ADOLESCENT DECISION MAKING: LEGAL ISSUES WITH RESPECT TO TREATMENT FOR SUBSTANCE MISUSE AND MENTAL ILLNESS

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I. INTRODUCTION

The April 15, 2011 Roundtable Conference on Adolescent Decision-Making, sponsored by the University of Maryland Francis King Carey School of Law's Law and Health Care Program and the Johns Hopkins Berman Institute of Bioethics, included a panel on decision making in the context of treatment for substance use disorders and other mental health treatment.[1] The panel was organized around two case studies. The first involves Denise, a sixteen-year-old high school student, who has received an assessment and initial treatment at a residential drug treatment program for heroin use. Denise wants to leave the program against medical advice and her mother's wishes. This case study squarely presents the question of how decision-making authority with respect to substance misuse treatment for adolescents is allocated within a family, particularly when the adolescent patient is at odds with his or her parent or legal guardian[2] over whether to participate in treatment.

According to the brief history provided in the first scenario, Denise joined her mother in making the decision to enter the residential treatment program. Denise was initially motivated to seek treatment because one of her friends had suffered a severe health crisis as a result of using heroin. This distinguishes her case from that of many others who are required to undergo substance misuse treatment as a

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1. *Conferences & Symposia: Roundtable on Adolescent Decision-Making*, UNIV. OF MD FRANCIS KING CAREY SCHOOL OF LAW, http://www.umaryland.edu/faculty/conferences/detail.html?conf=108 (last visited Oct. 17, 2011).

2. Throughout this essay, references to an adolescent's "parent" or "parents" are meant to include his or her legal guardian as well.

consequence of their involvement in either the criminal justice or juvenile justice systems.[3]

The second case study involves Steve, a fourteen-year-old who uses alcohol and marijuana without his parents' knowledge. In this scenario, Steve is receiving outpatient treatment for his substance use, but has refused to permit his counselors to share information with his parents about his alcohol and other drug use or his treatment. While the treatment providers have concluded that the parents' involvement in a family counseling process could aid Steve's therapeutic progress, Steve is reluctant to consent to the disclosure of this information to his parents because of his father's intolerant attitude toward the use of alcohol and other drugs. This case study presents difficult questions about confidentiality and medical privacy, even between family members, in the context of substance misuse treatment and, by extension, within the field of mental health treatment more broadly.

The first section of this article examines the central question, presented by the case study of Denise, of how decision-making authority with respect to treatment for substance misuse is (or should be) organized within the triad made up of an adolescent patient, his or her parents, and a treatment provider.[4] Subsumed within this discussion is a consideration of the respective capacity of adolescents and their parents both to grant and to withhold consent for treatment.[5] The following section then takes up a related set of questions concerning a treatment provider's disclosure of confidential information about an adolescent's diagnosis and/or treatment for substance misuse to the adolescent's parents.[6] This discussion, although prompted by the second case study, is related to a larger analysis of decision making, because communication with an adolescent's parents for purposes of arranging informed consent for treatment may itself constitute a legally prohibited disclosure of confidential information.[7]

The article concludes by suggesting that adolescents' rights should be safeguarded in those situations in which the law treats them as the ultimate

3. *See* Randolph Muck et al., *An Overview of the Effectiveness of Adolescent Substance Abuse Treatment Models*, 33 YOUTH & SOC'Y 143, 145 (2001) (explaining that adolescents in treatment for substance misuse "are typically referred by a parent, juvenile justice system official . . . , school official, child welfare worker, or representative of some other community institution").

4. *See infra* Part II.

5. *See infra* Part II.

6. *See infra* Part III.

7. *See* 42 U.S.C. § 290dd–2 (2006) (prohibiting the disclosure, under most circumstances, of information about an individual's identity, diagnosis or prognosis maintained "in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research . . ."); 42 C.F.R. § 2.14(C)(2) (2010) (governing federal confidentiality protections for minors who seek or receive substance misuse treatment); *see also infra* Part III.

decision-maker.[8] When the law does not permit adolescents to exercise independent and final authority, however, parents and clinicians should still seek to structure opportunities for adolescents to participate in the decision-making process, while openly acknowledging the limits of that participation.[9] In the end, tensions in the law between according decision-making authority to adolescents for some purposes and withholding it for others are likely to be managed best in practice rather than resolved in advance on the basis of abstract legal analysis.[10] This process of working out the sometimes competing interests of adolescents and their families, both with respect to making treatment decisions and managing confidential information, requires sensitive contextualized judgments by treatment professionals and others concerned about the wellbeing of minors with substance misuse disorders and other mental disabilities.[11] Legal rules have an important role to play in framing the decision-making processes by which these choices are made by and on behalf of adolescents, but ultimately, the outcomes in individual cases are just as likely to be driven by clinical and interpersonal considerations that require sensitive attention to the individual circumstances presented by each adolescent in need of treatment services.[12]

II. THE ALLOCATION OF DECISION-MAKING AUTHORITY BETWEEN PARENTS AND CHILDREN

The basic legal framework for determining the allocation of authority between adolescents and their parents with respect to health-care decisions, including decisions regarding treatment for mental illness and alcohol and other drug use disorders, rests on two fundamental foundations.[13] The first is the doctrine of informed consent, which is a central organizing feature of virtually all relationships between health-care providers and the recipients of their services.[14]

8. *See infra* Part IV.

9. *See infra* Part IV.

10. Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J.L. & MED. 409, 451 (2002).

11. *See infra* Part IV.

12. *See infra* Part IV; *see also* Linda L. Caldwell et al., *A Person-Centered Approach to Individualizing a School-Based Universal Prevention Intervention*, 35 AM. J. DRUG & ALCOHOL ABUSE 214, 214, 218 (2009) (advocating for an individualized assessment of adolescents in the early stages of intervention).

13. *See generally* Tara L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent*, 38 ADOLESCENCE 343, 344 (2003) (noting the importance of informed consent as a bedrock legal and moral responsibility of health-care providers); Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 147–49 (2000) (outlining the development of minors' limited constitutional rights to participate in health-care decision making).

14. *See* JON R. WALTZ & FRED E. INBAU, MEDICAL JURISPRUDENCE 152, 164–65 (1971) (explaining how the requirement of informed consent defines the communicative duties of a physician);

The second is made up of the constitutional principles that define the essential rights of parents and their children in the field of medical decision making.[15] Even though each state has a statutory overlay that builds upon and, in some cases, modifies this basic framework,[16] it is important to start at the foundations of the system.

The doctrine of informed consent, although of ancient origin,[17] really only came to apply to the treatment of persons with mental disabilities beginning in the 1960s, with the Kansas case *Natanson v. Kline*[18] and the Missouri case *Mitchell v. Robinson*.[19] The doctrine has two components: a duty of disclosure and a duty to obtain a patient's agreement to undergo treatment based upon his or her understanding of the information that has been conveyed.[20] As with informed consent doctrine generally, the law requires a provider of mental health treatment to disclose essential information about the costs and benefits of a proposed therapeutic intervention and to ascertain the patient's assent in light of that information.[21] In

see also Timothy J. Paterick et al., *Medical Informed Consent: General Considerations for Physicians*, 83 MAYO CLINIC PROC. 313, 313 (2008) (noting that "informed consent is ethically, morally, and legally" part of the doctor-patient relationship).

15. *See generally* Schlam & Wood, *supra* note 13, at 147–49 (stating that parents' rights to care for their children often supersede children's rights to due process and privacy). The rights of minors have been limited by the Supreme Court's recognition of the interests of parents and the state in the upbringing and welfare of children. *See, e.g.*, Carey v. Population Serv. Int'l, 431 U.S. 678, 692 (1977) (noting that while the Constitution protects both minors and adults alike, the state's ability to "control the conduct of children reaches beyond the scope of its authority over adults") (quoting Prince v. Massachusetts, 321 U.S. 158, 170 (1944)).

16. *See* Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 712 (1993) (describing state statutes providing for mature minor and emancipation exceptions); Tori Lallemont et al., *Decision-Making Authority and Substance Abuse Treatment for Adolescents: A Survey of State Laws*, 44 J. ADOLESCENT HEALTH 323 (2009) (identifying and classifying state laws governing the provision of voluntary inpatient substance misuse treatment for adolescents); *see, e.g.*, IDAHO CODE ANN. § 39–307(1) (2011) (requiring the patient's parent or legal guardian to apply for voluntary substance abuse treatment if the patient in question is a minor); FLA. STAT. ANN. § 397.601(4)(a) (West 2011) (authorizing minors to consent to voluntary substance abuse treatment services from a licensed provider).

17. RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 61–63 (1986) (setting out a history of informed consent).

18. 350 P.2d 1093, 1104–06 (Kan. 1960) (agreeing with Salgo v. Leland Stanford Jr. Univ. Bd. Of Trustees, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957), which stated that a physician must "recognize that each patient presents a separate problem . . . and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent").

19. 334 S.W.2d. 11, 19 (Mo. 1960) (holding that informed consent was required in the treatment of a person with an "emotional illness" while the patient was lucid), *abrogated in part by* Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965).

20. CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 258 (5th ed. 2009).

21. *See Mitchell*, 334 S.W.2d at 18 (holding that a patient suffering from an "emotional illness" should have been informed about the risks associated with electro-shock therapy); *see also* SLOBOGIN ET

Mitchell, which involved a claim that a physician had failed to disclose the risks associated with electro-shock therapy, the court held that a "doctor owes a duty to his patient to make reasonable disclosure of all significant facts . . . a doctor who fails to perform this duty is guilty of malpractice."[22]

For a number of years, the doctrine was limited to mental health treatments other than psychotherapy, especially psychosurgery, pharmacotherapy and other "physically intrusive treatment modalities."[23] In part, this limitation was a product of the relationship between the doctrine of informed consent and the rules governing tort damages.[24] Traditionally, a tort recovery required the plaintiff patient to show that he or she had suffered a physical injury as a consequence of the health-care provider's negligence.[25] As jurisdictions increasingly have come to recognize a right to compensation for non-physical injuries,[26] the application of the doctrine of informed consent has spread to forms of treatment (i.e., talking therapies) whose risks are primarily non-physical in nature.[27] Wholly apart from its connection to the law of torts, however, the doctrine of informed consent has also evolved as more clearly articulated notions of patient autonomy have helped to reshape the ethical responsibilities of health-care providers.[28] From this perspective, the obligation of physicians and other care providers to insure that recipients of services understand the costs and benefits of undergoing treatment, and have given their assent in light of that understanding, is as much an obligation of professional ethics as it is of the law governing liability for physical harms.[29]

AL., *supra* note 20, at 258–59, 284, 290 (noting the recent trend of states extending informed consent doctrine into fields such as psychotherapy).

22. *Mitchell*, 334 S.W.2d at 18 (quoting Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 427 (1957)).

23. SLOBOGIN ET AL., *supra* note 20, at 258–59.

24. *Id.* at 259.

25. *Id.* Alternatively, a cause of action could be based on a claim of assault or battery, depending on the jurisdiction's theory of liability. *See, e.g.*, Schloendorff v. Soc'y N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (describing an operation without the patient's consent as an assault, for which the physician was liable for damages).

26. *See* Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 140–52 (1992) (discussing the development of various compensable non-physical harms that have arisen in tort law).

27. *See* Paul S. Appelbaum, *Informed Consent to Psychotherapy: Recent Developments*, 48 PSYCHIATRIC SERVICES 445, 445–46 (1997) (describing the developing application of the informed consent doctrine to psychotherapy and arguing for its increased use); *see also* Suzanne W. Hadley & Hans H. Strupp, *Contemporary Views of Negative Effects in Psychotherapy*, 33 ARCHIVES GEN. PSYCHIATRY 1291, 1293–94 (1976) (providing primarily non-physical examples of the potential harms that can result from psychotherapy).

28. *See* Benjamin Freedman, *A Moral Theory of Informed Consent*, 5 HASTINGS CENTER REP. 32, 32–35 (1975) (discussing the ethics of informed consent in the medical profession and the personal autonomy interests associated with an individual's right to be informed about the risks and benefits of a medical procedure).

29. *Id.* at 32.

