (2003), available at http://nahic.ucsf.edu/downloads/AA_2003.pdf.

105. U.S. DEPT. OF HEALTH & HUMAN SERVS., CHILD MALTREATMENT 2003: REPORTS FROM THE STATES TO THE NATIONAL CHILD ABUSE AND NEGLECT DATA SYSTEMS 21 (2005).

emotional or behavioral problems” in 2003, the most common reasons for seeking treatment were that they “felt depressed,” followed by “breaking rules or acting out,” and “[feeling] very afraid or tense.”¹⁰⁶ Adolescents face other health problems, many of which are attributable to risky behaviors, including tobacco use, alcohol and drug abuse, unsafe sexual practices, poor dietary habits, lack of exercise, carrying firearms, and risky vehicle use.¹⁰⁷ Because these behaviors are preventable, efforts to improve adolescent health require a focus on social and behavioral issues and the creation of environments that support healthy choices.¹⁰⁸ Encouraging adolescents to seek assistance from health professionals and counselors is critical to these efforts. A therapist can not only provide counseling during emotional crisis, but can encourage the child to seek other types of treatment, thereby improving the minor’s overall health and well-being.

Health and counseling professionals have long viewed confidentiality as *essential* to the delivery of care to adolescents.¹⁰⁹ As the U.S. Supreme Court observed in *Jaffee*, “Because of the sensitive nature of the problems for which individuals [seek counseling], disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.”¹¹⁰ Children have added concerns of not wanting to share this information with parents for fear of embarrassment, disapproval, or violence.¹¹¹ In some cases, particularly those of sexual, physical, or mental abuse, parents may be the cause of a teen’s emotional or physical problems.

Without assurances of confidentiality, adolescents may forgo treatment.¹¹² One study indicated that only 45% would seek care for depression and 20% would seek reproductive health or substance abuse treatment if their parents were notified.¹¹³ Those who seek care may be less likely to share information, without which counselors or physicians cannot deliver accurate diagnoses or treatment.¹¹⁴ “[P]hysician confidentiality assurances increase adolescents’ willingness to discuss

106. OFFICE OF APPLIED STUDIES, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, 2003 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE, Chapter 8(2004).

107. OZER, ET AL., *supra* note 104, at 1; CENTERS FOR DISEASE CONTROL, U.S. DEPT. OF HEALTH & HUMAN SERVS., YOUTH RISK BEHAVIOR SURVEILLANCE-UNITED STATES, 2003 (2004).

108. OZER, ET AL., *supra* note 104, at 1.

109. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CONFIDENTIAL CARE FOR MINORS 1 (1992); Society for Adolescent Medicine, *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine* (1997).

110. *Jaffee*, 518 U.S. at 10.

111. Carol A. Ford, Peter S. Bearman & James Moody, *Forgone Health Care Among Adolescents*, 282 J. AM. MED. ASS’N 2227, 2228 (1999).

112. *Id.*; Jeannie S. Thrall, *Confidentiality and Adolescents’ Use of Providers for Health Information and for Pelvic Examinations*, 154 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 885 (2000); Ford, et al., *supra* note 111, at 2228; T.L. Cheng, J.A. Savageau, A.L. Sattler & Thomas DeWitt, *Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes among High School Students*, 269 J. AM. MED. ASS’N 1404 (1993).

113. Andrea Marks, Joan Malizio, Jennifer Hoch, Robert Brody & Martin Fisher, *Assessment of Health Needs and Willingness to Utilize Health Care Resources in a Suburban Population*, 102 J. PEDIATRICS 456 (1983).

114. Shelly Jackson & Thomas Hafemeister, *Impact of Parental Consent Notification Policies on the Decisions of Adolescents to Be Tested for HIV*, 29 J. ADOLESCENT HEALTH 81, 88 (2000).

sensitive topics related to sexuality, substance use, and mental health and increase adolescents' willingness to return for future health care."¹¹⁵

Recognizing lack of confidentiality as a barrier to care, medical and counseling professionals have adopted policies supporting confidential services for adolescents.¹¹⁶ The American Medical Association and the Society for Adolescent Medicine concluded that while adolescents should be encouraged to involve their families in health care decisions, they should be assured confidentiality under most circumstances.¹¹⁷ They recognize that "the health risks to the adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care."¹¹⁸

C. Procedural Fairness Considerations

Allowing an adolescent to be heard by the court to assert the psychotherapist-patient privilege also provides important procedural fairness benefits in that it gives her a "voice" in the judicial process and "validation" from the experience of participating in that process.

Empirical studies of how litigants experience judicial and administrative hearings have led to the development of literature on the psychology of procedural justice.¹¹⁹ Research on the psychology of procedural justice suggests that people are more satisfied with, and comply more with, the outcome of legal proceedings when they perceive those proceedings to be fair and have an opportunity to participate in them.

The process, or dignitary value, of a hearing is important to litigants. People who feel that they have been treated fairly at a hearing—dealt with in good faith

115. Carol A. Ford, Susan Millstein, Bonnie Halpern-Felsher & Charles Irwin, *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care*, 278 J. AM. MED. ASS'N 1029, 1033 (1997).

116. See, e.g., American School Counselor Association, *Position Statement: The Professional School Counselor and Confidentiality* (1999), available at <http://www.schoolcounselor.org/ethics/index.htm> (students have "the right to privacy and confidentiality," which "must not be abridged by the counselor except where there is clear and present danger to the student and or other person."); American Counseling Association, Code of Ethics, 2005, Section B, available at www.counseling.org/resources/codeofethics.htm (protecting minors' confidentiality consistent with laws and ethical standards); see also American Association of Pastoral Counselors, Code of Ethics, 1994, section IV, available at www.aapc.org/ethics.htm (requiring confidentiality for all clients); National Board for Certified Counselors Code of Ethics, 1997, sections B.4-B.8, available at www.nbcc.org/ethics/nbcc-code.htm (same).

117. American Medical Association, Code of Medical Ethics, *Professionalism: Confidential Care for Minors*, E-5.055, available at <http://www.ama-assn.org/ama/pub/category/8355.html>; Society for Adolescent Medicine, *Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine* (1997).

118. *Archival Posting: Confidentiality in Adolescent Health Care*, American Academy of Pediatrics News, 2005, available at <http://aapnews.aappublications.org/cgi/content/full/e2005175v1> (joint statement by five healthcare organizations recommending same degree of confidentiality protection for adolescent and adult patients).

119. See, e.g., E. ALLEN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* (1988); TOM R. TYLER, *WHY PEOPLE OBEY THE LAW* (1990); E. Allen Lind, Ruth Kanfer & Christopher Earley, *Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments*, 59 J. PERSONALITY & SOCIAL PSYCHOL. 952 (1990); John Thibaut & Laurens Walker, *A Theory of Procedure*, 66 CALIF. L. REV. 541 (1978).

and with respect and dignity—experience greater litigant satisfaction than those who feel treated unfairly, with disrespect, and in bad faith. People highly value “voice,” the ability to tell their story, and “validation,” the feeling that what they said was taken seriously by the judge or other decision-maker. Even when the result of the hearing is adverse, people treated fairly, in good faith, and with respect, are more satisfied with the result and comply more readily with the outcome of the hearing. Moreover, they perceive the result as less coercive than when these conditions are violated and even feel that they have voluntarily chosen the course that is judicially imposed. Such feelings of voluntariness, rather than coercion, tend to produce more effective behavior on the part of the litigants.

Giving the child a place in the court process provides the child with a sense that his or her voice is genuinely heard and taken seriously, which gives him or her a sense of validation.¹²⁰ In turn, the child is more accepting of the final outcome, whether favorable or not, because the child recognizes that direct involvement in the court proceeding made a difference in the judge’s decision, thus empowering the child.¹²¹ This sense of participation in the process can also initiate the healing process and help the adolescent take more responsibility for her future.¹²² The importance of involving a child in the process is particularly compelling for foster children such as S.C. and E.C. As one commentator has observed,

Children who are the subjects of dependency proceedings have faced terrible situations and may have been subjected to abusive and/or neglectful behaviors by the very people who are supposed to love and protect them . . . many children are involved in court processes precisely because they shared secret information with persons they thought they could trust: doctors, social workers, therapists, and social workers. . . . Children who have been abused

120. See Amy D. Ronner, *Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda, and Juveniles*, 71 U. CIN. L. REV. 89, 95 (2002) (“Voice, validation, and voluntary participation should be essential components in a juvenile proceeding. As with other human beings, juveniles need to be treated with ‘respect, politeness and dignity’ and they need to feel that ‘their rights as citizens are acknowledged.’”) (citations omitted).

121. *Id.* at 94–96.

122. See Emily Buss, *Failing Juvenile Courts, and What Lawyers and Judges Can Do About It*, 6 NW. J. L. & SOC. POL’Y 318 (2011):

One of the primary developmental tasks for adolescents is learning to harness their newly acquired cognitive capacities to make “good decisions,” that is, decisions that will allow them to assume responsibility for their own lives and function successfully in society. It takes practice to become a competent decision maker who can assess short and long-term interests, develop plans to serve those interests, act on those interests, and then take responsibility for those actions. To be effective, this practice should occur in contexts in which adolescents care about the outcomes of the decisions being made. Moreover, to ensure that adolescents have the opportunity to learn from their mistakes, it is also important that the decision making occur in contexts in which the decision-making process can be monitored and supported by caring adults.

Id. at 322–23 (citations omitted).

or neglected often arrive at the legal proceeding in an incredibly disempowered state. They have been violated and hurt by the people who are supposed to love and protect them. *They have had their private lives and stories publicized and repeated by those who promised to keep it secret.*¹²³

Indeed, in a key survey of children leaving the foster care system in the early 1980s, these “graduates” of foster care repeatedly asked for opportunities to be consulted and heard by decision-makers involved in crucial decisions about their lives:

The remarks and suggestions made by foster care graduates contained a recurrent theme—the importance of consultation with the young people themselves. They felt like pawns—subject to the many powers of others. They felt disregarded, that it did not matter what they wanted or had to say, because too often they were never asked. Whether it was a decision about a foster home, about changes in placement, about visiting arrangements with kin, or about their goals in life, they felt they should have been heard. . . . Such a practice can be beneficial in the long run since it is almost axiomatic that those who participate in making decisions are more concerned about making things work out.¹²⁴

Respect for confidentiality rights is particularly crucial for such children. It allows them to exert some measure of control over their world and develop a degree of trust in those around them.¹²⁵

Thus, a parent’s assertion or waiver of the privilege, or a guardian *ad litem*’s use of a blanket order (giving it *carte blanche* access to all of the adolescent’s mental health treatment records), without first giving the child an opportunity to protect the confidentiality of those records, denies the child both voice and validation. It forces disclosure of private and intimate details shared with her therapist and deprives her of the chance to have her voice heard by the court before the records are disclosed. This can only have a negative effect on the relationship with her therapist, and a negative effect on her perceptions of the fairness of the legal process. Indeed, the overwhelming consensus of the empirical research confirms the importance of the confidentiality guarantee safeguarded by the legal

123. Randi Mandelbaum, *Rules of Confidentiality When Representing Children: The Need For A “Bright Line” Test*, 64 *FORDHAM L. REV.* 2053, 2057–58 (1996) (emphasis added).

124. TRUDY FESTINGER, *NO ONE EVER ASKED US . . . A POSTSCRIPT TO FOSTER CARE* 296 (1983).

125. See THE FLORIDA BAR, *COMM’N ON THE LEGAL NEEDS OF CHILDREN, EXECUTIVE SUMMARY FINAL REPORT* (2002) (“Many children involved with [social] service agencies have suffered repeated violations of their sense of personal privacy. They have been abused by parents or relatives, or transferred from one foster care placement to another, or treated like commodities on an assembly line by harried or overworked agency staff. Respect for confidentiality rights is particularly crucial for such children.”).

privilege both on patient willingness to share information with therapists and on patient confidence in the legal system.¹²⁶

D. Therapeutic Jurisprudence Considerations

In a similar vein, a substantial body of therapeutic jurisprudence scholarship suggests that a breach of the privilege can have a significantly negative impact on the patient's willingness to participate in therapy and in treatment.¹²⁷ As described above, therapeutic jurisprudence is a field of interdisciplinary research with a law reform agenda that focuses attention on the consequences of law for the psychological functioning and emotional well-being of the people affected.¹²⁸ Therapeutic jurisprudence sees the law, and the way in which it is applied by various legal actors (including lawyers, judges, and guardians *ad litem*), as having inevitable consequences for psychological well-being that should be studied with the tools of the behavioral sciences. It suggests that these consequences should be taken into account in reforming law, when consistent with other important normative values, in the direction of making it less anti-therapeutic and more therapeutic.¹²⁹ It is a mental health approach to law in the way it is applied, suggesting the need for legislatures and courts to be sensitive to the law's impact on psychological health and to perform their roles with an awareness of basic

126. See P. S. Appelbaum, G. Kapen, B. Walters, C. Lidz & H. Roth, *Confidentiality: An Empirical Test of the Utilitarian Perspective*, 12 BULL. AM. ACAD. PSYCHIATRY & LAW 109, 115 (1984) (reviewing studies showing empirical support for effect of privilege and for fact that people are "overwhelmingly confident that their therapists would protect their privacy"); Daniel O. Taube & Amiram Elwork, *Researching the Effects of Confidentiality on Patients' Self-Disclosures*, 21 PROF. PSYCHOL.: RES. & PRAC. 72 (1990) (privilege shown to be important where law is understood and relevant to particular patients); John M. McGuire, Philip Toal & Burton Blau, *The Adult Client's Conception of Confidentiality in the Therapeutic Relationship*, 16 PROF. PSYCHOL.: RES. & PRAC. 375 (1985) (patients significantly valued confidentiality); Leon Van de Creek, Russell D. Miars & Cindy E. Herzog, *Client Anticipations and Preferences for Confidentiality of Records*, 34 J. COUNSELING PSYCH. 62 (1987); David J. Miller & Mark H. Thelen, *Knowledge and Beliefs About Confidentiality in Psychotherapy*, 17 PROF. PSYCHOL.: RES. & PRAC. 15 (1986) (same); Tina Cheng Judith Savageau, Ann Sattler & Thomas DeWitt, *Confidentiality in Health Care: A Survey of Knowledge, Perceptions and Attitudes Among High School Students*, 269 J. AM. MED. ASS'N 1404 (1993) (confidentiality important to adolescents seeking counseling).

127. See generally Bruce J. Winick, *The Psychotherapist-Patient Privilege: A Therapeutic Jurisprudence View*, 50 U. MIAMI L. REV. 249, 257 (1996) (rejection of the privilege may seriously diminish the effectiveness of therapy for individuals who are in or decide to undertake therapy; many patients, out of concern for potential disclosure, will predictably inhibit their own disclosure to the therapist if privilege does not attach).

128. See, e.g., BRUCE J. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW (1997); THERAPEUTIC KEY, *supra* note 10.

129. Therapeutic jurisprudence has been relied on by the Florida Supreme Court in several rulings with significant implications for children's due process rights and dignitary interests. See, e.g., *M.W. v. Davis*, 756 So. 2d 90, 107 (Fla. 2001) (Pariente, J.) (noting the psychological benefits to juveniles from being afforded procedural protections prior to being placed in psychiatric treatment facilities); Amendment to the Rules of Juvenile Procedure, FLA. R. JUV. P. 8.350; 804 So. 2d 1206, 1210-11 (Fla. 2001) (Pariente, J.) (expressly applying the principles of therapeutic jurisprudence in the court's adoption of a rule of juvenile procedure requiring the court to consider the child's views before ordering him or her into residential treatment); *In re* Amendments to the Florida Rules of Juvenile Procedure, 26 So. 3d 552, 556 (Fla. 2009) (finding indiscriminate courtroom shackling of Florida children "repugnant, degrading, humiliating, and contrary to the stated primary purposes of the juvenile justice system and to the principles of therapeutic justice.").

principles of psychology. This is particularly apropos in the context of child welfare and family court proceedings.¹³⁰

The literature on the therapeutic impact of a forced breach of the psychotherapist-patient privilege strongly suggests that the breach can have significant anti-therapeutic consequences for the patient.¹³¹ If a patient does not perceive that the other parties and the court will adequately protect the confidentiality of her communications, the trust vital to the psychotherapeutic relationship is likely to be significantly impaired or destroyed.

As observed decades ago by Chief Judge Henry Edgerton, in a seminal pronouncement on the therapeutic value of preserving psychotherapist-patient confidentiality in court proceedings:

The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. . . . It would be too much to expect them to do so if they knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to the whole world from a witness stand.¹³²

Breach of the therapeutic relationship for an adolescent enmeshed in a family court custody or juvenile court dependency proceeding, particularly an adolescent grappling with sexual abuse or other past trauma, is likely to discourage the adolescent from seeking therapy. It also is likely to destroy the trust vital to the

130. See, e.g., Amendment to Florida Rule of Juvenile Procedure, FLA. R. JUV. P. 8.100(a), 796 So. 2d 470 (Fla. 2001) (recognizing the deleterious therapeutic consequences for juveniles of video conference arraignments); *In re* Report of the Family Court Steering Committee, 794 So. 2d 518, 537 (Fla. 2001) (recognizing “therapeutic justice” as a “guiding principle” in unified family court); see also Susan L. Brooks, *Therapeutic Jurisprudence and Preventive Law in Child Welfare Proceedings: A Family Systems Approach*, 5 PSYCHOL. PUB. POL’Y & L. 951, 953–55 (1999) (proposing application of therapeutic jurisprudence research to child welfare proceedings).

131. Studies show that when clients are told that their therapist might be required to disclose their communications in court, their willingness to discuss sensitive topics declines markedly. See Daniel W. Shuman & Myron Weiner, *The Privilege Study (Part III): Psychotherapist-Patient Communications in Canada*, 9 INT’L J. OF L. & PSYCHIATRY 393, 407, 410, 416, 420 (Table I) (1986); Shuman & Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893, 919–20, 926, 929 app. tbl. 1 (1982); Comment, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 YALE L.J. 1226, 1255 (1962) (forty-nine percent of people questioned by the author would be less likely to make full disclosure to a psychotherapist if the therapist had a legal obligation to disclose confidential information if asked to do so by a lawyer or judge); see also Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV., 165, 183 (1978) (majority of therapists surveyed by author “thought that patients will withhold information important to treatment if they believe the therapist may breach confidentiality”); *Allred v. State*, 554 P.2d 411, 417 (Alaska 1976) (“Without foreknowledge that confidentiality will attach, the patient will be extremely reluctant to reveal to his therapist the details of his past life and his introspective thoughts and feelings.”).

132. *Taylor v. United States*, 222 F.2d 398, 401 (D.C. Cir. 1955) (quoting GUTTMACHER & WEIHOFFEN, PSYCHIATRY AND THE LAW 272 (1972)).

formation of healthy relationships with family members, adults, and peers in school, the workplace, and society.