In most states, if a patient's mental illness or other mental disability precludes the giving of informed consent, non-emergency treatment cannot be administered without a judicial determination of legal incompetency and the appointment of a guardian or other legal representative.[30] Adolescents and other minors, however, need not be adjudicated incompetent on an individual basis, and instead are treated systematically in the law as incompetent for a variety of legal purposes,[31] including the capacity to give informed consent for most kinds of medical care.[32] For this reason, the principal medical decision-maker for adolescents for most purposes is the adolescent's parent.[33]

A. The Balance of Interests With Respect to Treatment of Children with Mental Illness

These background principles came together in 1979 in a U.S. Supreme Court decision, *Parham v. J.R.. et al.*,[34] in which a class of minors challenged, on due process grounds, the right of their parents to authorize their "voluntary" psychiatric hospitalization without a prior judicial determination or other adversary proceeding.[35] In his opinion for a majority of the court, Chief Justice Burger wrote at length about the "family as a unit" and about the law's understanding of parental decision making in cases in which the judgment of a parent is at odds with the wishes of an adolescent.[36] The Chief Justice explained that:

> The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children.[37]

30. *See* Paul S. Appelbaum & Thomas Grisso, *Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 107 (1995). A severe mental illness or other mental disability may disrupt either or both of the components of informed consent. *See id.* at 108–11 (identifying legal factors for evaluating the competence of mentally disabled patients to understand their options and communicate their decisions). The range of impairments a court could consider includes an individual's inability: (1) to evidence a choice; (2) to understand relevant information; (3) to harbor no clearly false beliefs with respect to information relevant to the choice; (4) to rationally manipulate and/or appreciate that information; or (5) to reach a reasonable outcome. *Id.*

31. *See* Elizabeth S. Scott et al., *Evaluating Adolescent Decision Making in Legal Contexts*, 19 LAW & HUM. BEHAV. 221, 226–27 (1995) (describing how the theory of adolescents' lack of "capacity for understanding and reasoning" motivates the paternalistic limits on their autonomy in various contexts, including juvenile justice, contract law, education, marriage and employment).

32. *Id.* at 227.

33. Schlam & Wood, *supra* note 13, at 148–49.

34. 442 U.S. 584 (1979).

35. *Id.* at 587–88.

36. *Id.* at 598–617.

37. *Id.* at 602.

In light of the *Parham* majority's presumption that parents ordinarily act in their child's best interests,[38] it is worth exploring the nature of the various kinds of interests held by children that may be at stake in health-care decisions, including decisions about whether to consent to treatment for substance misuse or other mental disabilities. John Eekelaar has identified three categories of interests held by children.[39] The first category covers "basic interests," which are interests relating to a child's general physical, emotional and intellectual wellbeing.[40] The second category is comprised of "developmental interests."[41] Child care-givers concerned especially with developmental interests make choices designed to equip children during their early years with the tools they will need to succeed later in life, to insure that children's "capacities . . . [are] developed to their best advantage," and to minimize "avoidable prejudices incurred during childhood."[42] The third category of interests is made up of "autonomy interests."[43] According to Eekelaar, these interests involve the freedom to select lifestyles and relationships according to the child's preferences.[44]

With respect to medical decision making, these distinct interest domains may be aligned or they may come into conflict.[45] When the interest categories are in conflict, parents and other adult decision-makers may weigh them differently than the adolescents who are subject to their judgments.[46] Thus, basic and developmental interests often are valued most by parents,[47] while autonomy interests frequently are more important in the decision-making calculations of adolescents.[48]

While Chief Justice Burger recognized the potential for parental abuse in the exercise of decision-making discretion,[49] his opinion did not unpack the more subtle ways in which the distinct components of a child's interests might come into conflict even when a parent seeks to act in good faith.[50] Given his view that

38. *Id.*

39. John Eekelaar, *The Emergence of Children's Rights*, 6 O.J.L.S. 161, 170–71 (1986).

40. *Id.* at 170.

41. *Id.*

42. *Id.* at 170–71.

43. *Id.* at 171.

44. *Id.*

45. *Id.* at 171 (noting that a child's autonomy interest may conflict with his or her developmental or basic interests).

46. *See id.* (stating that adults are likely to value basic and developmental interests more than autonomy interests, which children are likely to value more highly).

47. *Id.*

48. *See id.* at 170–71, 177 (noting that autonomy interests may be especially important to children).

49. Parham v. J. R., 442 U.S. 584, 602–03 (1979).

50. *Compare id.* at 598–604 (discussing the interests of children and those of their parents), *with* Eekelaar, *supra* note 39, at 170–72 (acknowledging the three interests of children, developmental, basic and autonomy interests, often are at odds).

parents' "natural bonds of affection" generally lead them to make good choices,[51] the Chief Justice adopted a position of deference with respect to evaluating (or second guessing) the decision of parents to hospitalize their children for mental health treatment.[52] He explained:

> As with so many other legal presumptions, experience and reality may rebut what the law accepts as a starting point; the incidence of child neglect and abuse cases attests to this. That some parents "may at times be acting against the interests of their children" . . . creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests. The statist notion that government power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition.[53]

To be sure, Chief Justice Burger's analysis did acknowledge that "parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized," given the child's liberty interests and the nature of the decision to approve psychiatric treatment.[54] Instead, the *Parham* court recognized that parents' "plenary authority to seek such care for their children," must be "subject to a physician's independent examination and medical judgment."[55]

The Chief Justice's analysis was framed by the due process balancing test the Court previously had set out in *Mathews v. Eldridge*.[56] On one side of that constitutional balance is the "private interest that will be affected by the official action."[57] Of course, on the facts of *Parham*, and in other cases in which a parent seeks to authorize health care for a child in the face of that child's resistance, the private interests are not necessarily unitary, but can be understood as residing both

51. *Parham*, 442 U.S. at 602.

52. *Id.* at 602–03. Chief Justice Burger is not alone in taking the position that parents' deep emotional bonds and superior knowledge about their children make them the most appropriate primary decision-makers for purposes of health care choices. *See, e.g.*, James Rachels, *Morality, Parents, and Children*, *in* PERSON TO PERSON 46, 53 (George Graham & Hugh LaFolette eds., 1989) ("[P]arents are assigned special responsibility for their own children because parents are *better situated* to look after their own."). The European Court of Human Rights has also held that a parent's voluntary admission of a twelve-year-old boy to a psychiatric hospital, against the wishes of the boy, was not a deprivation of liberty contrary to Article 5 of the European Convention on Human Rights, because the parent was exercising her parental decision-making authority in the child's best interests. Nielsen v. Denmark, 144 Eur. Ct. H.R. (ser. A) (1988).

53. *Parham*, 442 U.S. at 602–03 (quoting Bartley v. Kremens, 402 F. Supp. 1039, 1047-48 (E.D. Pa. 1975), *vacated*, 431 U.S. 119 (1977)) (citation omitted).

54. *Id.* at 604.

55. *Id.*

56. 424 U.S. 319, 334–35 (1976) (noting the three interests that must be balanced to insure due process of the law).

57. *Id.* at 335.

with the child and with his or her parents.[58] In the context of the medical decision in *Parham*—hospitalization for treatment for mental illness—Chief Justice Burger acknowledged that the child has a substantial liberty interest in "not being confined unnecessarily for medical treatment."[59] In addition, he conceded that the "child has a protectable interest" in avoiding the stigma associated with mental illness and with "being labeled erroneously,"[60] although the Chief Justice suggested that a voluntary hospitalization for mental health treatment authorized by a parent was less likely to stigmatize the child than would an involuntary civil commitment or a juvenile delinquency determination reached by a state actor.[61]

While the parent's interests were treated by Chief Justice Burger as largely derivative of those held by the child, the Court's opinion does suggest a basis for recognizing parental liberty interests that derive as well from the "family as a unit."[62] These parental interests, Burger explained, could be undermined by a constitutional rule requiring a pre-hospitalization judicial determination, because such a process could create family discord and place unnecessary strain on the parent-child relationship.[63] In a similar fashion, others who have explored these issues also have suggested that, with respect to making health-care decisions for their children, parents not only have rights "on behalf of their children, as proxy decision-makers or legal representatives," but also possess rights "as parents because of the importance of family integrity or family autonomy," and rights as "those responsible for children."[64]

In his partial dissent in *Parham*, Justice Brennan, while acknowledging the importance of the interests held by parents, described the child's interests as more vulnerable and therefore entitled to greater constitutional protection.[65] In the context of in-patient mental health treatment, Justice Brennan noted that children often are confined for a "longer period of time" than are adult patients, and may suffer life-long "scars" as a consequence of the emotional toll and stigma associated with commitment.[66] He also stressed the uncertainty surrounding mental

58. *Parham*, 442 U.S. at 600; *see also* R.J.D. v. Vaughan Clinic, P.C., 572 So. 2d 1225, 1227 (Ala. 1990) (explaining that while a child has a substantial liberty interest, parents also have a "legal duty of providing medical attention for their children").

59. *Parham*, 442 U.S. at 600.

60. *Id.* at 601.

61. *Id.* at 600–01.

62. *Id.* at 600, 602. *Cf.* Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925) (noting that parents have a right to decide how to nurture and educate their children); Meyer v. Nebraska, 262 U.S. 390, 400 (1923) (noting that a parent has a "natural duty" to insure that his or her child receives a suitable education).

63. *Parham*, 442 U.S. at 634–35.

64. Moli Paul, *Decision-Making About Children's Mental Health Care: Ethical Challenges*, 10 ADVANCES PSYCHIATRIC TREATMENT 301, 303 (2004) (citation omitted).

65. *Parham*, 442 U.S. at 627–28 (Brennan, J., dissenting).

66. *Id.* at 628 (majority opinion).

illness diagnosis and treatment decisions, especially for adolescents and other children, the tendency of clinicians to err on the side of medical caution, and the resulting over-institutionalization of children as a broad statistical matter.[67]

B. The Balance of Interests With Respect to Treatment of Children for Substance Use Disorders

The literature on treating adolescents with substance use disorders describes a number of considerations that inform a similar analysis of these young patients' interests. First, with respect to stigma and labeling, it is important to note that not all adolescents who use alcohol and other drugs meet the diagnostic criteria for a drug use disorder or are likely to develop a dependency or other persisting disability.[68] Pursuant to the disease model of alcoholism and other drug addiction that has dominated thinking in this field since the middle of the twentieth century, individuals who are diagnosed with a substance use disorder are thought to have an "abnormal, constitutional disposition influenced by enduring biological factors" that causes them to lose control over their drinking or other drug-taking behavior.[69] According to this "disease model," the disability, "although incurable, can be suppressed through abstinence."[70] Because of the poor fit between the diagnostic criteria for substance use disorders generally used for adults and actual patterns of adolescent drug use,[71] the American Academy of Pediatrics ("AAP") has created an alternative diagnostic system that sets out six stages of adolescent drug involvement.[72] In addition to the more severe stages of "abuse" and "dependence" the AAP's typography also includes "experimental use" and "early abuse,"[73]

67. *Id.* at 628–29.

68. *See* Ken C. Winters, *Treating Adolescents with Substance Use Disorders: An Overview of Practice Issues and Treatment Outcome*, 20 SUBSTANCE ABUSE 203, 204–05 (1999) (arguing that most adolescents who use drugs do not become addicted).

69. Daniel W. Hungerford, *Interventions in Trauma Centers for Substance Use Disorders: New Insights on an Old Malady*, 59 J. TRAUMA S10, S10–S11 (Supp. 2005).

70. *Id.* at S10.

71. *See* Rosalind Brannigan et al., *The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs: Results of an In-depth National Survey*, 158 ARCHIVES PEDIATRICS & ADOLESCENT MED. 904, 904 (2004) (noting that the "*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria for substance abuse and dependence" were developed for adults and therefore have "significant limitations when applied to adolescents").

72. *See* Winters, *supra* note 68, at 205 (outlining the six stages of adolescent drug involvement developed by the American Academy of Pediatrics).

73. *Id.* The American Academy of Pediatrics identifies the six stages as:

> (1) *Abstinence.* (2) *Experimental use:* minimal use, typically associated with recreational activities; often limited to alcohol use. (3) *Early abuse:* more established use, often involving more than one drug; greater frequency than experimental use; adverse personal consequences begin to emerge. (4) *Abuse:* regular and frequent use over an extended period; several adverse consequences emerge. (5) *Dependence:* continued regular use despite repeated severe consequences; signs of tolerance;

neither of which necessarily requires the sort of intensive interventions and life-long abstinence ordinarily associated with treating drug use disorders according to the disease model.[74] As a consequence, some experts caution clinicians to "be careful not to prematurely diagnose or label adolescents or otherwise pressure them to accept that they have a chronic disorder that will require life-long abstinence."[75]

In addition to holding an interest in avoiding the stigma and harmful labeling associated with a substance misuse diagnosis and invasive treatment, adolescents also may have interests that can be adversely affected by being coerced into undergoing treatment.[76] "Coercive influences can take several forms, such as exclusion from the decision-making process about seeking treatment, use of force and deceit to impose treatment on the individual, and use of restraint to retain the person in treatment."[77] Although there is some support in the research literature for the view that coerced treatment can be effective for some adults with substance use problems,[78] there is also reason to conclude that coercion can be counter-therapeutic in some instances.[79] In the case of adolescents, the negative consequences of coercion, including the decision of parents to approve treatment against the wishes of their child, may be especially pronounced.[80] Some experts warn of "motivational barriers linked to circumstances surrounding the youth's

> adjustment of activities to accommodate drug-seeking and drug use. (6) *Recovery:* return to abstinence; some youth may relapse and cycle through the stages again.

Id.

74. *Compare id*. at 204–05 (noting that most adolescents who engage in drug use do not become drug dependent), *with* Hungerford, *supra* note 69, at S10 (noting that the dispositional disease model considers alcoholism an "incurable" disease that requires suppression through abstinence).

75. Winters, *supra* note 68, at 209.

76. *See* Paul, *supra* note 64, at 309 (stating that a minor who is coerced into medical treatment may lose a "sense of himself" and miss out on developmental learning opportunities that prepare the minor for future decision making); Winters, *supra* note 68, at 210 (explaining that coercing adolescents often impedes "behavioral change").

77. Winters, *supra* note 68, at 210.

78. *See* Norman S. Miller & Joseph A. Flaherty, *Effectiveness of Coerced Addiction Treatment (Alternative Consequences): A Review of the Clinical Research*, 18 J. SUBSTANCE ABUSE TREATMENT 9, 14 (2000) (noting that coerced treatment can result in improved psychosocial status for the patient and reduced costs for society).

79. *See* Richard C. Boldt, *Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom*, 62 S.C. L. REV. 261, 328–29 (2010) (discussing the low rate of program completion and the high rate of recidivism among offenders coerced into treatment and asserting that "success in treatment may depend significantly on the participants' motivation"); *see also* Karen Duke, *Out of Crime and Into Treatment?: The Criminalization of Contemporary Drug Policy Since* Tackling Drugs Together, 13 DRUGS: EDUC. PREVENTION & POL'Y 409, 412–13 (2006) (arguing that coercive drug treatment is not always successful).

80. *Cf.* ANNENBERG FOUND. TRUST AT SUNNYLANDS', ANNENBERG PUB. POLICY CTR. OF THE UNIV. OF PA., TREATING AND PREVENTING ADOLESCENT MENTAL HEALTH DISORDERS 407 (Dwight L. Evans et al. eds., 2005) [hereinafter ANNENBERG FOUND.] (pointing out that, with regard to cocaine use by adolescents, coercion by an authority figure may result in limited effectiveness of treatment approaches).

contact with the service," and suggest that "coercive pressure to seek and continue treatment is believed to be a barrier to behavior change."[81] Indeed, even if treatment for a substance use disorder is an appropriate measure for safeguarding an adolescent's basic interests (his or her ongoing physical and psychological wellbeing),[82] the decision of a parent to force that treatment in the face of the adolescent's resistance could undermine the effectiveness of the treatment, precisely because the child's developmental and autonomy interests may be in tension with the parent's use of coercion.[83] Developmental issues, "which include negotiating levels of autonomy and dependence in relation to parents and families," frequently are at the center of effective therapeutic interventions for adolescents with drug use disorders.[84] Preserving space in the therapeutic relationship for some measure of autonomous discretion on the part of an adolescent, then, may be an especially important asset in a successful clinical response to harmful alcohol or other drug use by that young person.[85]

There are a number of features associated with the diagnosis and treatment of adolescent substance misuse that weigh in the other direction, in favor of according parents greater decision-making authority.[86] As a general matter, individuals with substance use disorders often experience ambivalence about their circumstances and the need for behavioral change.[87] As the negative consequences of their drug misuse accumulate, some adults are able to overcome this ambivalence and become motivated to change harmful drug use behaviors.[88] Often, therapeutic interventions

81. Winters, *supra* note 68, at 210.

82. *See* Rebecca A. Powers & Robert Matano, *Substance Use and Abuse*, *in* TREATING ADOLESCENTS 77, 78 (Hans Steiner & Irvin D. Yalom eds., 1996) (arguing that adolescent alcohol and drug use contributes to mental health problems and delinquency, and as a result all health professionals have a key role in prevention and treatment).

83. Gains with respect to an adolescent's "sense of himself as an active and responsible participant in his own health care" may be lost when his or her refusal of treatment is overridden. Paul, *supra* note 64, at 309. In addition, forced treatment may cause a minor to experience a "loss of trust in professionals or parents, feeling unheard and therefore abandoning participation, learned helplessness or protest at being treated unfairly." *Id. See* ANNENBERG FOUND., *supra* note 80, at 407 (noting the limited effectiveness of treatment programs for cocaine use when adolescents are pressured into treatment).

84. Winters, *supra* note 68, at 209.

85. *See* Paul, *supra* note 64, at 309. To the extent that effective treatment for substance use disorders requires individuals to develop the capacity to assert control over their choices, and to take responsibility for the consequences of their decisions, safeguarding their autonomy interests may be especially important; *see infra* text accompanying notes 248–49.

86. *See* OSCAR GARY BUKSTEIN, ADOLESCENT SUBSTANCE ABUSE: ASSESSMENT, PREVENTION, AND TREATMENT 138 (1995) (noting that adolescents are vulnerable to making poor decisions due to a lack of maturity concerning social, cognitive, and emotional functioning).

87. Howard J. Shaffer, *Psychology of Stage Change*, *in* SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 100, 102 (Joyce Lowinson et al. eds., 3d ed. 1997).

88. *See id.* (noting that ambivalence gives way as "[i]ncreasing levels of self observation develop"); *see generally* James O. Prochaska et al., *In Search of How People Change: Applications to Addictive*

that assist these individuals to project the costs of their drug use into the future are crucial to this process of developing the capacity for change.[89] For developmental reasons, adolescents are less adept than adults at organizing decision-making processes that take into account the long-range consequences of present actions.[90] Adolescents with drug use disorders are especially vulnerable because of this developmental deficit.[91] Because adolescents have more difficulty than adult users projecting the consequences of their use into the future, their capacity to mobilize for change, indeed their capacity to understand the need for a new direction, is likely to be inadequate to overcome the ambivalence or denial that surrounds their harmful conduct.[92]

Recent research into brain development suggests that alcohol and other drug misuse by young people can be especially damaging because of the particular neurological vulnerability of adolescents.[93] Early misuse of alcohol and other drugs is closely correlated with substance dependence later in life.[94] In part, this is likely due to the "plasticity" of the developing brain, which remains physiologically immature until a person reaches his or her mid-twenties.[95] This plasticity fosters a remarkable capacity for learning in adolescents, but it also means that alcohol and other drug misuse can change a teen's neurophysiology in ways that interfere with his or her decision making and increase the risk for future dependence.[96] This research suggests that alcohol and other drug use disorders are diseases of the

Behaviors, 47 AM. PSYCHOLOGIST 1102 (1992) (discussing the "stages of change" with respect to addictive behaviors).

89. *See* Kathleen M. Carroll et al., *Motivational Interviewing to Enhance Treatment Initiation in Substance Abusers: An Effectiveness Study*, 10 AM. J. ON ADDICTIONS 335, 337–38 (2001) (noting that motivational interviewing seeks to heighten an individual's awareness of the personal consequences of substance abuse, and concluding that motivational strategies may "substantially increase the likelihood of treatment initiation" in substance-abusing individuals); *see also* Winters, supra note 68, at 206 (explaining that a substance misuse patient may not have the capacity for change until that person understands the negative consequences of his or her actions).

90. *See* Winters, *supra* note 68, at 206.

91. *See* R. Andrew Chambers et al., *Developmental Neurocircuitry of Motivation in Adolescence: A Critical Period of Addiction Vulnerability*, 160 AM. J. PSYCHIATRY 1041, 1042 (2003) (describing adolescent neurodevelopment as a period of "addiction vulnerability").

92. *See* Winters, *supra* note 68, at 206 (noting that ambivalence is a barrier to the treatment process for all users, but because an adolescent's faculties are not yet fully developed, he or she may have more problems realizing the "destructive power of drug involvement").

93. NAT'L INST. ON ALCOHOL ABUSE AND ALCOHOLISM, NAT'L INST. OF HEALTH, ALCOHOL AND THE DEVELOPING ADOLESCENT BRAIN 1, *available at* www.niaaa.nih.gov/AboutNIAAA/NIAAA SponsoredPrograms/Documents/NIAAA_Brain_Fact_Sheet_508.pdf (last visited Jan. 15, 2012).

94. *Id.* at 2.

95. *Id.* at 1.

96. *Id.* For example, some researchers have reported that repeated alcohol use during adolescence can result in cognitive impairments and memory response changes weeks after the use has terminated. Brain imaging studies have found adolescent alcohol misuse to be associated with a reduction in the size of the hippocampus. *See id.*

young and that interventions early in the process are important to prevent the development of chronic disorders.

Adolescent substance abuse frequently is associated with additional delays in the developmental process that further compound the problem and make effective decision making even more difficult.[97] Both cognitive and social-emotional development often are arrested in young people who misuse alcohol and other drugs, and learning disorders and other psychopathologies also are frequently co-occurring challenges.[98] Even in the case of adolescent substance users without co-occurring mental disabilities or other developmental deficits, the interests of family harmony may weigh in favor of deferring to the parent's decision with respect to seeking treatment.[99] In *Parham*, Chief Justice Burger stressed that interposing a judicial proceeding between parents seeking treatment for their children and those children could force adversarial interactions that might undermine the very family relationships that often are crucial to successful outcomes in the treatment of minors with mental illness.[100] Similarly, for adolescents with substance use disorders, the child's family relationships may provide clinicians with important material for exploring the origins of the alcohol or other drug use and may provide effective pressure points for accomplishing beneficial change in the adolescent's environment and his or her harmful behaviors.[101] Given the importance of these family relationships and the key role accorded to the involvement of parents in some forms of treatment for adolescent substance use disorders,[102] it may be that similar caution is called for in devising decision-making processes likely to

97. *See* Winters, *supra* note 68, at 209.

98. *Id.*; *see also* Howard B. Moss et al., *Psychiatric Comorbidity and Self-Efficacy to Resist Heavy Drinking in Alcoholic and Nonalcoholic Adolescents*, 3 AM. J. ON ADDICTIONS 204, 205 (1994) (noting that other psychopathologies, such as "major depressive disorder" and "attention-deficit hyperactivity disorder," often co-occur with substance use disorders).

99. *See* Paul, *supra* note 64, at 303 (noting that the parent's right to make decisions for his or her child's health care is justified, partly, because of the "importance of family integrity or family autonomy"). Of course, there may already be substantial family conflict surrounding an adolescent who is actively resisting his or her parent's insistence on unwanted treatment.

100. Parham v. J. R., 442 U.S. 584, 610 (1979).

101. *See* Randolph Much et al., *An Overview of the Effectiveness of Adolescent Substance Abuse Treatment Models*, 33 YOUTH & SOC'Y (SPECIAL ISSUE) 143, 151 (2001) (noting the "critical influence" an adolescent's family has in adolescent substance abuse problems); Deborah Deas & Suzanne E. Thomas, *An Overview of Controlled Studies of Adolescent Substance Abuse Treatment*, 10 AM. J. ON ADDICTIONS 178, 179 (2001) (noting that dysfunctional relationships within families play a role in the maintenance of "problem behaviors"); *see also infra* text accompanying notes 239–49.

102. *See* Ashley M. Austin et al., *Effective Family-Based Interventions for Adolescents with Substance Use Problems: A Systematic Review*, 15 RES. ON SOC. WORK PRAC. 67, 68 (2005) (describing family-based substance abuse interventions and the important role of the family system in substance abuse problems).

provoke conflict between parents who seek substance use treatment for their children and those children.[103]

C. An Alternative Perspective on the Decision-Making Process

In light of the potential tension between the domains of interest held by adolescents considering treatment for substance misuse or for other mental illness, and given the sometimes competing interests held by their parents,[104] it is worth thinking about the decision-making involvement of these adolescents along a continuum instead of simply assuming, in a dichotomous fashion, that children either have the authority to consent (or to withhold consent) to treatment or they do not. Alderson and Montgomery have suggested such an alternative perspective.[105] In their formulation, the degree of decision-making involvement by an adolescent in a medical decision-making process can range from simply being informed of the decision, to being invited to express a view, to being permitted to influence the decision, to being the main decision-maker.[106] Thus, the decision whether or not an adolescent will undergo treatment for substance misuse or for other mental illness could conceivably be made by a parent with no involvement by the child, by the adolescent himself or herself with no parental input, or through a variety of processes that involve both the adult and the adolescent.[107]

Elaborating on the relative involvement of adolescents and adults in health-care decision making, Moli Paul has suggested that children ordinarily should be encouraged to view their role as that of a "partner" along with the adults involved in the consideration of alternatives.[108] Paul distinguishes between instances in which the adolescent is made a participant in the decision-making process and those in which he or she has the "final say" with respect to treatment.[109] In Paul's view, withholding the final say (thereby placing the treatment decision in the hands

103. The question of parental involvement in the treatment process is taken up in greater detail in Part III *infra*.

104. *See* Paul, *supra* note 64, at 302–03 (outlining the rights and interests of both children and parents when considering treatment and how those interests may differ).

105. *See* PRISCILLA ALDERSON & JONATHAN MONTGOMERY, HEALTH CARE CHOICES: MAKING DECISIONS WITH CHILDREN 85–86 (1996) (proposing a "code of practice for children's health care rights" in which a minor may consent to treatment if the minor is competent to do so).