Given the high incidence of emotional problems among children and adolescents, it is vitally important that society encourage them to seek counseling. Therapy is critical because most children in this situation will not seek out mental health counseling, and existing resources already are overburdened. Without counseling, the adolescent's response to the traumatic events revisited and litigated by parties in the custody or dependency proceeding may escalate, leading to substance abuse, sexually transmitted diseases, domestic violence, criminal court involvement, and even suicide.¹³³

Thus, society has a strong interest in fostering the psychotherapist-patient relationship in the case of a child who is in need of therapy, and in fostering her interest in keeping her intimate thoughts and feelings private in order to further her therapeutic treatment. The paramount interest in court proceedings is safeguarding the health and well-being of the child.¹³⁴ While the parent or guardian has a responsibility to assure that the child is healthy and to advocate for appropriate health care interventions, the adult's need to know the intimate details of her treatment should not take precedence over the child's right of access to confidential health care services.

E. Public Health Considerations

Federal and state courts have long viewed minors as having a protected right of privacy in a variety of health care and related contexts, particularly those that relate to abortion and reproductive health care decisions.¹³⁵ The view that children are entitled to protection under the Constitution originated in teenage abortion cases,¹³⁶

133. See, e.g., Gene Griffin & Michael J. Jenuwine, *Using Therapeutic Jurisprudence to Bridge the Juvenile Justice and Mental Health Systems*, 71 U. CIN. L. REV. 65, 72 (2002) ("The Surgeon General of the United States refers to the prevalence of mentally ill juveniles in the justice system in several of his recent reports. In his report on Children's Mental Health, the Surgeon General states, 'too often, children who are not identified as having mental health problems and who do not receive services end up in jail. Children and families are suffering.'") (quoting Report of the Surgeon General's Conference on Children's Mental Health: a National Active Agenda, available at <http://www.ncbi.nlm.nih.gov/books/NBK44237/> (last visited Nov. 1, 2011)).

134. See New York State Permanent Judicial Commission on Justice for Children, *Ensuring the Healthy Development of Children: A Guide for a Judges, Advocates and Child Welfare Professionals* (no date available) (foreword by Commission Chair Judith E. Kaye, Chief Judge of the State of New York):

While we do not suggest, or expect, that court appearances become medical inquiries, we hope that at some point an opportunity might be found to check these fundamental guideposts. By asking [questions about the child's basic health needs] we can create a climate that spotlights the critical connection between foster children's healthy development and their prospects for a permanent home. Hopefully, the inquiry will ensure that needed services are provided. Where questions expose the inadequacy of resources available to meet the needs, we hope that judicial leadership can help spur new initiatives to ensure the healthy development of every foster child.

135. See, e.g., *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) ("Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority."); see also discussion *infra* Parts III.F and G.

136. Cf. Martin Guggenheim, *Minor Rights: The Adolescent Abortion Cases*, 30 HOFSTRA L. REV. 589 (2002) [hereinafter Guggenheim, *Minor Rights*] (criticizing the view that the adolescent abortion cases expand

but it has influenced laws governing children's rights to access to treatment for alcohol and drug abuse and sexually transmitted diseases.

State laws that bar minors' access to private reproductive health care have been ruled unconstitutional, unless laws requiring parental involvement contain alternatives, such as judicial bypass.¹³⁷ States have passed laws authorizing minors to consent to health care related to sexual activity, substance abuse, and mental health.¹³⁸ In certain states, older minors or those with special status (e.g., emancipated, married or parents) can consent to all of their health care—not just in these sensitive areas.

Many of these statutes also provide explicit confidentiality protections for information related to health care. Lawmakers recognize that while parental involvement is desirable, many minors will not seek services if obligated to tell their parents. Some programs, such as Title X of the Public Health Act, which provides funding for family planning clinics, require access to confidential services “without regard to age.”¹³⁹ The Public Health Services Act protects confidentiality of drug and alcohol treatment records, sometimes providing greater protection than state law.¹⁴⁰ While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations do not give minors confidentiality rights beyond state law, when adolescents have a right to consent under state law, the health care provider must comply with HIPAA's requirements to reduce the risk of disclosure.¹⁴¹

As Professor Martin Guggenheim has argued, legislatures have enacted these laws guaranteeing adolescents access to treatment for sexually transmitted diseases or drug and alcohol addiction, without prior parental approval or knowledge, primarily out of concern for the public's health and safety.¹⁴² In doing so for pragmatic public health reasons, they have effectively negated the traditional weight given to plenary parental authority over children in the health care sphere:

children's rights and arguing that they “use a construct of children's constitutional ‘rights’ to restrict the rights of children”).

137. See, e.g., *Carey v. Population Svs. Int'l*, 431 U.S. 678 (1977); *Danforth*, 428 U.S. at 52; *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); see also discussion *infra*.

138. ABIGAIL ENGLISH & KIRSTEN KENNEY, CENTER FOR ADOLESCENT HEALTH & THE LAW, *STATE MINOR CONSENT STATUTES: A SUMMARY* (2d ed. 2003). For example, twenty-five states and the District of Columbia allow minors to consent to contraceptive services; twenty-five states and the District of Columbia allow minors to consent to testing for sexually transmitted diseases, including HIV; forty-four states and the District of Columbia allow confidential counseling and medical care for minors suffering from drug and alcohol abuse; and twenty states and the District of Columbia allow minors to consent to outpatient mental health services. *Id.*; see also Abigail English, Carol Ford & John Santelli, *Clinical Preventive Services for Adolescents: Position Paper of the Society for Adolescent Medicine*, 35 AM J.L. & MED. 351, 362 (2009) (“every state has a law that allows minors to consent for some services—usually diagnosis and treatment—related to sexually transmitted or venereal disease.”).

139. 42 U.S.C. § 300a (2005); 42 C.F.R. §§ 447.66, 440.30, 447.70, 411.163.

140. 42 U.S.C. § 201, *et seq.*; Rebecca Gudeman, *Adolescent Confidentiality and Privacy Under the Health Insurance Portability and Accountability Act*, YOUTH LAW NEWS, at 1–6 (July–Sept. 2003) (when state law requires parental consent for a minor's substance abuse treatment, federal law generally prohibits providers from disclosing any information without the written consent of both the minor and the minor's parents).

141. *Id.*; 45 C.F.R. § 164.510.

142. MARTIN GUGGENHEIM, WHAT'S WRONG WITH CHILDREN'S RIGHTS 235–36 (2005).

For more than forty years, legislatures have seen the wisdom of enacting laws in every state that permit children ready access to such treatment without any requirement of parental consent or even notice. . . . Legislators simply don't think about this subject in terms of children's rights. These are intelligent rules for society. Legislators recognize the terrible consequences to society (in other words, to the world inhabited by adults) when children with sexually transmitted diseases go untreated.¹⁴³

As Judge Warner's analysis in *D.K.* shows, the Florida legislature has provided that mature minors can consent to mental health services, alcohol and drug abuse treatment services, and treatment for sexually transmitted diseases.¹⁴⁴ The court also points out that the legislature has limited parental access to the child's medical records for treatment of these and other medical conditions.¹⁴⁵ As observed above, Florida allows minors to seek out medical services in a variety of contexts.¹⁴⁶ Florida statutory law also allows pregnant minors or minor mothers to give consent to medical services for themselves and their children.¹⁴⁷

But while these policies clearly reflect pragmatic social and public health policy judgments from the legislative branch, to what extent do they also reflect the courts' privacy jurisprudence (emerging from the penumbras of the federal constitution and the explicit guarantees of the state constitution) which also appears to favor varying degrees of adolescent medical decision-making autonomy and authority?

143. *Id.*; see also Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 567 (2000) ("parental consent is set aside under certain circumstances and for particular kinds of treatment, giving adolescents legal authority to make their own medical decisions. The policy objectives of these exceptions vary, but most involve circumstances in which general social welfare and the welfare of the young person needing treatment would be undermined if parental consent were required and the traditional boundary of childhood were maintained."); Caitlin M. Cullitan, *Please Don't Tell My Mom! A Minor's Right to Informational Privacy*, 40 J. L. & EDUC. 417, 421 (2011) ("To the extent that health care services related to sexuality are available to minors, strongly protecting informational privacy also empowers minors to proactively seek out such services.").

144. See *D.K.*, 780 So. 2d at 304–05 ("not all decisions are removed from a minor"). Judge Warner cites to Ch. 743, Florida Statutes (2000), which provides for the removal of the disabilities of non-age under certain circumstances and notes that where such disabilities are removed, "[t]he minor may assume the management of his or her estate, contract and be contracted with, sue and be sued, and perform all acts that he or she could do if not a minor." FLA. STAT. § 743.01 (2000). She also observes that the disabilities of non-age are removed in a limited fashion for any child over the age of thirteen to request treatment when the child experiences an emotional crisis to such a degree that the child perceives the need for such services. See FLA. STAT. § 394.4784(1) (2000). "While a parent must be notified if the services exceed two visits in any one week period, parental participation in such treatment is allowed 'when determined to be appropriate by the mental health professional or facility.'" *Id.*

145. See *D.K.*, 780 So. 2d at 301.

146. See e.g., FLA. STAT. § 394.4784 (2010) (allowing a minor over age thirteen who "experiences an emotional crisis to such degree that he or she perceives the need for professional assistance" to access therapy or counseling services); FLA. STAT. § 397.601(4)(a) (2010) (removing the disability of minority for the purpose of obtaining voluntary substance abuse services); FLA. STAT. § 397.501(7)(e) (2010) (protecting minor's treatment records from disclosure without minor's consent); FLA. STAT. § 384.30 (2010) (providing minors the right to consent to treatment for sexually transmitted diseases).