106. *Id.* at 45, 64–82 (explaining that "[m]any young patients choose to accept their doctors' or parents' decisions, others wish to share in deciding, a few want to be 'the main decider'"). *See also* Paul *supra* note 64, at 309 (setting out four levels of decision-making involvement for parents and children).

107. *See* ALDERSON & MONTGOMERY, *supra* note 105, at 45, 64–82. Of course, the range of potential decision-making processes should also identify the appropriate role for other participants, including clinicians, and, potentially, judicial officers and child welfare workers. *Id.* at 87, 91–92 (discussing the role of different participants, such as doctors and judges, in the decision-making process).

108. Paul, *supra* note 64, at 305.

109. *Id.*

of others) does not mean that the adolescent's views should not be accorded some weight in the final outcome.[110] In circumstances in which the parent authorizes treatment, the decision may turn on whether the benefits warrant incurring the costs (to "human dignity" and to the therapeutic relationship) of imposing treatment over the child's objections, and on the degree of physical or psychological "force" required to implement the treatment decision.[111] To the extent possible, Paul argues, children should be permitted to take an active part in evaluating options, even if they independently lack the capacity to grant or withhold consent, or to have the final say.[112]

D. Legal Framework for Decision-Making Authority with Respect to Medical Treatment

1. State Statutory Standards Governing Consent for the Treatment of Minors with Substance Use Disorders

Although the legal default position recognized in *Parham* for adolescent health-care decisions in general is that adolescents and other children do not have the final say and thus lack the authority either to consent or to withhold consent for medical care,[113] the vast majority of states have created statutory exceptions to the default rule by providing minors with the capacity to consent to treatment for substance misuse without requiring parental consent as well.[114] Some thorny questions remain, however, in the majority of states that permit minors to consent to alcohol and other drug misuse treatment. First, in a state that permits minors to consent to treatment, do parents also have the authority to provide consent for treatment, either under the general authority that they have to direct the health-care decisions of their minor children, or pursuant to specific statutory authorization? And, does this legal authority effectively permit parents to override the decision of a minor who has withheld his or her consent to treatment? Second, if parents can authorize substance abuse treatment against the wishes of their children, what legal procedures, if any, are in place to insure that a parent is acting in the child's interests? In *Parham*, of course, the majority held that a neutral judicial decision-

110. *Id.* at 305, 309 (emphasizing that children should be made aware that their participation in the decision-making process is important even where the child's preferences may not be decisive).

111. *Id.* at 305.

112. *Id.* at 305, 309.

113. Parham v. J. R., 442 U.S. 584, 603–04 (1979).

114. *See* sources cited *infra* note 116. For a general discussion of the competence of minors to consent to mental health treatment, *see also* Redding, *supra* note 16 at 712. A few states distinguish between inpatient and outpatient substance misuse treatment and some prohibit minors from consenting to methadone treatment. *See, e.g.*, VA. CODE. ANN. § 16.1-338 (2010) (addressing inpatient treatment); VA. CODE. ANN. § 54.1-2629(E)(3)(2009) (addressing outpatient treatment); S.C. CODE ANN. § 44–53–760 (2002) (requiring that parents consent to adolescents' methadone treatment).

maker is not required prior to the hospital admission of a child for mental illness, but an independent medical judgment as to the appropriateness of the contemplated treatment is required.[115]

In the aggregate, thirty-one states have statutes that permit a minor of any age to consent to alcohol or other drug abuse treatment.[116] In many of these states, the relevant statute simply provides that minors have the legal capacity to apply for treatment services.[117] For example, in Idaho, "[a]n alcoholic or a drug addict may apply for voluntary treatment directly to any approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, legal guardian, or other legal representative shall make the application."[118] In other states, the law explicitly removes the disability of minority that otherwise would preclude an adolescent from obtaining substance misuse treatment on his or her own.[119] For instance, in Florida:

> [t]he disability of minority for persons under 18 years of age is removed solely for the purpose of obtaining voluntary substance abuse impairment services from a licensed service provider, and consent to such services by a minor has the same force and effect as if executed by an individual who has reached the age of majority. Such consent is not subject to later disaffirmance based on minority.[120]

115. *Parham*, 442 U.S. at 606–08.

116. *See* ALA. CODE § 22-8-6 (LexisNexis 2006); ARIZ. REV. STAT. ANN. § 36–2024 (2009); COLO. REV. STAT. ANN. § 13–22–102 (West 2005); CONN. GEN. STAT. ANN. § 17a–682 (West 2006); FLA. STAT. ANN. § 397.601(4)(a) (West 2011); GA. CODE ANN. § 37-7-8(b) (1995); HAW. REV. STAT. ANN. § 577-26(e) (LexisNexis 2010); IDAHO CODE ANN. § 39-307(1) (2011); 20 ILL. COMP. STAT. ANN. 301/30–5(d) (West 2008); IND. CODE. ANN. § 12-23-12-1 (LexisNexis 2008); IOWA CODE ANN. § 125.33(1) (West 2007); KY. REV. STAT. ANN. § 222.441 (West 2006); LA. REV. STAT. ANN. § 40:1096(A) (2008); ME. REV. STAT. ANN. tit. 22, § 1502 (2004); MD. CODE ANN., HEALTH–GEN. § 20-102(c)–(d) (LexisNexis 2009); MICH. COMP. LAWS ANN. § 333.6121(1) (West 2001); MINN. STAT. ANN. § 144.343(1) (West 2011); MO. ANN. STAT. § 431.061(1)(4)(c) (West 2010); MONT. CODE ANN. § 41-1-402(2)(c) (2011); NEV. REV. STAT. ANN. § 129.050(1)(a) (LexisNexis 2010); N.J. STAT. ANN. § 9:17A–4 (West Supp. 2011); N.Y. MENTAL HYG. LAW § 22.11(b)–(c)(1) (McKinney 2006); N.C. GEN. STAT. § 90-21.5(a) (2009); OHIO REV. CODE ANN. § 3719.012(a) (LexisNexis 2005); OKLA. STAT. ANN. tit. 63, § 2602(A)(3) (West 2004); 71 PA. STAT. ANN. § 1690.112 (West 1990 & Supp. 2011); R.I. GEN. LAWS § 14-5-4 (2002); S.D. CODIFIED LAWS § 34–20A–50 (2004); TEX. FAM. CODE ANN. § 32.003(a)(5) (West 2008); VA. CODE. ANN. § 54.1-2969(E)(3) (2009); W. VA. CODE ANN. § 60-6-23 (LexisNexis 2010).

117. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36–2024(A) (Supp. 2010); COLO. REV. STAT. ANN. § 27–82–105 (West 2010).

118. IDAHO CODE ANN. § 39-307(1) (2011).

119. *See, e.g.*, FLA. STAT. ANN. § 397.601(4)(a) (West 2011).

120. *Id.*

An additional thirteen states permit minors above a specified age to consent to substance abuse treatment.[121] The statutory ages range from twelve[122] to sixteen-years-old.[123] Six states do not have statutes permitting minors to consent on their own to substance abuse treatment.[124] One state, New York, has adopted a statutory scheme under which a minor's consent is recognized only in circumstances in which a physician or other authorized treatment provider makes specific findings that drug or alcohol treatment is in the child's medical interest, and that either the involvement of the parent or guardian in the treatment process would be detrimental to the minor, or the parent or guardian refuses to give consent or is unavailable.[125] In Massachusetts a child over the age of twelve may consent to treatment for drug dependency, but only if two physicians have found that that the child is drug dependent.[126]

The laws in a handful of states permit minors to consent to outpatient substance abuse treatment, but not inpatient services.[127] In addition, four states withhold from minors the authority to consent to methadone treatment[128] or other "replacement narcotic abuse treatment."[129] This last restriction is problematic, given that pharmacotherapy has come to play "an increasingly important role in the treatment of adult alcoholism and drug addiction," and "data and clinical

121. *See* CAL. FAM. CODE § 6929(b) (West 2004); DEL. CODE ANN. tit. 16, § 2210(b) (2003); KAN. STAT. ANN. § 59-29b49(B) (2005); MASS. GEN. LAWS ANN. ch. 112, § 12(E) (West 2003); MISS. CODE. ANN. § 41-41-14(1) (2009); N.H. REV. STAT. ANN. § 318-B:12-a (LexisNexis 2010); N.D. CENT. CODE § 14-10-17 (2009); OR. REV. STAT. § 109.675 (2009); S.C. CODE ANN. § 44–52–20 (2002); TENN. CODE ANN. § 33-6-201(1) (2007); VT. STAT. ANN. tit. 18, § 4226 (2002); WASH. REV. CODE ANN. § 70.96A.095 (West 2011); WIS. STAT. ANN. § 51.47 (West 2008). In a few states the age requirement depends on whether the proposed treatment is inpatient or outpatient. *See, e.g.*, DEL. CODE ANN. tit. 16, § 2210(b) (2003) (non-residential substance abuse treatment may be provided to minors over fourteen years of age without parental consent); WASH. REV. CODE ANN. § 70.96A.095 (West 2011) (authorizing minors over age thirteen to consent to outpatient treatment).

122. *See, e.g.*, VT. STAT. ANN. tit. 18 § 4226(a) (2002).

123. *See, e.g.*, S.C. CODE ANN. § 44–52–20 (2002).

124. Those states are Alaska, Arkansas, Nebraska, New Mexico, Utah and Wyoming. *See* ALASKA STAT. § 47.37.170 (2010) (general statute not particularized for minors); ARK. CODE ANN. § 20-64-810 (2001) (general statute not providing for minors to consent to treatment); NEB. REV. STAT. § 71-5041 (2009) (repealed 2004) (as of 2004, the state no longer permits minors to consent to treatment for substance abuse); N.M. STAT. ANN. § 32A-6A-21(B) (LexisNexis 2009) (stating that minors over the age of fourteen can consent to treatment only in conjunction with parental consent); UTAH CODE ANN. § 62A-15-301(1)–(2) (LexisNexis 2006) (giving only parents the ability to consent to minors treatment); WYO. STAT. ANN. § 14-1-101(b) (2011) (allowing minors to consent only if married, in the armed forces, or when a parent cannot be reasonably located).

125. N.Y. MENTAL HYG. LAW § 22.11(c)(1) (McKinney 2006).

126. MASS. GEN. LAWS ANN. ch. 112, § 12E (West 2003).

127. *See, e.g.*, WASH. REV. CODE ANN. § 70.96A.095 (West 2011).

128. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 112, § 12(E) (West 2003); OR. REV. STAT. § 109.675 (2009); S.C. CODE ANN. §44–53–760 (2002).

129. *See, e.g.*, CAL. FAM. CODE § 6929(e) (West 2004).

experience provide sufficient justification for substance use disorder treatment to suspend blanket 'no-medication' rules for deserving adolescent clients."[130]

On the other side of the coin, there is more variation from state to state (and greater uncertainty in many states)[131] with respect to the authority of parents to approve substance use treatment over the objection of a resisting adolescent.[132] A small minority of jurisdictions accompany the statutory grant of authority to minors with a corresponding provision reserving a parallel right for parents to consent to treatment even if their child does not consent.[133] Another group of states recognizes parental authority to approve substance use treatment for children, but conditions the exercise of that authority on satisfying procedural requirements that go beyond the constitutional minima set out in *Parham*.[134] In Wisconsin, for example, a parent may authorize the testing by a treatment facility of a minor for alcohol or other drug abuse, even without the minor's consent, and, if the facility deems it necessary, may agree to an appropriate plan of treatment, including outpatient services, day treatment, or inpatient care.[135] However, if an adolescent who is fourteen-years-old or older is admitted to inpatient treatment for substance misuse (or for other mental disabilities) without consenting to that treatment, Wisconsin law requires the treatment director of the facility to which the minor is admitted, or his or her designee, to file within three days of admission a verified petition for review of the admission in a court of appropriate jurisdiction in the county in which

130. Winters, *supra* note 68, at 210; *see* Richard C. Boldt, *Introduction: Obstacles to the Development and Use of Pharmacotherapies for Addiction*, 13 J. HEALTH CARE L. & POL'Y 1, 3 (2010) (explaining the role pharmacotherapies have played and could play in substance abuse treatments).

131. *See* David M. Vukadinovich, *Minors' Rights to Consent to Treatment: Navigating the Complexity of State Laws*, 37 J. HEALTH L. 667, 668 (2004) (noting that state laws attempting to "balance the rights and obligations of parents against the privacy rights of minors" have resulted in a confusing and sometimes conflicting set of provisions); *see also* Lallemont et al., *supra* note 16, at 332–34 (discussing lack of clarity and resulting confusion in how state laws manage conflict between parents and adolescents over whether to approve inpatient substance misuse treatment); *cf.* CAL. FAM. CODE § 6929(b)–(f) (West 2011) (granting children over the age of twelve the right to consent to substance use treatment, but requiring the involvement of the child's guardian if a physician deems it appropriate, and permitting a child's guardian to seek treatment for the child over the child's objections).

132. *Compare* R.I. GEN. LAWS § 23-1.10-12 (2002) (providing that a guardian can consent to the involuntary treatment of a person if he or she is an alcoholic), *with* KY. REV. STAT. ANN. § 222.441(2) (West 2006) (providing that a minor who is being treated pursuant to the consent of his or her parents can petition the court to evaluate the necessity of treatment).

133. *See, e.g.*, CAL. FAM. CODE § 6929(f) (West 2004); N.J. STAT. ANN. § 9:17A–4.1 (West 2002); *see also* Vukadinovich, *supra* note 131, at 684 (comparing New Jersey and California law regarding authority to consent to drug and alcohol abuse treatment and counseling).

134. *See, e.g.*, 71 PA. CONS. STAT. ANN. § 1690.112a (West Supp. 2011) (requiring that parents petition the court to authorize treatment for their child).

135. WIS. STAT. ANN. § 51.48 (West 2008).

the facility is located.[136] Within five days after the filing of the petition, the court is directed to:

> determine, based on the allegations of the petition and accompanying documents, whether there is a prima facie showing that the minor is in need of . . . services for . . . alcoholism, or drug abuse, whether the treatment facility offers inpatient therapy or treatment that is appropriate to the minor's needs; [and] whether inpatient care in the treatment facility is the least restrictive therapy or treatment consistent with the needs of the minor . . . .[137]

A majority of states neither have clarifying statutes nor additional procedural protections, presumably relying on the background legal presumption of parental authority over medical decision making for minors.[138] In some of these jurisdictions, the rights of parents to authorize treatment against their child's wishes have been clarified by judicial decision or attorney general opinion.[139] In Louisiana, for instance, the Attorney General issued an opinion stating that even though a minor has the statutory right to consent to treatment, he or she does not have the right to refuse care when that treatment is authorized by the child's parent or legal guardian and is proposed by a licensed physician.[140]

In Maryland, while "[a] minor has the same capacity as an adult to consent to treatment for or advice about drug abuse . . . [or] alcoholism,"[141] the governing statute makes clear that this capacity "does not include the capacity to refuse treatment for drug abuse or alcoholism in an inpatient alcohol or drug abuse treatment program . . . for which a parent or guardian has given consent."[142] Because Maryland law only deals explicitly with the rights of parents regarding inpatient treatment, it is an open question whether the capacity of the minor to

136. *Id*. § 51.13(4). The petition must contain a statement of "facts substantiating the petitioner's belief in the minor's need for . . . services for . . . alcoholism or drug abuse; . . . [t]he facts substantiating the appropriateness of inpatient treatment in the inpatient treatment facility; . . . [t]he basis for the petitioner's opinion that inpatient care in the facility is the least restrictive treatment consistent with the needs of the minor; . . . [and n]otation of any statement made or conduct demonstrated by the minor in the presence of the director or staff of the facility indicating that inpatient treatment is against the wishes of the minor." *Id*.

137. *Id*. The statute provides that the "rules of evidence in civil actions shall apply to any hearing under this section. A record shall be maintained of the entire proceedings. The record shall include findings of fact and conclusions of law. Findings shall be based on a clear and convincing standard of proof." *Id*.

138. *Cf*. Vukadinovich, *supra* note 131, at 668 (noting that while states attempt to balance parental interests against minors' privacy rights, statutes fail to address varying concerns in a uniform manner).

139. *See, e.g.*, *In re* F.C. III, 2 A.3d 1201, 1205 (Pa. 2010) (holding that a Pennsylvania Law allowing parents to authorize treatment against their child's wishes does not violate the due process protections of the Fourteenth Amendment).

140. La. Op. Att'y Gen., No. 88–232 (1988).

141. MD. CODE ANN., HEALTH–GEN. § 20-102(c) (LexisNexis 2009).

142. *Id*. § 20-102(c-1).

consent permits him or her to refuse outpatient substance misuse treatment for which a parent has given consent.[143] The argument against the right of the minor to resist such treatment is that it is inherent in the background norm that parents have the authority to make health-care decisions for their minor children.[144] The argument for the minor's right to refuse is that the statutory limitation to inpatient care implies no equivalent reservation of the parent's authority to override the adolescent's decision with respect to outpatient services.

With respect to procedural protections, Maryland's law governing the admission of minors to inpatient treatment facilities for the treatment of substance misuse parallels the *Parham* approach in relying on the independent medical judgment of the care provider, rather than a judicial determination that the treatment is necessary and appropriate.[145] This provision states that a parent may apply for his or her child's admission to a certified inpatient alcohol and drug abuse program, but that the program may not admit the child until it has determined that:

> (1) The [child] has an alcohol or other drug dependency that necessitates the level of care provided by the program or facility; (2) The [child] would benefit from treatment; (3) The parent or guardian making application for admission of the [child] understands the nature of the request for admission and the nature of the treatment provided by the program or facility; and (4) Assent to the admission has been given by the Director or the Director's designee of the program or facility.[146]

Michigan law provides yet another variation on how to manage the conflict between a parent who seeks substance use treatment for his or her child and the

143. *See id.* ("The capacity of a minor to consent to treatment for drug abuse or alcoholism under subsection (c)(1) or (2) of this section does not include the capacity to refuse treatment for drug abuse or alcoholism in an inpatient alcohol or drug abuse treatment program certified under Title 8 of this article for which a parent or guardian has given consent.").

144. *See* Paul, *supra* note 64, at 303 (providing an overview of parents' rights with regard to the health care of their children).

145. *Compare* MD. CODE ANN., HEALTH–GEN. § 8-502.1(b)(1)–(4) (LexisNexis 2009) (permitting minors to be admitted based on "program or facility" determinations), *with* Parham v. J. R., 442 U.S. 584, 604 (1979) (noting that parents do not always have absolute authority to decide whether to commit a child to a treatment facility, but they do "retain plenary authority to seek such care for their children, subject to a physician's independent examination and medical judgment").

146. MD. CODE ANN., HEALTH–GEN. § 8-502.1(b)(1)–(4) (LexisNexis 2009). The Maryland statute also sets out conditions for retention of the minor in inpatient substance abuse treatment. *See id.* § 8-502.1(c). "In order for an individual to be retained for treatment under this section[,] [t]he parent or guardian who applied for admission of the individual shall have the right to be actively involved in treatment." *Id.* § 8-502.1(c)(1). It is important to note the potential confidentiality problem here, if the minor withholds consent to disclose information to the parent. *See infra* Part III (discussing confidentiality and disclosure of treatment information to an adolescent's parent).

adolescent who resists that care.[147] If the minor is less than fourteen-years-old, the parent or guardian's consent is sufficient to authorize treatment.[148] If the child is fourteen or older, the treatment program must conduct a diagnostic evaluation within forty-eight hours to determine whether the minor is physiologically dependent.[149] If the evaluation indicates the minor is in need of detoxification, then parental consent is sufficient to authorize up to five days of treatment.[150] On the other hand, if the evaluation indicates the minor is in need of substance misuse treatment and rehabilitation services beyond detoxification, then the treatment and services cannot begin until the minor consents, or there is a court hearing to determine if such services are necessary.[151] This statutory scheme structures a decision-making process that affords Michigan parents significant authority, particularly in the case of minors whose substance misuse requires intensive detoxification services. At the same time, it is notable that the procedure also insures that the views of older adolescents are taken into consideration to some degree, at least in the context of a mandated court hearing.

2. Laws Governing Consent for the Treatment of Minors with Mental Illness

Although a few states deal with the capacity of minors to consent to substance misuse treatment in statutes that also deal with their authority to consent to treatment for mental illness,[152] in most states it is a separate question whether minors are permitted to consent to mental health treatment other than treatment for substance abuse without the involvement of their parent or guardian.[153] Since the

147. *See* MICH. COMP. LAWS ANN. § 333.6123(1)–(7) (West 2001) (permitting a program to provide substance abuse treatment and rehabilitation services without the child's consent if the child is under the age of fourteen, and providing specific requirements for treatment if the child is over the age of fourteen and does not consent).

148. *Id.*

149. *Id.* § 333.6123(3).

150. *Id.* § 333.6123(4).

151. *Id.* § 333.6123(5)–(6).

152. *See, e.g.*, N.C. GEN. STAT. § 122C-221 (2009) ("Except as otherwise provided in this Part, a minor may be admitted to a facility if the minor is mentally ill or a substance abuser and in need of treatment."); OKLA. STAT. ANN. tit. 43A, § 5–503(A) (West Supp. 2011) ("A parent of a minor or a minor sixteen (16) years of age or older may consent to the voluntary admission of the minor for inpatient mental health or substance abuse treatment."); TENN. CODE ANN. § 33-6-201(1) (2007) (referring to treatment for "mental illness"); *id.* § 33-1-101(19) (Supp. 2011) (defining "mental illness" as a "psychiatric disorder, alcohol dependence, or drug dependence . . .").

153. *Compare* N.Y. MENTAL HYG. LAW § 33.21(b) (McKinney 2006) (focusing on consent for mental health treatment of minors and recognizing the importance of involving the parent or guardian in the mental health treatment of a minor), *with id.* § 22.11(b) (addressing separately the treatment of minors for chemical dependency, but also recognizing the importance of parental/guardian involvement). *Compare* MD. CODE ANN., HEALTH–GEN. § 8-502.1(a)–(c) (LexisNexis 2009) (stating the conditions for admission and retention of minors to alcohol and drug abuse programs or facilities), *with id.* § 10-610(c) (detailing limitations for admission of minors to treatment facilities for mental health treatment).

United States Supreme Court's ruling in *Parham*, some states have enacted legislation to meet the procedural standards set forth in that case.[154] Other states have adopted statutes that go beyond the minimal due process protections afforded in *Parham*.[155] Overall, there is considerable variation among the states as to the procedural requirements, if any, over and above the constitutional minima established by the *Parham* court, for evaluating a parent's request for inpatient treatment of a minor child for mental disabilities other than drug and alcohol abuse.[156]

In Maryland, while "[a] minor who is [sixteen] years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic[,]"[157] this capacity to consent to mental health treatment "does not include the capacity to refuse consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has given consent."[158] The provisions in Maryland for dealing with the voluntary admission of a minor for inpatient treatment for mental illness are similar but not identical to those for substance abuse treatment.[159] A parent may apply for admission of a minor by submitting a formal written application.[160] The application requires the endorsement of a physician stating that he or she has examined the patient and has

154. *See, e.g.*, MICH. COMP. LAWS ANN. § 330.1498e(3)(a)–(b) (West 1999) (requiring the executive director of a treatment facility to decide if a minor is in need of treatment or hospitalization, whether he or she will benefit from such treatment and whether other treatment is available).

155. Parham v. J. R. 442 U.S. 584, 606 (1979) (setting out the constitutional minima to protect a minor's interest by requiring an application from a parent or guardian and a subsequent review by a neutral fact finder, such as a physician). *See, e.g.*, ALASKA STAT. § 47.37.190(a) (2010) (requiring a parent or guardian seeking involuntary commitment of a minor to petition court for a 30-day involuntary commitment order by showing that the minor has threatened, attempted to, or harmed another person, or "is incapacitated by alcohol or drugs").

156. *Compare* MICH. COMP. LAWS ANN. § 330.1498e(3)(a)–(b) (West 1999) (requiring the executive director to decide if a minor requires treatment or hospitalization, whether he or she will benefit from such treatment, and whether another treatment option is available), *with* OHIO REV. CODE ANN. § 5122.02(B)–(C) (LexisNexis 2010) (requiring the chief clinical officer of the hospital to find that hospitlization of the minor is appropriate, and a court to determine that the admission is in the best interest of the minor).

157. MD. CODE ANN., HEALTH–GEN. § 20-104(a)(1) (LexisNexis 2009).

158. *Id.* § 20-104(a)(2).

159. *Compare id.* § 10-610(c) (requiring that an applicant submit a formal, written application establishing the presence of a mental disorder that can be aided through treatment, that the applicant comprehends his or her request for treatment, and that a physician at the admission facility has agreed or that two doctors or a doctor and psychologist have agreed in the case of an adolescent in a State facility), *with id.* § 8-502.1(b) (requiring a determination that the patient has a need for substance abuse treatment, the patient would benefit from treatment, the parent or guardian understands the ramifications in asking for treatment, and the Director or designee of the program has assented to admission).