147. FLA. STAT. § 743.065 (2010).

F. Federal Privacy Considerations

The adolescent's confidentiality rights are arguably, although controversially, compelled by the long-accepted shibboleth that "[a] child, merely on account of his minority, is not beyond the protection of the Constitution."¹⁴⁸ An adolescent's right to assert the privilege to protect confidential therapeutic disclosures also arguably flows out of "the recent judicial trend towards affording children greater protection under the Constitution," suggesting that "a minor's right to make medical decisions for herself should receive full protection, and a minor should enjoy standing in contested medical treatment cases to protect her rights of informed consent, bodily integrity and self-determination, and privacy."¹⁴⁹

The assertion of the privilege is specifically rooted in the federal cases establishing a right to privacy in the abortion context.¹⁵⁰ In *Carey v. Population Servs. Int'l*,¹⁵¹ the U.S. Supreme Court restated the parameters of the right to privacy as protected by the federal constitution, as developed to that point:

Although "[t]he Constitution does not explicitly mention any right of privacy," the Court has recognized that one aspect of the "liberty" protected by the Due Process Clause of the Fourteenth Amendment is "a right of personal privacy, or a guarantee of certain areas or zones of privacy." While the outer limits of this aspect of privacy have not been marked by the Court, it is clear that among the decisions that an individual may make without unjustified governmental interference are personal decisions "relating to marriage . . . procreation . . . contraception . . . child rearing and education."¹⁵²

The Court has also noted that the privacy right, by definition, involves "the most intimate of human activities and relationships."¹⁵³

Although the U.S. Supreme Court has never decided whether a right to privacy inheres in the doctor-patient relationship generally,¹⁵⁴ the protection of

148. *Bellotti v. Baird*, 443 U.S. 622, 633 (1979) (invalidating Massachusetts statute requiring parental consent or court order before a pregnant minor can obtain an abortion, and requiring the minor to initiate a judicial bypass proceeding to show that she is mature enough and well enough informed to make her own abortion decision in consultation with her physician, independently of her parents' wishes).

149. Susan D. Hawkins, Note, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 *FORDHAM L. REV.* 2075, 2093 (1996) (citing Hillary Rodham, *Children Under the Law*, 483 *HARV. ED. REV.* 487, 509 (1973) (minors are persons under the Constitution, and as such, they are "entitled to the protective procedures of the Bill of Rights" whenever their liberties or interests are adversely affected.)).

150. Guggenheim, *Minor Rights*, *supra* note 136, at 591. Prof. Guggenheim is a key dissenter on this point, arguing persuasively that "current law does not afford minors a constitutional right to terminate a pregnancy."

151. *Carey*, 431 U.S. at 678.

152. *Id.* at 684–85 (quoting *Roe v. Wade*, 410 U.S. 113, 152–53 (1973)) (citations omitted).

153. *Id.* at 685.

154. See *Casey*, 505 U.S. at 884 (1992) (leaving undecided "[w]hatever constitutional status the doctor-patient relation may have as a general matter"); see also *Rust v. Sullivan*, 500 U.S. 173, 202 (1991) (regulations depriving Title X clients of information concerning abortion as a method of family planning do not violate a woman's Fifth Amendment right to medical self-determination and to make informed medical decisions free of

psychotherapeutic communications, which the psychotherapist-patient privilege is designed to serve, fits squarely within the principles of the privacy right as pronounced in *Carey*. Unlike most information conveyed to a doctor treating physical ailments, the information communicated to the psychotherapist in the course of therapy concerns virtually, without exception, “the most intimate of human activities[,] . . . relationships” and thoughts.¹⁵⁵ In the words of one federal district court, “[n]o area could be more deserving of protection than communication between a psychiatrist and his patient. Such communications often involve problems in precisely the areas previously recognized by the [Supreme] Court as within the zone of protected privacy, including family, marriage, parenthood, human sexuality, and physical problems.”¹⁵⁶

Recognizing the similarities between psychotherapeutic communications and the intimate spheres of decision accorded constitutional solicitude under the right to privacy, several state and federal courts have decided that the psychotherapist-patient privilege is grounded in the constitutional right to privacy. The first court to do so was the California Supreme Court in *In re Lifschutz*.¹⁵⁷ There, the court said:

We believe that a patient’s interest in keeping such confidential revelations from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. In *Griswold v. Connecticut*, . . . the United States Supreme Court declared that “Various guarantees [of the Bill of Rights] create zones of privacy,” and we believe that the confidentiality of the psychotherapeutic sessions falls within one such zone.¹⁵⁸

The opinion of the *Lifschutz* court was essentially followed by the Ninth Circuit in *Caesar v. Mountanos*,¹⁵⁹ which also found that the privilege was grounded in the right to privacy.¹⁶⁰ However, a preferable position was articulated by Judge Shirley Hufstедler, writing in concurrence and dissent in *Caesar*. Judge Hufstедler criticized *Lifschutz* for “incorrectly assess[ing] the weight of the patient’s right of privacy as against competing litigation.”¹⁶¹ Despite finding that the “confidential communications between a psychotherapeutic patient and his doctor have the indicia to place those communications squarely within the constitutional right of privacy,”¹⁶² Judge Hufstедler nonetheless found that a limited intrusion on the constitutional right was justified. Judge Hufstедler

government-imposed harm); cf. *Jaffee*, 518 U.S. at 119 (acknowledging that “[b]y protecting confidential communications between a psychotherapist and her patient from involuntary disclosure, the proposed privilege thus serves important private interests.”); *Whalen v. Roe*, 429 U.S. 589 (1977).

155. *Carey*, 431 U.S. at 685.

156. *Haw. Psychiatric Soc’y v. Ariyoshi*, 481 F. Supp. 1028, 1038 (D. Haw. 1979).

157. 2 Cal. 3d 415 (1970).

158. *Id.* at 431–32 (citation omitted).

159. 542 F.2d 1064, 1065 (9th Cir. 1976).

160. *Id.* at 1067 n.9.

161. *Id.* at 1071.

162. *Id.*

proposed a limited exception to the privilege allowing a party to discover *the fact of treatment, the cost of treatment and the ultimate diagnosis, but no more*, unless the party could establish a compelling need to obtain the substance of the therapeutic communications.¹⁶³

Recent U.S. Supreme Court precedent suggests that Judge Hufstедler's resolution of the issue strikes the appropriate balance. In *Planned Parenthood v. Casey*,¹⁶⁴ the Court held constitutional a state statute requiring doctors to give certain information to women considering abortion and mandating a 24-hour waiting period between the provision of that information and the exercise of the woman's capacity to give informed consent for the procedure. The Court held that the statutory provisions did not constitute an unconstitutional "undue burden" on a woman's right to an abortion before fetal viability, because the provisions did not place a "substantial obstacle" in the path of a woman seeking such an abortion.¹⁶⁵ In reaching this holding, the Court gave particular emphasis to the fact that the Pennsylvania statute at issue required the giving of truthful, non-misleading information about the abortion procedure and its alternatives, a resolution which did not unduly invade the abortion patient's privacy.¹⁶⁶

If this analysis is used to determine the scope of the right to privacy in the family court custody or dependency court psychotherapist-patient context, it is clear that testimony cannot be compelled (by the parent, guardian or any other party to the proceeding) concerning the substance of confidential communications made during such therapy. Expected and actual confidentiality is crucial to successful psychotherapeutic treatment. Were that confidentiality eliminated, it would not only place a "substantial burden" in the path of a child seeking psychotherapy, but in many cases, it would make it impossible for a person even to consider confiding secret troubles that psychotherapy can uniquely address. A requirement that a patient (or her therapist) reveal confidences shared in therapy would thus place an "undue burden" on the patient's right to seek and receive psychotherapy treatment, and would thus place an "undue burden" on the patient's right to privacy surrounding the psychotherapist-patient relationship.¹⁶⁷

Furthermore, the *Casey* Court noted the importance that the information, which the state required women to have, was "truthful, nonmisleading" information and

163. *Id.* at 1074–75 (emphasis added). This test would appear to at least superficially resemble the test formulated by a California appellate court in a decision relied on by the Fourth District Court of Appeal in *S.C., In re Kristine W.*, 94 Cal. App. 4th 521, 528 (Dist. Ct. App. 2001) (holding that details of the child's psychotherapy were protected by the privilege and limiting the "circumscribed information" that the therapist was expected to provide to "matters that reasonably assist the court in evaluating whether further orders are necessary for [the child's] benefit . . . [while] preserv[ing] the confidentiality of the details of her therapy.").

164. 505 U.S. at 838–39.

165. *Id.* at 877–78.

166. *Id.* at 882–83.

167. Judge Hufstедler's resolution of the issue delineates the proper parameters of the relevant privacy concerns. The limited, objective information she proposes to require in her opinion in *Caesar* is "truthful [and] nonmisleading," and probably would not place a "substantial obstacle" in the path of those who need and seek psychotherapeutic treatment. The information—perhaps most notably, the diagnosis—would nevertheless aid the legal system in determining whether there existed a compelling need for further disclosures. In keeping with the gravity of the constitutional privacy right attending the psychotherapeutic relationship, however, seldom would such a showing be possible.

found a significant state interest in providing such information to women seeking abortions.¹⁶⁸ This is particularly the case when the state (*e.g.*, a court-appointed guardian) seeks through the legal process (*i.e.*, its order of appointment) to force the patient (or her doctor) to reveal, rather than to receive information. But the guardian's interest in the revelation of that information is not similarly weighty, because the information it seeks is not generally likely to be "truthful, nonmisleading" information. Instead, such "information" is heavily weighted toward exaggeration, distortion, and fantasy—products of a mind that is almost by definition not coping well with one or more aspects of reality. This information is not "truthful" in the judicial sense, and therefore it is not "non-misleading."¹⁶⁹ The parent or guardian thus has little or no legitimate interest in forcing its revelation under circumstances that call out to keep the materials private.

Balanced against the weighty—indeed, indispensable—privacy concerns surrounding the psychotherapist-patient privilege, a parent's or guardian *ad litem*'s demand for the details of an adolescent's confidential communications to her therapist must surely fail under the federal privacy right guaranteed by the Fourteenth Amendment.¹⁷⁰

G. State Privacy Considerations

An adolescent's privacy rights under the Florida Constitution are arguably weightier than those flowing out of the federal Constitution.¹⁷¹ Unlike the federal Constitution, the Florida Constitution contains an explicit provision discussing the right to privacy for all residents of Florida. Article I, Section 23, of the Florida

168. *Id.* at 882.

169. See Donald P. Spence, *The Special Nature of Psychoanalytic Facts*, 75 INT'L J. OF PSYCHOANALYSIS 915, 915–16 (1994) (in a therapy session, "it does not matter from an epistemological point of view whether a patient's statement is literally true or false."); Comment, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 EMORY L.J. 777, 802 (1985) ("Certainly a court has no interest in allowing an individual's case to be prejudiced by narrations of his fantasies.").

170. Federal privacy implications of an adolescent's communications with the therapist are inherently limited in the abortion context by virtue of the parental notification requirements that *Bellotti* imposes, even with the judicial bypass proviso. As Jennifer Rosato observes, burdening adolescent decision-making in the abortion context is itself a reflection of confused and inconsistent views about the minor's decision-making capabilities:

Overall, the existing doctrine is out of touch with reality. For example the doctrine reflects an overwhelming desire for parents to be involved, even though the reality is that such forced involvement is unnecessary and, worse yet, may be harmful to the minor. Specifically, it is important for the law to recognize that for some girls, just notifying a parent can be as significant a burden on her decision as obtaining parental consent. Moreover, most pregnant girls consult with a parent and do not need to be coerced into doing so. The law operates under the mistaken notion that even though a minor may be too immature to have an abortion, she is mature enough to make major medical decisions related to her pregnancy and subsequently to make decisions regarding the upbringing of the child. This selective burdening of the abortion right is not justified.

Rosato, *supra* note 3, at 774–75 (citations omitted).

171. Unlike the U.S. Constitution, Florida's Constitution, until its amendment in 2004, yielded greater decision-making authority to the child in this realm. See, *e.g.*, *In re T.W.*, 551 So. 2d 1186, 1192 (1989) (a child has the right to decide on medical procedures relating to pregnancy, without the necessity for judicial bypass procedure required by the federal Constitution).

Constitution provides: “Right to privacy—Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein.” The right to privacy protected by the Florida Constitution is broader and deeper than that provided by the federal Constitution:

The citizens of Florida opted for more protection from governmental intrusion when they approved article I, section 23, of the Florida Constitution. This amendment is an independent, free-standing constitutional provision which declares the fundamental right to privacy. Article I, section 23, was intentionally phrased in strong terms. The drafters of the amendment rejected the use of the words “unreasonable” or “unwarranted” before the phrase “governmental intrusion” in order to make the privacy right as strong as possible. Since the people of this state exercised their prerogative and enacted an amendment to the Florida Constitution which expressly and succinctly provides for a strong right of privacy not found in the United States Constitution, it can only be concluded that the right is much broader in scope than of the Federal Constitution.¹⁷²

In its 1989 decision, *In re T.W.*, the Florida Supreme Court held that article I, section 23 of the Florida Constitution affords the right to privacy to every natural person irrespective of age.¹⁷³ The Florida Supreme Court held that our Constitution “embraces more privacy interests, and extends more protection to the individual in those interests, than does the federal Constitution.”¹⁷⁴ Under article I, § 23 of the Florida Constitution, the right to privacy extends to every natural person irrespective of age.¹⁷⁵ “Minors are natural persons in the eyes of the law and constitutional rights do not mature and come into being magically only when one attains the state defined age of majority.”¹⁷⁶

It cannot be disputed that, in Florida, the psychotherapist-patient privilege implicates constitutionally protected privacy rights. As discussed *supra*, Florida statutes provide for a psychotherapist-patient privilege.¹⁷⁷ The statute provides that “communication between a psychotherapist and a patient is confidential if it is not intended to be disclosed to third persons.”¹⁷⁸ Additionally, the statute provides that a “patient has a privilege to refuse to disclose, and to prevent any other person from disclosing, confidential communications or records made for the purpose of

172. *Winfield v. Div. of Pari-Mutuel Wagering*, 477 So. 2d 544, 548 (Fla. 1985); see generally Gerald B. Cope, Jr., *To Be Let Alone: Florida's Proposed Right of Privacy*, 6 FLA. ST. U. L. REV. 671 (1978) (detailing history of privacy amendment).

173. *T.W.*, 551 So. 2d at 1186.

174. *Id.* at 1192.

175. *Id.*

176. *Id.*

177. FLA. STAT. § 90.503.

178. FLA. STAT. § 90.503(1)(c).

diagnosis or treatment of the patient's mental or emotional condition, including . . . between the patient and the psychotherapist."¹⁷⁹

The statute grants the psychotherapist-patient privilege irrespective of age. A "patient" is defined as "a *person* who consults, or is interviewed by, a psychotherapist for purposes of diagnosis or treatment of a mental or emotional condition. . . ."¹⁸⁰ As the *D.K.* court noted in its decision, an *in pari materia* construction of Florida statutes reveals that under the general statutory definitions, "[t]he word 'person' includes individuals and *children*. . . ."¹⁸¹

The Florida Supreme Court recognized in *Matter of Dubreuil*, "the overarching principle that article I, § 23 of the Florida Constitution guarantees that 'a competent person has the relevant decisions concerning one's health.'"¹⁸² Although *Dubreuil* involved an adult, the Florida Supreme Court has long recognized that the constitutional protections afforded to this kind of personal choice extend to minors as well.

In 2003, the Florida Supreme Court revisited the issues litigated in *T.W.* when considering the constitutionality of the Florida legislature's recently enacted parental notification law in *North Florida Women's Health & Counseling Servs., Inc. v. State*.¹⁸³ At first, the court rejected the notification statute and the state's argument that it should replace the strict scrutiny standard. The court also rejected the notion that *T.W.* was distinguishable on the ground that the notification law was less burdensome than a consent law.¹⁸⁴ The court also reiterated its concern with the state singling out abortion for regulation without compelling justification.¹⁸⁵

Ultimately, in response to the *North Florida Women's Health* decision, the Florida Constitution was amended to permit parental notification for abortion,¹⁸⁶ and in 2005, the Florida legislature reenacted a parental notice law.¹⁸⁷ In reenacting the parental notice law, the legislature stated that the intent of the law was to both "safeguard individual liberty and empower families."¹⁸⁸ The legislature hoped that the law would encourage minors "to seek the help and advice of their parents in making the important decision whether or not to bear a child" as well as to "protect the fundamental right of parents to raise their children free from unnecessary government interference."¹⁸⁹

For minors who do not want to seek help and advice from their parents prior to seeking an abortion, they must petition the court for judicial waiver of parental

179. FLA. STAT. § 90.503(2).

180. FLA. STAT. § 90.503(1)(b) (emphasis added).

181. FLA. STAT. § 1.01(3). (emphasis added); see generally *Attorney ad Litem for D.K.*, 780 So. 2d at 306 (citing *Wray v. Dept. of Prof'l Regulation*, 410 So. 2d 960 (Fla. Dist. Ct. App. 1982) and *Arias v. Urban*, 595 So. 2d 230 (Fla. Dist. Ct. App. 1992)).

182. 628 So. 2d 819, 822 (Fla. 1994).

183. 866 So. 2d 612, 615 (Fla. 2003).

184. See *id.* at 631–32.

185. See *id.* at 633.

186. FLA. CONST. art X, § 22.

187. ABORTION-PARENTAL NOTICE, 2005 Fla. Sess. Law Serv. Ch. 2005-52 (H.B. 1659).

188. Fla. Staff An., H.B. 1659, 4/19/2005, section 1A.

189. H.B. 1659, 107th Reg. Sess. (Fla. 2005).

notification.¹⁹⁰ To ensure confidentiality, the judicial bypass procedure allows the minor to petition under a pseudonym and in a circuit court outside of the immediate home jurisdiction; and it explicitly provides that all identifying information is confidential. The reason for assuring confidentiality is to protect the parent-child relationship from spiraling out of control due to the child's decision to terminate her pregnancy.¹⁹¹

Thus, while minors' constitutional privacy protections in seeking abortions have been significantly curtailed, they arguably retain rights to confidentiality, which are specifically designed to preclude a parent or guardian from learning of the adolescent's intention to terminate a pregnancy. In other contexts, the Florida Constitution and statutes broadly provide for the protection of the adolescent's privacy interests in health care and family matters. A mature child may not be prosecuted for having sex with another mature minor.¹⁹² A child has the right to participate in proceedings relating to his own adoption.¹⁹³ A child may consent to the adoption of her own child.¹⁹⁴

If a minor is able to give consent to sexual activity and to intrusive medical procedures, including abortion (with the additional requirement of parental notification inserted in 2005), and can surrender her baby for adoption then certainly a minor is entitled to have her voice heard, independent from her parent or the state (*i.e.*, her court-appointed guardian *ad litem*), in order to protect the privacy of her psychotherapist-patient communications from being breached by these parties or entities.

Finally, as analyzed in Parts III.B–D, *supra*, in order to conduct effective psychotherapy, there must be an atmosphere of confidence and trust in which “a patient of a psychologist is expected to bare her soul and reveal matters of a private nature in order to receive help, but will not do so if the psychologist can be compelled to reveal these innermost thoughts and confidences. . . .”¹⁹⁵

In evaluating statutes that affect the privacy rights of minors, the Florida Supreme Court has noted that, in addition to those interests considered in the case of an adult, the court must consider “the state's interest in protecting minors.”¹⁹⁶ In order to outweigh the minor's privacy rights, the interest must be “compelling.”¹⁹⁷ But even where a compelling state interest is found, the state must choose the least

190. FLA. STAT. § 390.01114; *see also Bellotti*, 443 U.S. at 633.

191. *Id.*; FLA. STAT. § 390.0116; *see, e.g., In re* Petition of Jane Doe, 932 So. 2d 278, 281 (Fla. Dist. Ct. App. 2005) (“According to Doe, she has a good relationship with her parents. But she believes that they would adamantly oppose her decision. Beyond that, she testified that the issue might well destroy the relationship and that her parents might ask her to leave their home.”).