160. *Id.* § 10-610(b).

determined that the criteria for admission have been met.[161] In New York, the law governing outpatient mental health treatment largely tracks the provision for minors seeking treatment for alcohol or other drug misuse.[162] Thus, a mental health clinician is permitted to provide outpatient mental health services to a consenting adolescent without obtaining parental consent if the clinician:

> determines that: (1) the minor is knowingly and voluntarily seeking such services; and (2) provision of such services is clinically indicated and necessary to the minor's well-being; and (3)(i) a parent or guardian is not reasonably available; or (ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or (iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.[163]

A Michigan statute that protects the procedural rights of minors whose parents seek their "voluntary" hospitalization is typical of state provisions that codify the *Parham* requirements.[164] Pursuant to the statute, before a minor can be hospitalized for mental health treatment, the County Director must determine that inpatient treatment is required.[165] If the minor is determined to need hospitalization, the suitability of the placement must be evaluated ninety days after the initial

161. *Id.* § 10-610. These criteria are: (1) the proposed patient must have a mental disorder; (2) the mental disorder must be "susceptible to care or treatment;" and (3) the parent or guardian must understand the request for admission. *Id.* § 10-610 (c)(1)–(3). If all of these criteria are met, the minor can be admitted if a physician (if a private facility) or two physicians or a physician and a psychologist (if a state facility) determine it is appropriate. *Id.* § 10-610(c)(4). If the application is to a state facility, admission is limited to a maximum of 20 days. *Id.* § 10-610(d).

162. *Compare* N.Y. MENTAL HYG. LAW § 33.21 (McKinney 2006) (focusing on consent for mental health treatment of minors and recognizing the importance of involving the parent or guardian in the mental health treatment of a minor), *with id.* § 22.11 (addressing the treatment of minors for chemical dependency, but also recognizing the importance of parental and guardian involvement).

163. *Id.* § 33.21(c). Moreover, "[a] mental health practitioner may provide a minor voluntarily seeking outpatient services an initial interview without parental or guardian consent or involvement to determine whether the criteria of subdivision (c) of this section are present." *Id.* § 33.21(d).

164. *Compare* MICH. COMP. LAWS ANN. § 330.1498e(3)(a)–(b) (West 1999) (requiring the executive director to decide whether a minor requires treatment or hospitalization, whether he or she will benefit from such treatment and whether alternative treatment is available), *and* UTAH CODE ANN. § 62A-15-301(1)–(2) (LexisNexis 2006) (permitting a parent to consent to the involuntary treatment of a minor only after a neutral fact-finder conducts a private interview evaluating the need for child's treatment), *with* Parham v. J. R., 442 U.S. 584, 585 (1979) ("The child's rights and the nature of the commitment decision are such that parents do not always have absolute discretion to institutionalize a child; they retain plenary authority to seek such care for their children, subject to an independent medical judgment.").

165. MICH. COMP. LAWS ANN. § 330.1498e(3)(a)–(b) (West 1999). Under the statute, the following must be established: (1) the minor is in need of treatment; (2) hospitalization will help the minor; and (3) there is no "appropriate, available alternative to hospitalization." *Id.* In order to determine the appropriateness of hospitalization, the county director must consult with several agencies, including the school board, hospitals, and other public and private agencies. *Id.* § 330.1498e(3)(c).

admission and every sixty days thereafter.[166] Minors have thirty days to file an objection in court challenging their hospitalization.[167]

In addition to legislative codification, minors' rights to due process and judicial oversight when institutionalized have occasionally received consideration in state courts and lower federal courts since *Parham*.[168] For example, in *T.B. v. CPC Fairfax Hospital*,[169] the Washington Supreme Court reviewed the case of a fifteen-year-old girl who was admitted to a hospital as an inpatient after a ten-minute evaluation by a psychiatrist, during which she did not cooperate.[170] After the hospital refused repeated attempts by T.B.'s attorney's to contact T.B., the minor filed a petition for a writ of habeas corpus.[171] Upon review, the Washington Supreme Court found that minors who refuse to consent to inpatient mental health treatment but are admitted by their parents nonetheless, have a statutory right to a prompt judicial review of the admission decision.[172] In addition to a right to be heard, some courts have also found that minors have a right to legal representation.[173] Overall, however, courts have shown an overriding concern for safeguarding the decision-making authority of parents, and have sought to avoid infringing on family autonomy.[174] Consequently, courts rarely have overturned the decision of parents, acting with clinicians, to authorize inpatient treatment for children with mental illness.[175]

166. *Id.* § 330.1498*l*(1).

167. *Id.* § 330.1498m.

168. *See In re* Antoine C., 230 Cal. Rptr. 738, 739 (Ct. App. 1986) (holding that due process requires that an attorney be appointed for a minor in a recommitment hearing); *In re* F.C. III., 2 A.3d 1201, 1220 (Pa. 2010) (concluding that a statute permitting court-ordered treatment of a drug dependent minor comports with the due process requirements of the Fourteenth Amendment); Washington *ex rel.* T.B. v. CPC Fairfax Hosp., 918 P.2d 497, 504 (Wash. 1996) ("We cannot ignore these statutory violations in light of our previous holding that '[t]here is no question that due process guaranties must accompany involuntary commitment for mental disorders. . . .'").

169. 918 P.2d 497 (Wash. 1996).

170. *Id.* at 498–99.

171. *Id.* at 500.

172. *Id.* at 508. *See also* M.W. v. Davis, 756 So. 2d 90, 108 (Fla. 2000) ("Whether or not an evidentiary hearing is constitutionally mandated, our legal system at the very least should afford the child, through his or her attorney and/or guardian ad litem, a meaningful opportunity to be heard.").

173. *See* In re *Antoine C.*, 230 Cal. Rptr. at 739. *See generally* Jinanne S.J. Elder, *The Role of Counsel for Children: A Proposal for Addressing a Troubling Question*, 35 BOSTON BAR J. 6 (1991) (discussing minors' right to counsel and the role and ethical responsibilities of counsel for minors).

174. Schlam & Wood, *supra* note 13, at 149–50; *see also* Newmark v. Williams, 588 A.2d 1108, 1115 (Del. 1991) (noting that upholding the integrity of the family unit is a recognized principle of law, which involves acknowledging parental decision-making authority).

175. *See, e.g.*, *In re* Long, 214 S.E.2d 626, 629 (N.C. Ct. App. 1975) (stating that although minors are entitled to constitutional protection at some stage, a parent's authority in initially seeking treatment outweighs the necessity for a court hearing prior to initial admission).

III. THE DISCLOSURE OF CONFIDENTIAL TREATMENT INFORMATION TO AN ADOLESCENT'S PARENTS OR OTHERS

In some states, the legislature has addressed the question whether a minor's parents either may or must be notified in instances in which the minor is receiving substance misuse treatment on his or her own consent. In one group of states, treatment providers have a statutory duty to notify the minor's parents, even if the child refuses to give permission for this disclosure.[176] Other states either encourage or permit treatment providers to notify parents in these circumstances, even without the minor's agreement to disclose.[177] By contrast, only a small minority of states have statutes that expressly prohibit treatment providers from disclosing information or otherwise notifying the minor's parent or guardian absent the minor's consent for disclosure.[178]

These various parental notification provisions under state law implicate, and in some cases conflict with, the federal law and regulations governing the confidentiality of alcohol and other drug misuse treatment information.[179] Indeed,

176. See, e.g., CAL. FAM. CODE § 6929(b)–(c) & (g) (West 2004), which states:

> A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem . . . . The treatment plan of a minor authorized by this section shall include the involvement of the minor's parent or guardian, if appropriate, as determined by the professional person or treatment facility treating the minor. The professional person providing medical care or counseling to a minor shall state in the minor's treatment record whether and when the professional person attempted to contact the minor's parent or guardian, and whether the attempt to contact the parent or guardian was successful or unsuccessful, or the reason why, in the opinion of the professional person, it would not be appropriate to contact the minor's parent or guardian.

177. See, e.g., MICH. COMP. LAWS ANN. § 333.5127(2) (West 2001), which provides:

> For medical reasons a treating physician, and on the advice and direction of the treating physician, a physician, a member of the medical staff of a hospital or clinic, or other health professional, may, but is not obligated to, inform the spouse, parent, guardian, or person in loco parentis as to the treatment given or needed. The information may be given to or withheld from these persons without consent of the minor and notwithstanding the express refusal of the minor to the providing of the information.

178. *See, e.g.*, IOWA CODE ANN. § 125.33 (West 2007) ("The fact that the minor sought treatment or rehabilitation or is receiving treatment or rehabilitation services shall not be reported or disclosed to the parents or legal guardian of such minor without the minor's consent, and the minor may give legal consent to receive such treatment and rehabilitation.").

179. *See* 42 U.S.C. § 290dd-2 (2006). The drug abuse treatment information confidentiality law was initially passed as § 408 of the Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, 86 Stat. 79 (codified as amended at 21 U.S.C. § 1175 (1982)). That section was transferred and amended by Alcohol and Drug Abuse Amendments of 1993, Pub. L. 98-24, 97 Stat. 182 to § 527 of the Public Health Service Act, codified at 42 U.S.C. § 290ee-3 (1988 & Supp. 1993). The codification of an identical provision relating to the confidentiality of alcohol abuse treatment information can be found at 42 U.S.C. § 290dd-3 (1988 & Supp. 1993). Both statutes were amended in 1986 to allow treatment providers to comply with state law child abuse and neglect reporting requirements. Children's Justice and Assistance Act of 1986, Pub. L. No. 99-401, § 106, 100 Stat. 907 (1986) (amending sections 523(e) and 527(e) of the Public Health Service Act, 42 U.S.C. §§ 290dd-3(e), 290ee-3(e)). In 1992, Congress

most of the issues with respect to the relative legal authority of actors within the triad made up of a minor patient, his or her parents, and the treatment provider, regarding treatment decisions, are further complicated by the complex interaction of federal and state rules governing the confidentiality of this information.[180] For present purposes, two questions under the confidentiality law and regulations are of central importance. First, if an adolescent or other minor is in substance abuse treatment pursuant to his or her own consent, may the treatment provider communicate patient-identifying information to the child's parent over the minor patient's objections, if doing so would support the minor's treatment, perhaps under a "family systems" approach to treatment?[181] Second, if the treatment of an adolescent or other minor for substance misuse is based on parental consent that was given over the objections of the child, what health privacy protections attach to information about that treatment, and what information can be shared with the parents or with others, even in the absence of the minor's agreement to a disclosure?

A. The Federal Alcohol and other Drug Misuse Confidentiality Law and Regulations

Although the rules governing the disclosure of mental health treatment information to a minor's parents are relatively permissive in many states,[182] the provisions in federal law governing the disclosure of substance misuse treatment information are far more restrictive.[183] Generally, under the federal confidentiality

consolidated the two confidentiality statutes into a single provision. The regulations implementing these statutes are entitled Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. §§ 2.1–2.67 (2010).

180. *Id.*; *cf.* Douglas C. Smith et al., *Parental Consent in Adolescent Substance Abuse Treatment Outcome Studies*, 37 J. SUBSTANCE ABUSE TREATMENT 298, 299 (2009) (describing the complex relationship between federal confidentiality laws and state statutes).

181. Those states that have adopted statutes either requiring or permitting this sort of disclosure have done so on the theory that parental involvement in treatment is in the child's interest. *See, e.g.*, N.Y. MENTAL HYG. LAW § 22.11(b) (McKinney 2006) (recognizing that parents play a critical role in treating a minor for chemical dependency). Presumably, this policy preference for parental involvement is based on a family systems view of treatment for adolescent drug use. *See* Timothy J. Ozechowski & Howard A. Liddle, *Family-Based Therapy for Adolescent Drug Abuse: Knowns and Unknowns*, 3 CLINICAL CHILD & FAM. PSYCHOL. REV. 269, 270 (2000) (discussing the importance of family-based treatment in adolescent substance abuse intervention); *see also infra* text accompanying notes 239–49.

182. *See, e.g.*, N.Y. MENTAL HYG. LAW § 33.21 (McKinney 2006) (recognizing the importance of the parental role and when possible requiring a parent's or guardian's consent); MD. CODE ANN., HEALTH–GEN. § 20-102(f) (LexisNexis 2009) (allowing an attending physician or psychologist to decide whether to notify the parent or guardian of a minor who voluntarily seeks treatment, even without the minor's consent).

183. *See* 42 U.S.C. § 290dd-2(b)(2) (2006).

law and implementing regulations,[184] a substance misuse treatment program[185] is prohibited from disclosing information about an individual, even to family members and close friends, if the disclosure would identify that person as someone who misuses alcohol or other drugs.[186] A "disclosure" under this law is any oral or written "communication of patient-identifying information," even if the communication simply confirms information the recipient already knows.[187] The prohibition on disclosure applies to all persons who are "patients" within the meaning of the statute and regulations.[188] A "patient" is any person "who has applied for" or received "diagnosis or treatment" for alcohol or other drug misuse.[189] "Diagnosis" is defined as "any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment."[190] "Treatment" is "the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient."[191] Putting these provisions together, a person becomes a "patient" protected by the federal confidentiality law the moment he or she has received an assessment, counseling services, or any other related diagnostic, referral, or treatment service by a substance misuse treatment provider, even if the individual is not ultimately admitted for ongoing treatment.[192]

184. *Id.*; 42 C.F.R. §§ 2.1–2.67 (2010).

185. The regulations define a "program" as "[a]n individual or entity . . . who holds itself [*sic*] out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment . . . ." 42 C.F.R. § 2.11 (2010). The regulations consider a program to be "federally assisted" if it accepts any type of funds from the federal government. This may include Medicaid or Medicare reimbursements, or a tax exemption by the Internal Revenue Service. *Id.* § 2.12(b). The 1987 amendments to the regulations state that they are limited to specialized personnel within a general hospital or community mental health center. *Id.* § 2.11. For a more detailed analysis of the effect of these amendments, and their interpretation by several courts, see Richard C. Boldt, *Confidentiality of Alcohol and Other Drug Abuse Treatment Information for Emergency Department and Trauma Center Patients*, 20 HEALTH MATRIX 387, 403–08 (2010) [hereinafter *Confidentiality of Alcohol*].

186. 42 C.F.R. §§ 2.12–2.13(a) (2010).

187. *Id.* § 2.11.

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.* In order for a communication of information to be a "disclosure" that is subject to the federal law restriction, it must identify an individual as a substance misuse "patient." *Id.* § 2.12(e)(4). Consequently, a communication that does not associate an individual with alcohol or other drug misuse treatment (which may be possible when the program conveys information through an "umbrella" agency such as a general hospital or county public health department) or that appears in the form of aggregate data is not prohibited. *See id.* § 2.12(e)(3) (noting that the restrictions on disclosure only apply to "any information which would identify a patient as an alcohol or drug abuser"). In addition, a communication of information that is patient-identifying is not considered a prohibited disclosure if it takes place

Notwithstanding the unusually restrictive nature of the federal confidentiality law and regulations,[193] the disclosure of patient information is permitted if a patient executes a proper written consent form.[194] The rules governing disclosure pursuant to patient consent apply to adolescents and other minors in treatment.[195] The possibility of sharing confidential information pursuant to the minor's written consent becomes potentially important in arranging the parental approval for substance misuse treatment required under some states' laws. The federal confidentiality law and regulations leave the issue of whether a minor can obtain substance abuse treatment without parental consent up to state law.[196] With respect to authorizing the disclosure of patient-identifying information, however, the federal regulations provide that parental consent for disclosure to a third party is required only if parental consent is also required for treatment under state law.[197] If parental consent is not required to treat then it also is not required in order for a treatment program to disclose confidential information.[198] On the other hand, the minor's written consent is always required for a disclosure of patient-identifying information, even if the disclosure is to a child's parents and the state law requires

between personnel "within a program," so long as the recipient of the protected information has a need for the information in connection with his or her duties in the provision of treatment services to the patient. *Id.* § 2.12(c)(3). The regulations also permit the communication of patient-identifying information to outside entities that provide services in support of the treatment provider, if the outside entity enters into a "qualified service organization" agreement in which it agrees to treat any patient-identifying information it receives with full confidentiality. *Id.* § 2.12(c)(4). Essentially, this sort of an agreement brings the outside service provider into the program, thus converting the disclosure into an internal communication. *Id.* Other exceptions exist for patient-identifying disclosures in cases of "medical emergency," *id.* § 2.51 (This exception is limited to extremely serious circumstances, and only "medical personnel" may receive patient-identifying information), when a crime has been threatened or committed on program premises or against program staff, *id.* § 2.12(c)(5), when program personnel suspect that a patient is engaged in child abuse or neglect, *id.* § 2.12(c)(6), or when a court has issued a proper authorizing court order, *id.* §§ 2.61–.67. (Before such an order may be issued, the court must follow elaborate procedures, must find "good cause" for the information to be disclosed, and must limit the disclosure accordingly. These procedural and substantive requirements make this order much more difficult to obtain than other more familiar forms of compulsory process, such as warrants and subpoenas.)

193. *See generally id.* §§ 2.12–.13 (specifying limited circumstances for disclosure of patient information).

194. *Id.* § 2.31. The consent provisions of the federal regulations require that the patient's waiver of confidentiality be in writing. *Id.* The form must identify the patient, the treatment provider, and the recipient of the information to be disclosed. *Id.* The written form also must contain a statement of the purpose for the proposed disclosure, a description of the precise information to be communicated, an identification of the date, event or condition upon which the consent will expire, and "[a] statement that the consent is subject to revocation at any time" unless the program "has already acted in reliance on it." *Id.*

195. *See id.* § 2.14 (stating that a minor's consent is necessary for disclosure to a parent or guardian); *id.* § 2.31(a)(6).

196. *Id.* § 2.14.

197. 42 C.F.R. § 2.14(c).

198. *Id.* § 2.14(b).

parental consent to authorize treatment.[199] This means that the minor's written permission is required under the federal confidentiality regime before a treatment provider can contact the child's parents in order to obtain parental consent to treat in a state that does not permit minors to consent to substance abuse treatment on their own.[200]

One of the most difficult problems in this area arises when a minor has applied for treatment without his or her parents' knowledge in a state where treatment requires the parents' approval. In this situation, the program can contact the parents to obtain their permission only if the minor has signed a consent form, because the request for parent approval is itself a disclosure of patient-identifying information (that the child has sought substance misuse treatment services).[201] If the child refuses to consent to this disclosure in a state that requires parental approval, the treatment provider must refuse to proceed with treatment. The federal regulations do contain a very limited exception to the requirement that the minor must authorize disclosure to his or her parent, for situations where the program director determines that the minor "lacks the capacity to make a rational choice" about whether or not to consent to disclosure.[202] In order to find a lack of capacity, however, the director must determine that, because of "extreme youth or medical condition," the minor is incapable of a rational decision, and the situation poses a "substantial threat to the life or physical well-being of the [minor] or another individual."[203]

As noted earlier, New York's law contains a strong presumption in favor of parental involvement in the treatment of minors for substance misuse,[204] but permits clinicians to provide treatment without parental consent if, in their judgment, "parental or guardian involvement and consent would have a detrimental effect on the course of treatment of a minor who is voluntarily seeking treatment for chemical dependence," or the "parent or guardian refuses to consent to such treatment and the physician believes that such treatment is necessary for the best interests of the child," or the treatment provider "cannot locate the parents or guardians of a minor seeking treatment."[205] Significantly, the statutory requirement applicable to all other minors in New York receiving substance misuse treatment, that "[s]teps shall be taken to involve the parents or guardians in the course of

199. *Id.* § 2.14(c)(2).

200. *Id.*

201. *Id.*

202. *Id.* § 2.14(c)(2)(ii).

203. *Id.* § 2.14(d).

204. *See* N.Y. MENTAL HYG. LAW § 22.11(b) (McKinney 2006) (stating that when treating a minor for substance abuse, it is important to involve the parents or guardians as much as possible).

205. *Id.* § 22.11(c).

treatment,"[206] does not apply to minors whose parents have not provided consent for treatment. In the place of mandated parental involvement, New York law directs the provider of inpatient or residential treatment services to "use its best efforts to obtain from the minor the name, address, and telephone number of an adult who may serve as an emergency contact," and then directs the provider to notify that adult when the minor patient seeks a discharge from treatment.[207] While the statute seeks to comply with the federal confidentiality law and regulations by providing that "the facility shall verify the existence and availability of such contact upon notice to *and with the prior written consent of the minor*,"[208] no similar requirement of written consent by the minor is included in the provision directing that the adult contact person be notified upon the minor's application for discharge.[209] This subsequent communication of patient-identifying information to the contact person could constitute a violation of the federal confidentiality law, even if the minor previously had consented to communication with that person, if the child later withdraws his or her consent. The federal regulations generally grant patients an ongoing right to withdraw their written consent for disclosure, except to the extent that the treatment provider has acted in reliance on that consent.[210] Presumably, the treatment provider could require, as a condition of initiating treatment, that the minor provide written consent for a future disclosure to the contact person in the event the minor seeks discharge. In such a case, the treatment provider might argue that the minor's subsequent revocation of consent should not be deemed to be effective for purposes of the federal confidentiality law and regulations because the treatment had been provided in reliance on the minor's agreement. While such a position is not explicitly foreclosed by the language of the federal confidentiality regulations, it does push the logic of those provisions to their limits and would not likely prevail if tested in court.

B. The Confidentiality Interests of Resisting Minors in Treatment

While adolescents and other minors can obtain substance misuse treatment in most states without the consent of their parents, the more common circumstance is that such treatment is authorized by a minor's parents, often over the minor's objections.[211] In these instances, it is natural for the parents who have arranged for

206. *Id.* § 22.11(b).

207. *Id.* §§ 22.11(d)(1)(iv)(B), (d)(2)(ii)(A).

208. *Id.* § 22.11(d)(1)(iv)(B) (emphasis added).

209. *See id.* § 22.11(d)(2)(ii)(A) (stating that when a discharge request is received, the director must immediately notify the minor's designated emergency contact person of that request, but making no mention of consent by the minor for such disclosure).

210. *See* 42 C.F.R. § 2.31(a)(8) (2010).

211. Muck et al., *supra* note 3, at 145. The authors report the following:

> Motivation for treatment is a key factor in addressing adolescent substance use because adolescents presenting for treatment almost never enter as a self-referral.

and consented to treatment to wish to receive ongoing information about their child's progress in treatment, and, perhaps, even to participate in that care through family counseling or other services directed to the family. However, under the federal confidentiality law and regulations, the sharing of patient-identifying information to a child's parents is still a covered disclosure, even if the parents already know that the child is in treatment.[212] Of course, the parents may not know the details of their child's substance use history or other sensitive information that has emerged in counseling sessions and that has been memorialized in the caregiver's written notes, and the minor may wish to prevent that information from being disclosed. The law in some states addresses this question, at least in part, by granting the parents a right to receive this information.[213] In California, for example, "in cases where a parent or legal guardian has sought the medical care and counseling for a drug- or alcohol-related problem of a minor child, the physician *shall disclose* medical information concerning the care to the minor's parent or legal guardian upon his or her request, even if the minor child does not consent to disclosure, without liability for the disclosure."[214]

As a formal legal matter, a treatment program's compliance with this California statute, or with similar statutes on the books in some other states, would constitute a violation of the federal confidentiality law and regulations, unless the minor patient has authorized the state-mandated disclosure by executing a proper written consent form.[215] Moreover, the federal law and regulations make clear that, in cases of conflict between the requirements of the federal confidentiality regime and state law requirements, the federal obligations must prevail, and the operation of the supremacy clause of the U.S. Constitution insures that this hierarchy of law has force.[216] Thus, 42 § 2.20 of the federal confidentiality regulations explicitly provides that, while the federal provisions do not preempt all state laws in the field, "no State law may either authorize or compel any disclosure prohibited by these

> Instead, they are typically referred by a parent, juvenile justice system official (judge or probation or parole officer), school official, child welfare worker, or representative of some other community institution.

Id.

212. *See generally* 42 C.F.R. § 2.13(b) (2010) (noting that restrictions on disclosure apply even if person seeking information already has it).

213. *See, e.g.*, CAL. FAM. CODE § 6929(g) (West 2004); MD. CODE ANN., HEALTH–GEN. § 20-102 (LexisNexis 2009); MISS. CODE ANN. § 41-41-14 (2009); OKLA STAT. ANN. tit. 63 § 2602(B) (West 2004).

214. CAL. FAM. CODE § 6929(g) (West 2004) (emphasis added).

215. *See* 42 C.F.R. § 2.31 (stating the elements required for executing a proper written consent form). The federal confidentiality regulations do permit disclosures without consent in the case of proper court orders issued pursuant to Subpart E of the regulations, but the substantive criteria for obtaining such a court order ordinarily would not be satisfied in the typical case. *See id.* §§ 2.61–.67 (specifying precise requirements for obtaining an authorizing court order).

216. *See* U.S. CONST. art. VI, § 2.

regulations."[217] But beyond the technical legal conflict between the federal law favoring non-disclosure and state laws that seek to insure the involvement of parents in the treatment of their children, there is a broader conflict of values and interests that animate the legal obligations in tension. If that broader conflict could effectively be managed, it is possible that such a process of reconciliation could help to render the legal tension less problematic.

The values and interests served by the California law, and by similar laws in other states mandating disclosure to parents, closely track the interests held by parents as medical decision-makers for their children more generally.[218] As discussed previously, adult decision-makers are likely to focus especially on "basic interests" relating to their child's general physical, emotional and intellectual wellbeing, and on "developmental interests" relating to their child's acquisition of the tools he or she will need to succeed later in life.[219] Consistent with this perspective, Chief Justice Burger's analysis in *Parham* cast the parents' interests as largely derivative of those held by the child, although his opinion (and the work of some academic commentators in this field)[220] suggests that parents' interests also derive from their investment in the "family as a unit" and in the parents' stake in their ongoing relationship with their child.[221] Presumably, each of these parental concerns plays a role in supporting the state law disclosure obligations of treatment providers charged with informing parents of the progress of their child's treatment for alcohol or other drug misuse.[222]

Determining the values and interests animating the strict anti-disclosure regime in the federal confidentiality law and regulations is somewhat more complex. Presumably, the enforcement of a rigorous legal norm of non-disclosure that ordinarily can be overridden only by the affirmative (and written) permission of the patient, advances important "autonomy interests."[223] Seen in this way, the federal confidentiality rules operate to empower patients receiving substance

217. 42 C.F.R. § 2.20 (2010).