192. *B.B. v. State*, 659 So. 2d 256 (Fla. 1995).

193. *Peregood v. James*, 663 So. 2d 665 (Fla. Dist. Ct. App. 1995).

194. *In re Brock*, 25 So. 2d 659 (Fla. 1946).

195. *Palm Beach Cnty. Sch. Bd. v. Morrison*, 621 So. 2d 464, 468 (Fla. Dist. Ct. App. 1993) (citation omitted).

196. *T.W.*, 551 So. 2d at 1995.

197. *Id.*

intrusive or restrictive means of furthering that interest.¹⁹⁸ “Any inquiry under this prong must consider procedural safeguards relative to the intrusion.”¹⁹⁹

Thus, the Florida Supreme Court held in *T.W.* that the statute requiring parental consent or a waiver hearing for a minor seeking an abortion was unconstitutional because, among other reasons, the state was intruding on the minor’s privacy rights without appointed counsel and a hearing on the record that comported with due process.²⁰⁰ *T.W.* makes clear that the state cannot brush aside a child’s due process, however “compelling” the state’s interests may be.²⁰¹ This fundamental interest remains intact, even in light of the added requirement of parental notification for a minor seeking to terminate a pregnancy.

As discussed above, § 61.403 of the Florida Statutes provides the *only* legislatively authorized mechanism for a court appointed guardian *ad litem* to obtain confidential medical, mental health, or other records pertaining to a child. That statute incorporates a specific procedural safeguard that protects the child’s privacy interest in her mental health records by requiring the guardian to petition the court and give notice to the child and all the parties before it can obtain an order allowing it to inspect and copy any confidential records or documents relating to the minor child. As the *S.C.* court’s analysis shows, this procedure is the least restrictive or intrusive means of furthering the guardian’s compelling interest in acquiring confidential information about the child’s mental health treatment.²⁰²

H. Age Considerations

At what magic age should the child be entitled to assert the privilege? Is there a bright line that delineates a moment in time when the child is deemed sufficiently mature and competent to override the parents’ authority with respect to the child’s confidential medical and privileged psychotherapy interests? As the Fourth District Court of Appeal observed in *D.K.*:

[T]he age of the minor is a factor which the court must look to in determining whether the child himself or herself can assert the privilege. A child less than twelve years old does not have the emotional maturity or capacity of a seventeen year old. A court faced with the child’s desire to assert the privilege in such circumstances should determine whether the child is of sufficient emotional and intellectual maturity to make the decision on his or

198. *Id.*

199. *Id.* at 1195–96.

200. *Id.*

201. It is true that the Florida Supreme Court has acknowledged that children are different from adults and may be treated differently by the courts. *See, e.g., Brennan v. State*, 754 So. 2d 1 (Fla. 1999) (unconstitutionality of death penalty where defendant was sixteen years of age at time of the crime). When the court has done so, it has recognized that children may present the courts with different kinds of problems, and may need more or different kinds of protection, but not less protection. *See Amendment to FLA. R. JUV. P.*, 8.100(a), 796 So. 2d 470 (Fla. 2001) (disallowing video detention arraignments for juveniles because “[i]n our view, children deserve more” legal protection than adults).

202. *S.C.*, 845 So. 2d at 959.

her own. If the court decides that the child is sufficiently mature, then the court should appoint an attorney ad litem to assert the child's position, as the court did here.²⁰³

Fourteen-year-old S.C., just a few years younger than D.K., was nonetheless deemed by the court to be old enough, mature enough, and competent enough to satisfy the test for competency and maturity articulated by the Fourth District Court of Appeal in *D.K.* The court deferred to the findings in the lower court record to thus deem her capable of asserting the psychotherapist-patient privilege through her court-appointed attorney *ad litem*, over her guardian *ad litem*'s efforts to invade the privilege.²⁰⁴ As the court held, "[t]here is no evidence in this record that Petitioner is not old enough, mature enough, and competent enough to seek relief through a court appointed attorney rather than cede control of her privileged privacy interest to a guardian ad litem."²⁰⁵

Indeed, there is a substantial and growing body of empirical research suggesting that mature minors should be accorded greater rights in a broad ambit of medical decisions.²⁰⁶ As one author has concluded, after summarizing the accumulating social science literature on children's decision-making capacity:

A sizeable body of empirical research has accumulated over the last decade suggesting that children have much more competence than has been recognized by the legal community. The general picture which emerges is that children are capable of quite a lot, if you just let them participate in the decision-making process.

Adolescents, and frequently even younger children, are capable of adult-like understanding and decision-making. For instance, children as young as about twelve appear to have a factual understanding and appreciation for the risks and benefits of psychotherapy. Discussing unpleasant or uncomfortable issues, discomfort with the therapist, violations of confidentiality, and poor treatment effectiveness are identified as risks; having

203. *D.K.*, 780 So. 2d at 308.

204. *S.C.*, 845 So. 2d at 957.

205. *Id.*

206. See, e.g., Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982) (research study finding that although there were significant differences between nine-year-old children and adults in decision-making capacity, little or no difference existed between fourteen-year-old adolescents and adults); see also Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL.: RES. & PRAC. 412, 423 (1978) (finding that minors age fifteen and above are no less competent than are adults, that no assumptions can be made about the ability of minors ages eleven to fourteen to consent to treatment, and that minors below age eleven generally do not have the intellectual ability to satisfy a legal standard for competent consent).

someone to talk with, learning things, and solving problems are seen as benefits.²⁰⁷

Moreover, the research on whether even younger children are able to process information necessary to provide informed consent for treatment suggests that they possess episodic capacities to participate in treatment decisions even at age nine, and at younger ages in other decision-making contexts:

Even nine-year-olds appear to understand many basic aspects of treatment, including differences between various diagnoses and prognoses and treatment risks and benefits. Twelve-year-olds are able to define accurately many basic legal concepts. Significantly, children as young as six can be astute in perceiving procedural injustice; thus, allowing children to participate in decision-making regarding their own health may enhance children's perception that they have been treated fairly. There is also evidence that allowing children to participate in treatment decision-making improves treatment by facilitating the child's willingness to cooperate. Such participation may also help reduce the stress of therapy, lead to better attitudes about treatment, reduce resistance to therapy, and foster appropriate treatment expectations. The child achieves a sense of control and self-efficacy critical for mental health and positive therapeutic outcomes. . . .²⁰⁸

Society benefits from giving mature minors access to medical treatment, which is supported by empirical research in developmental psychology and other fields demonstrating that older children have the capacity to make informed health care decisions in ways that are not markedly different from adults.²⁰⁹ Yet the evidence on adolescent decision-making is also decidedly equivocal on the question of whether they are developmentally closer to childhood or adulthood.²¹⁰

207. Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 708 (1993) (citations omitted).

208. *Id.* at 708–09; cf. Gerald P. Koocher, *Competence to Consent: Psychotherapy*, in CHILDREN'S COMPETENCE TO CONSENT 125–26 (GARY B. MELTON, GERALD P. KOOCHEER & MICHAEL J. SAKS eds., 1983) (“Children may be physically, socially, and psychologically more vulnerable than adults both because of their legal state because of their legal status [and] because of their relative developmental disadvantage.”).

209. See, e.g., Weithorn & Campbell, *supra* note 207 (research finding that although there were significant differences between nine-year-old children and adults in decision-making capacity, little or no difference existed between fourteen-year old adolescents and adults); see also Grisso & Vierling, *supra* note 207, at 423 (finding that minors age fifteen and above are no less competent than are adults, that no assumptions can be made about the ability of minors ages eleven to fourteen to consent to treatment, and that minors below age eleven generally do not have the intellectual ability to satisfy a legal standard for competent consent).

210. As one commentator observes, there is nonetheless conflicting empirical data about adolescent decision-making capacities:

The empirical assumptions about developmental immaturity that shape the legal images of childhood do not fit comfortably with conventional notions of adolescence. As compared with younger children, adolescents are close to adulthood. They are physically mature, and most have the cognitive capacities for reasoning and understanding necessary for making

IV. EVOLVING PUBLIC POLICY CONSIDERATIONS

While the Fourth District was ruminating on D.K.'s and S.C.'s health care confidentiality interests, Florida jurisprudence and policy on this topic was being studied and debated by the Florida Bar. The Florida Bar Commission on the Legal Needs of Children affirmed the importance of respecting the confidentiality interests of older children in a report that it submitted in June 2002 to the Florida Bar Board of Governors:

Many children involved with service agencies have suffered repeated violations of their sense of personal privacy. They have been abused by parents or relatives, or transferred from one foster care placement to another, or treated like commodities on an assembly line by harried or overworked agency staff. Respect for confidentiality rights is particularly crucial for such children. It allows them to exert some measure of control over their world, and to develop a degree of trust in those around them.²¹¹

The Commission paid specific attention to the unique interests for records confidentiality of children in state care:

Similarly, children in the foster care system have a vital interest in being able to view records generated by agencies, in order to establish a measure of control over personal information about them that is routinely generated and shared by these social service agencies and to have an opportunity to correct prejudicial,

rational decisions. Yet, adolescents are not fully formed persons in many regards; they continue to be dependent on their parents and on society, and their inexperience and immature judgment may lead them to make poor choices, which threaten harm to themselves or others. Conventional wisdom about adolescence generally tracks scientific knowledge about human development—individuals in this group are proceeding through a developmental stage between childhood and adulthood—they are neither children nor adults.

Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 555–56 (2000) (emphasis added) (citations omitted).

211. THE FLORIDA BAR, COMM'N ON THE LEGAL NEEDS OF CHILDREN FINAL REPORT, CONFIDENTIALITY SUBCOMMITTEE REPORT, C.2–C.5 (June 2002), available at <http://www.floridabar.org/tfb/TFBComm.nsf/840090c16eedaf0085256b61000928dc/3cd599427239920385256ec70064e689!OpenDocument>; see also Emily Buss, "You're My What?" *The Problem of Children's Misperceptions of Their Lawyers' Roles*, 64 FORDHAM L. REV. 1699, 1711 (1996) ("More specifically, children who have told secrets to therapists, doctors, or teachers about parental abuse and neglect have often already seen those secrets divulged, first to the protective service agency (through mandatory reporting mechanisms) and then to the court and the very people they 'betrayed.'") (citation omitted).

This experience of having their confidences to adults betrayed, which is so common among many children in foster care, is one of the reasons why Florida's legislature recognizes that a dependent child's dignitary interest in privacy is a "paramount concern" of the child welfare system. See FLA. STAT. § 39.4085(2) (2010) ("The Legislature . . . establishes the following goals for children in shelter or foster care: . . . To enjoy individual dignity, liberty and privacy, pursuit of happiness, and the protection of their civil and legal rights as persons in the custody of the state.") (emphasis added).

misleading or erroneous personal information contained in those records.²¹²

In addition to the core constitutional privacy interests identified in the Confidentiality Subcommittee Report, the Commission noted other interests implicated by preventing dissemination of children's intimate information: avoiding embarrassment or humiliation; protecting physical safety (*e.g.*, domestic violence); avoiding discrimination or differential treatment (*e.g.*, from schools and agencies); preventing denial of discretionary services (*e.g.*, expulsion from private or parochial school); and encouraging adolescents to seek medical care.²¹³

While the Bar Commission did not specifically address the question of whether a child enmeshed in a family or juvenile court proceeding has the right to assert the psychotherapist-patient privilege, it strongly urged that courts, agencies, and the legislature take steps to protect the privacy interests of older, mature adolescents enmeshed in the dependency and foster care systems. It set a bright line age of fourteen, as the standard, to promote confidential treatment of their emotional and physical health care needs:

Children with the capacity to consent or withhold consent to the release of confidential information concerning health care treatment (*e.g.*, records concerning mental health treatment, treatment for sexually transmitted diseases or HIV) should be consulted prior to an agency releasing such records and should be asked to give informed consent to the release of such information.

Children over 14 should be allowed to request that private information not be disclosed when the disclosure involves extraordinarily sensitive issues concerning the child's privacy.²¹⁴

212. THE FLORIDA BAR, *supra* note 211.

213. *Id.*; see also Sandy E. Karlan, *The Florida Bar Commission on the Legal Needs of Children*, 31 STETSON L. REV. 193, 198 (2002).

214. COMM'N ON THE LEGAL NEEDS OF CHILDREN FINAL REPORT, at C.19, 24. Similar findings and recommendations for policy reform were reached by the American Bar Association; see AMERICAN BAR ASSOCIATION STEERING COMMITTEE ON THE UNMET LEGAL NEEDS OF CHILDREN, AMERICA'S CHILDREN: STILL AT RISK (2001):

Confidentiality is extremely important; but it is a delicate balance. How do we encourage adolescents to involve parents or other trusted adults in their health care decisions without discouraging or barring their access to medical services? Fear of inappropriate disclosure prevents many adolescents from receiving needed care. Providing minors with access to confidential health care services increases their willingness to seek health professionals' advice regarding the prevention of pregnancy, HIV/AIDS, sexually transmitted diseases, substance abuse and mental health problems.

Id. at 78.

V. REWINDING *D.K.*, *S.C.*, AND *E.C.*: STORIES OF HEALING THROUGH CONNECTION

Whether any adult becomes the psychological parent of a child is based thus on day-to-day interaction, companionship, and shared experiences. The role can be fulfilled either by a biological parent or by an adoptive parent or by any other caring adult—but never by an absent, inactive adult, whatever his biological or legal relationship to the child may be.²¹⁵

Given the importance of recognizing and respecting the child's confidential communications with her therapist, to what extent does this recognition by the court in the heat of litigation hinder the child's ability to resume relationships with parents and other caring adults after the litigation ends? Indeed, it is hard to imagine any of the three children involved in these cases being able to emerge from the litigation and resume a well-adjusted relationship with their parents, or to trust their guardians *ad litem*. Does the elevation of the child's therapeutic interests in this emotionally-charged process undermine familial relationships and other important adult connections?

Beyond litigating the child's right to claim a privilege, what is the role of the child's attorney? Is the lawyer's job only to argue for the existence and recognition of the privilege, which is how the district court described the role of *D.K.*'s attorney?²¹⁶ Can the attorney fulfill this advocacy role in the adversarial process without an awareness of the broader family ecologies and kinships that are essential to the child's well-being? Or as Professor Jean Koh Peters has framed it, "the central question facing lawyers for children: How do lawyers for children represent children in a lawyerly way, one that is deeply respectful of the individuality and unique perspective of the client?"²¹⁷

Therapeutically-minded lawyers recognize that "all clients exist in a larger network of familial and communal relations, [and] therapeutic lawyers who represent children will learn to engage the child at multiple levels and may partner with parents, teachers, mentors and other relevant adults in the child's life."²¹⁸ Thus, this section of the article briefly "rewinds" the stories of advocacy for the three Florida children, pinpointing a few examples of how their court-appointed lawyers represented their clients, and it considers alternative ways that their legal counsel could have been attentive both to the important legal principles *and* the emotional and personal interests at stake in the litigation.

215. JOSEPH GOLDSTEIN, ANNA FREUD & ALBERT J. SOLNIT, IN THE BEST INTERESTS OF THE CHILD 66–67 (1986).

216. See *supra* note 17.

217. PETERS, *supra* note 46, at 1508.

218. Kristin Henning, *Defining the Lawyer-Self: Using Therapeutic Jurisprudence to Define the Lawyer's Role and Build Alliances That Aid The Child Client*, in MARJORIE A. SILVER, THE AFFECTIVE ASSISTANCE OF COUNSEL: PRACTICING LAW AS A HEALING PROFESSION 411, 434 (2007) (citation omitted).

As Bruce Winick and others have written, rewinding is a technique that encourages the lawyer to go back to before the occurrence of a critical act or omission that produced a problem and to consider what could have been done at that time to prevent the problem or to consider how a more therapeutic or less anti-therapeutic outcome could have been achieved.²¹⁹ In rewinding the past legal events, one asks: “What techniques or approaches could the lawyers have used? How should the lawyers have advised their clients concerning the litigation’s risks and emotional costs? What could the lawyers have done to dissipate the denial, anger, and distrust that fueled this intense and prolonged controversy?”²²⁰

There is no question that pitting a child against her parents or guardian in a controversy over their access to the child’s health care records is likely to stir up many concerns about the emotional well-being of the individual at the center of the controversy—the child. This concern was aptly summed up in a statement to the trial court in the S.C. litigation by the child’s counsel, as the parties’ counsel disputed whether or not the child’s former therapist could be compelled to testify about her communications to the therapist, before the court could decide whether to return her to one of her parents.

S.C.’s lawyer argued forcefully that “to call the doctor [the child’s therapist] to discuss those things violates the rule and violates the principle of the rule which really deals with this child being able to freely discuss her feelings and her emotions with her therapist . . .”²²¹ This point was countered by the arguments made by the attorney for the Department of Children and Families:

We have a child who has already been adjudicated dependent, the father is unable to take care of her, there are serious concerns about the child, she has been Baker Acted on several occasions and she has been in the custody of the mother. There are certain big concerns here. If Dr. Malloy is not able then to come to court and testify even to that limited purpose, then there is no other recourse than to have a professional to evaluate this child, as the judge is going to have to make a determination . . . as to whether to send this child home.²²²

The child’s attorney stood her ground, arguing that “The overriding public policy is to protect the communications, because it is so important to get therapy . . . this communication, the communications were privileged, any advice [the therapist] gave the child, any diagnosis she made, all those things are protected by [Florida

219. Bruce J. Winick, *The Challenge of the New ABA Standards*, 17 ST. THOMAS L. REV. 429, 442 (2005); Marc W. Paltry, David B. Wexler, Dennis P. Stolle & Alan J. Tomkins, *Better Legal Counseling Through Empirical Research: Identifying Psycholegal Soft Spots and Strategies*, 34 CAL. W. L. REV. 439, 445 (1998); Leslie Larkin Cooney, *Heart and Soul: A New Rhythm for Clinical Externships*, 17 ST. THOMAS L. REV. 407, 426 (2005).

220. Winick, *A Legal Autopsy*, *supra* note 12, at 596.

221. Transcript of hearing before Hon. Karen L. Martin, Fifteenth Judicial Circuit (Palm Beach County), In the Interest of S.C., Case No. 02-DP-30012 JL (June 5, 2002) at 15 (on file with author).

222. *Id.* at 20–21.

Statute] 90.503 and to allow the Department to invade that privilege certainly puts the child's ability to then go and seek future therapy in jeopardy."²²³

Conspicuously missing from either side's argument was consideration of whether the child herself favored allowing the therapist to speak to the court. If she had been asked this question, would she have been willing to allow her communications with Dr. Malloy to be disclosed to the court as a way to expedite her reunification with her mother? Did she even *want* to be reunified with her mother? Indeed, at no point in the half-hour hearing did the court hear testimony or even a word from S.C. herself. She was not even present before the court as the lawyers argued over her rights and privileges in this proceeding.²²⁴

Equally striking is the fact that no one appears to have asked the child whether she wanted to waive the disputed privilege so that the court could hear the testimony of the therapist, with her permission. There appears to be little awareness, in this brief point-counterpoint between counsel for the child and for DCF, about the profoundly unique, nuanced and complex character of the child's secrets, her private and personal need to have her confidences to the therapist preserved, or any consideration of the possibility that she might want those secrets revealed, and any clearly stated or even ambivalent reasons she why might want those secrets uncovered or revealed. As Professor Emily Buss has written:

Children involved in dependency and custody proceedings are often guarding many relevant secrets—secrets about how their parents have behaved (Did they beat their children? How often? Are they still drinking? Do they really use their income for food?), how they feel about their parents (Do they trust them? Fear them? Want to live with them? To visit them?), and why they want what they want out of the court process (Do they want to live with their grandmother because their mother is abusive? In hopes of seeing

^{223.} *Id.* at 19–20.

^{224.} The importance of the child attending all hearings in juvenile dependency court is emphasized in a comment to the AMERICAN BAR ASSOCIATION STANDARDS OF PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE AND NEGLECT CASES, which notes that “[a] child has the right to meaningful participation in the case, which generally includes the child’s presence at court hearings. Further the child’s presence underscores for the judge that the child is a real party in interest in the case.” Comment to Standard D-5.

Moreover, being present in court with her attorney, would have given the child a palpable and real sense of her own place in the legal proceeding, and a chance to bear witness to the unique character of the lawyer’s role in advocating for her interests. As Emily Buss writes:

For the child being represented by the traditional attorney, nothing so overcomes the child’s incredulity as seeing his lawyer in action. It is one thing for a lawyer to tell a child, at his school or in his living room, that she will go to court and tell the judge what the child wants (maybe she will, maybe she won’t, and what difference, the child may wonder, does it make, anyway?). It is quite another matter for the child to sit in court and hear the lawyer press for what he told her he wants, do battle with opposing viewpoints before the judge, and even, perhaps, persuade the judge, against the recommendations of other parties, that what the child wants should happen. The live demonstration can also provide a proving ground for promises of client confidentiality, where the particular issues being pressed in the proceeding bring the lawyer’s silence on the subject into sharp relief for the child.

Buss, *supra* note 211, at 1756.

their father? Because the grandmother has threatened them?). They may also be guarding personal secrets—such as secrets about their sexual or drug history—against discovery by their parents or the court.²²⁵

Moreover, being asked by counsel and the court to “tell her story” (secrets and all) is perhaps itself a therapeutic gesture in that it may reduce the feelings of helplessness associated with being enmeshed in the legal system due to a label of incompetency or mental illness,²²⁶ and it promotes feelings of greater control over the information given to her therapist and to the tribunal.²²⁷ As Bruce Winick writes, “Participation, dignity, and trust, as well as the opportunity to ‘tell their story’ are themes often voiced in the mental health consumer (or survivor) literature.”²²⁸

While the child’s lawyer presented cogent and principled legal arguments about the importance of protecting the child’s right to assert the psychotherapist-patient privilege, her argument seems less focused on reaching a compromise with the other side over the doctor’s testimony and more concerned with litigating a test case that could potentially change Florida law.²²⁹ The same unwillingness to collaborate and forge compromise appears in the *E.C.* litigation against the Guardian *ad Litem* Program over the form and breadth of its standard order of appointment giving it unrestricted access to the child’s confidential records.

If anything, this uncompromising posture exhibited by the children’s attorneys may be one reason why the GAL Program has gone back to business as usual and now routinely ignores the holdings of *S.C.* and *E.C.* mandating “a noticed *in camera* hearing, where the minor may assert the privilege,”²³⁰ before the Program can access the child’s mental health treatment records. Moreover, current policy at the national and state levels appears to be headed in the direction of favoring *more* information-sharing between agencies rather than emphasizing the need to safeguard the confidentiality interests of children in the foster care system, and their families.²³¹

225. Buss, *supra* note 211, at 1714–15.

226. See Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL’Y & L. 6, 20 (1995) (“When people are labeled incompetent and their decision-making control is removed, they are explicitly reminded that they lack an internal locus of control.”).

227. See Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES, 37, 47 (1999) (observing that “social cognition literature places emphasis on ‘information control,’ the perception that results when an individual obtains information relating to a stressful situation or event. Such information provides the individual with the opportunity to understand what is happening to him or her.”) (citations omitted).

228. *Id.*

229. Bruce Winick makes a similar observation in his rewind of the *Schiavo* lawyering, noting that “[t]he case got caught up in abortion politics and pitted the right-to-life movement against those supporting a libertarian right to die.” Winick, *A Legal Autopsy*, *supra* note 12, at 651.

230. *E.C.*, 867 So. 2d at 1195.

231. See, e.g., GLORIA HOCHMAN, ANNDEE HOCHMAN & JENNIFER MILLER, FOSTER CARE: VOICES FROM THE INSIDE: COMMISSIONED BY THE PEW COMMISSION ON CHILDREN IN FOSTER CARE 11 (2004), available at <http://pewfostercare.org/research/voices/> (“But many participants described a system in which decision-making is fragmented and information guarded rather than shared. While confidentiality certainly plays a crucial part in determining what facts about a family or child may be disclosed, and to whom, nearly everyone said that more information would help those involved to feel that the system is working with them.”); FAMILY SERVICES OF

Lastly, the children's attorneys appeared tone-deaf to the child's kinship and relational ties—to the child's "larger network of familial and communal relations,"²³² which is an acknowledged key element of therapeutic lawyering.²³³ Although the attorneys' zealous advocacy to advance and enforce their clients' rights to confidential therapy was highly commendable as a law reform strategy,²³⁴ the advocacy fell short of the mark in being attentive to the clients' connections to significant adults and to the potential of the litigation to rupture those connections. While the attorneys strove to further their clients' legal rights, and we can only speculate about how they counseled their clients, the lawyers did not seem truly client-centered, engaging the children in a realistic and objective appraisal of the advantages and disadvantages of the contemplated litigation.²³⁵

One of the aims of the emergency field of "relationship-centered lawyering" is to train lawyers to use research in "psychology, social work, and other behavioral sciences—matters such as family systems theory, strength-based approaches, emotional intelligence, cultural competence, and the like" to equip them to consider their clients "in a broader social, familial, cultural context."²³⁶ It suggests a more collaborative paradigm for client representation, moving beyond the gladiatorial litigation model toward a "contained, settlement-oriented, creative, private, respectful process without sacrificing the benefits of having a committed advocate at [the clients'] sides."²³⁷ It also represents a "move beyond an exclusive focus on clients' legal rights or interests, in favor of approaches that value clients' human needs and emotional well-being."²³⁸

The advocacy in these three cases seems to have been waged exclusively in the adversarial realm, enforcing the child's right to unimpeded access to psychotherapy, with less attention paid to "the need to strengthen individuals and families and to enhance their functioning."²³⁹ Relationship-centered lawyering, on the other hand, demands that lawyers also "examine the family holistically, identifying how family members interact with other aspects of the family ecology."²⁴⁰ This crucial element seems to be lacking in the strategies deployed by the children's counsel.

METRO ORLANDO, FINAL REPORT OF THE REGIS LITTLE TASK FORCE 16 (2010), available at cityofliferorlando.org/media/pdfs/rl_taskforce_report%20final.pdf ("All children in foster care deserve the best care possible. In order to facilitate this, their caregivers must have access to as much information as possible about the child, including information from other agencies serving the child.").

232. Henning, *Defining the Lawyer-Self*, *supra* note 218, at 434.

233. See generally RELATIONSHIP-CENTERED LAWYERING: SOCIAL SCIENCE THEORY FOR TRANSFORMING LEGAL PRACTICE (Susan L. Brooks & Robert G. Madden eds., 2010).

234. See generally Martin Guggenheim, *A Paradigm for Determining the Role of Counsel for Children*, 64 *FORDHAM L. REV.* 1399, 1420 (1996) ("A lawyer's first role is to enforce and advance her clients' legal rights. Everything else is secondary to this.").

235. See generally Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 *ARIZ. L. REV.* 501, 510–13 (1990).

236. David B. Wexler & Bruce J. Winick, *Foreword: Relationship-Centered Lawyering: A Transformational Tweak in RELATIONSHIP-CENTERED LAWYERING*, *supra* note 233, at x.

237. Pauline H. Tesler, *Collaborative Family Law*, 4 *PEPP. DISP. RESOL. L.J.* 317, 318 (2004).

238. Winick, *A Legal Autopsy*, *supra* note 12, at 597.

239. Babb, *supra* note 14, at 808.

240. *Id.*

CONCLUSION

In assessing the results of the four-year battle in Florida to establish a child's right to assert the psychotherapist-patient privilege over parental objections, we do not know whether the battle that their attorneys waged in the courtroom to enforce their clients' right to confidential therapy was, in the end, truly therapeutic. Did the lawyers advise their clients about the potential adverse impact of the representation on their clients' lives outside of the courtroom? We cannot say because we were not there. Their court victories for their three clients, while compelling and noble in advancing important therapeutic and legal objectives, may also have been pyrrhic. We do not know how the lives of any of these three vulnerable children were enhanced by the lawyers' fight for their therapeutic interests. There is no epilogue to this story.

What this tells us is that it is not just enough to be a skilled and passionate advocate for the child in the adversarial system. The lawyer must also be a compassionate healing agent for the child, assuring the child's healthy connections to "parents, extended family and fictive kin—who know the child best and who the child knows best."²⁴¹

241. Annette R. Appell, *Children's Voice and Justice: Lawyering for Children in the Twenty-First Century*, 6 NEV. L.J. 692, 717 (2006).