218. *See* Amy L. McGuire & Courtenay R. Bruce, *Keeping Children's Secrets: Confidentiality in the Physician-Patient Relationship*, 8 HOUS. J. HEALTH L. & POL'Y 315, 331 (2008) (describing the rights of parents in medicial decision making).

219. *See supra* text accompanying notes 40–42.

220. *See* Paul, *supra* note 64, at 302 (adults often value interests "on [their] children's behalf and by those adults for their own sakes").

221. *See supra* text accompanying note 64. Parents have "rights on behalf of their children, as proxy decision-makers or legal representatives," but also "as parents because of the importance of family integrity . . . or family autonomy," and rights as "those responsible for children." Paul, *supra* note 64, at 303.

222. *Cf.* SCOTT B. FRIZZIE, ASSEMBLY B. 2883 ANALYSIS (Ca. May 2, 1996) (amending state law to permit parents, who have sought medical care for their children, to access records regarding the treatment because "[c]oncerned parents need to be able to act on behalf of their child and to make informed decisions about their child's welfare").

223. *See supra* text accompanying notes 84–85.

misuse treatment services, including adolescents in treatment, to exercise more control over their lives, including the decision about whether private information should be shared with family, friends and others.[224] Beyond this interest, the rigorous requirements of non-disclosure also reflect a judgment by Congress and federal regulators that the ongoing social stigma associated with alcohol and other drug misuse requires special protections for individuals seeking treatment and for the treatment system itself.[225] The federal confidentiality statutes and the original implementing regulations promulgated in the 1970s made clear that Congress was concerned, not only about the harmful consequences that disclosure of treatment information could cause to individuals with substance use disorders,[226] but also that unnecessary disclosures could damage the broader delivery system for alcohol and other drug misuse treatment services by discouraging others from seeking treatment.[227]

Clearly, adolescents and other minors in need of treatment for substance use disorders could suffer individual harm, at school and elsewhere, if their alcohol or other drug use were broadly communicated.[228] And just as clearly, a regular practice of broad disclosure could discourage others, including adolescents who might otherwise be motivated to seek help, from obtaining treatment services.[229] But the carefully controlled communication of information about a minor's treatment to his or her parents would not seem to threaten either of these concerns.

224. *See* Hartman, *supra* note 10, at 426 (noting results from a study of adolescent patients indicating that they regard confidentiality as "the most important characteristic" in their decision to access medical care). *See generally* Vukadinovich, *supra* note 131, at 671 (stating that in some situations a minor may not seek services out of a concern that his or her parent will be informed of the treatment, and in these situations the minor's autonomy interests and "physical wellbeing" must prevail).

225. *See* S. REP. NO. 93–208, at 28 (1973) (adding a provision to the law that requires records of patient participation in substance abuse treatment to be withheld from all persons not connected to the treatment); *id*. at 31 (Taft statement recognizing the importance of eliminating discrimination against alcoholics); *see also Confidentiality of Alcohol*, *supra* note 185, at 388 & n.7 (stating that stigma associated with substance use disorders can have a harmful impact).

226. *See Confidentiality of Alcohol*, *supra* note 185, at 388. This is especially true with respect to those who use illegal drugs who may be exposed to criminal jeopardy, but also applies to alcohol misuse, the disclosure of which can negatively affect an individual's employment, occupational license, or family situation. *Id*.

227. *See* 42 C.F.R. § 2.3 (2010). In effect, the assumption was that if treatment providers adhered to a comprehensive and rigorous confidentiality scheme persons with substance use disorders would be more likely to seek treatment for these highly stigmatizing conditions. *See generally Confidentiality of Alcohol*, *supra* note 185, at 388.

228. *See* Reginald Simmons et al., *Bringing Adolescents into Substance Abuse Treatment Through Community Outreach and Engagement: The Hartford Youth Projec*t, 40 J. PSYCHOACTIVE DRUGS 41, 42 (2008) (stating that young people often do not receive substance abuse treatment because they are concerned about social stigma and embarrassment).

229. *See Confidentiality of Alcohol*, *supra* note 185, at 389 (stating that the restrictive rules were designed to insure people in need of substance abuse treatment would have safe access to treatment); H.R. Conf. Rep. No. 92-920, at 33 (1972) ("[F]ear of public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment . . . .").

Such a sharing of sensitive information with an adolescent's parents could, however, undermine the minor's autonomy interests and his or her developing sense of self control.[230]

In a certain way, this conflict, between the child's autonomy interests and the parents' interests in their child's care, is mirrored in the literature describing effective substance misuse treatment for adolescents.[231] Indeed, two of the "key elements for effective adolescent drug treatment" identified by a group of leading researchers, after reviewing the literature and consulting an advisory panel of twenty-two experts, track these competing interests closely.[232] On one side, the experts agreed that effective treatment requires programs to "build a climate of trust between the adolescent and the therapist."[233] The decision of a treatment provider to share sensitive information with a minor's parents over his or her objections certainly has the potential to diminish the child's sense of confidence in his or her therapist's loyalty, particularly if that information was revealed in counseling undertaken with the implied or explicit understanding that the clinician was on the child's side. Because trust between a minor patient and his or her therapist can be crucial in "engaging and retaining teens in treatment,"[234] the threat represented by an unconsented-to disclosure could severely damage the minor's motivation for change.[235] In addition, it also has the potential to diminish the minor's sense of control, not only over the course of his or her treatment, but also over other fundamental day-to-day decisions.[236] A primary focus of some of the leading forms

230. *See generally* Eekelaar, *supra* note 39, at 171 (discussing the autonomy interest held by children). Some experts have warned that the twelve-step treatment methodology associated with Alcoholics Anonymous and Narcotics Anonymous may be "antithetical to the developing adolescent" because it calls on the minor to accept his or her powerlessness and to "surrender, at a time when the adolescent is developing a personal identity and personal power. . . ." Deas & Thomas, *supra* note 101, at 187.

231. *See* Paul, *supra* note 64, at 302–03 (explaining that children tend to value autonomy whereas adults often place a higher value on their child's developmental interests); Laura Burney Nissen, *Effective Adolescent Substance Abuse Treatment in Juvenile Justice Settings: Practice and Policy Recommendations*, 23 CHILD & ADOLESCENT SOC. WORK J., 298, 305–06 (2006) (noting that substance abuse treatment success depends on a variety of factors including the involvement of family and the child's feeling of self-worth throughout the process).

232. *See* Brannigan et al., *supra* note 71, at 905 (competing interests of "family involvement in treatment" and "retaining teens in treatment" are embodied in two of the nine elements identified by the researchers).

233. *Id.*

234. *Id.*

235. *See* Sara Rosenbaum et al., *Health Information Law in the Context of Minors*, 123 PEDIATRICS S116, S120 (Supp. 2009) ("State and federal law have evolved to create certain health information privacy rights, particularly in the case of highly sensitive treatments whose disclosure could compromise a minor's safety or willingness or ability to seek care.").

236. *Cf.* Kathryn Hickey, *Minors' Rights in Medical Decision Making*, 9 JONA'S HEALTHCARE L. ETHICS, & REG. 100, 101 (2007) (noting that to allow an adolescent to give assent to decisions related to the adolescent's medical treatment promotes the feeling of empowerment).

of treatment for adolescents with substance use disorders involves assisting them in understanding that their harmful behaviors are the result of choices, that they can develop the capacity to evaluate these choices and can exercise control over them, and that they are responsible for the consequences of their decisions.[237] In light of this focus on helping adolescent patients develop a more responsible disposition toward decision making, an autonomy-reinforcing confidentiality rule that locates authority in the individual patient to decide whether to share treatment information (a choice that often presents the individual with a difficult mix of costs and benefits) can be understood as advancing the larger therapeutic aims of the program.[238]

On the other side of the divide, the experts who have identified essential criteria for the effective treatment of adolescents also stress the importance of encouraging family involvement in treatment.[239] They cite research demonstrating "that involving parents in the adolescent's drug treatment produces better outcomes,"[240] and other research suggesting that treatment models based on family systems theory often produce the best rates of treatment retention and relapse prevention.[241] A range of available treatment approaches based on family systems or social-ecological theory are available.[242] "A family systems view of adolescent drug abuse focuses on the manner in which adolescent functioning is related to parental, sibling, and extended-family functioning, as well as to patterns of communication and interaction within and between various family subsystems."[243] Family-based models identify overall family functioning and individual family

237. This is especially the case with respect to treatment approaches based on cognitive behavioral therapy, which focus on information processing, social learning, and problem solving. *See* Deas & Thomas, *supra* note 101, at 183 (noting that cognitive behavioral therapy strives to make individuals aware of, and avoid, situations that may lead to substance abuse.); *see also* NAT'L INST. ON DRUG ABUSE, NAT'L INST. OF HEALTH, NIDA INFOFACTS: TREATMENT APPROACHES FOR DRUG ADDICTION 4 (2009), *available at* http://www.drugabuse.gov/sites/default/files/if_treatment_approaches_2009_to_nida_92209.pdf (stating that cognitive–behavioral therapy aims to aid patients in identifying, avoiding, and coping with situations that may lead to drug abuse).

238. *See* Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1205, 1291–92 (1998) (stating that, since people with substance abuse problems are also likely to have little control over other features of their daily lives, being afforded the opportunity to exercise control over the disclosure of treatment information may help these individuals to develop a sense of responsibility for their own actions).

239. *See, e.g.*, Howard A. Liddle, *Family-Based Therapies for Adolescent Alcohol and Drug Use: Research Contributions and Future Research Needs*, 99 ADDICTION 76, 77 (Supp. 2 2004) (noting that parents and guardians play a critical role in "treatment engagement and outcome," and that practice guidelines highlight the significance of such involvement).

240. Brannigan, *supra* note 71, at 905.

241. *See, e.g.*, Austin et al., *supra* note 102, at 68 (noting a study that found that family-based interventions may produce more favorable results than other approaches).

242. *See* Ozechowski & Liddle, *supra* note 181, at 270–71 (noting that family-based therapies vary based on the amount of family involvement).

243. *Id.* at 270.

relationships as playing an important role in the adolescent's development of problematic drug use behaviors,[244] and target "a variety of familial factors, including communication skills, contingency management, and conflict resolution," for therapeutic interventions.[245] Many of the techniques utilized by family therapists require the involvement of parents and other family members. These include "observing the interactive patterns between members by encouraging them to speak directly to each other," helping family members to "clarify family roles and boundaries," and "reframing or relabeling problem behavior" in order to foster "new insights and opportunities to mend or develop relationships."[246]

In some cases, state laws that either encourage or require the sharing of information with parents may be sensible, given the assumptions underlying a family systems approach to treating adolescents. Thus, to the extent that family dynamics "play a role in the creation of conditions related to adolescent drug use," and to the extent that "parent-adolescent relationships can protect adolescents against drug use,"[247] enlisting the active assistance of parents in treatment may be a useful approach. On the other hand, if the origins of a drug use disorder lie in dysfunctional family relationships, or have been fostered by inappropriate or harmful features of the adolescent's relationship with his or her parents, a less than careful interjection of the parents into the therapeutic context could be counterproductive. Effective treatment often requires the therapist to attend to developmental issues, including the adolescent's ongoing work "negotiating levels of autonomy and dependence in relation to parents and families."[248] Moreover, harmful family dynamics may be especially pronounced in the case of some adolescent girls with substance use disorders. "It has been suggested that drug-abusing girls may need more attention with regard to family problems in that they often experience severe parental rejection and sexual or physical abuse."[249] The opportunity to work through identity issues and separation concerns in the relative safety of a therapeutic relationship protected from overbearing or anxious parental involvement may be a crucial component in an adolescent's earnest efforts to deal with drug use problems. On this understanding, then, an autonomic rule in favor of parental involvement could prejudge a clinical decision better left to the discretion of individual clinicians acting in context. In the final analysis, the decision whether (and how) to inform and involve parents in an adolescent's treatment for substance misuse is a complex clinical judgment likely to vary from instance to instance. The

244. *Id.* (stating that a family-based model looks at individual functioning in the context of one's family and analyzes recurring patterns of interaction).

245. Austin et al., *supra* note 102, at 68.

246. Muck et al., *supra* note 3, at 151 (emphasis omitted).

247. Deas & Thomas, *supra* note 101, at 179.

248. Winters, *supra* note 68, at 209.

249. *Id.* at 210.

tension between state law obligations to disclose and federal law obligations to maintain the adolescent's confidentiality are in this sense mirrored in a therapeutic tension between the need to attend to the autonomy interests of the adolescent on one side, and the potential advantages of family involvement on the other.[250]

IV. CONCLUSION

Adolescents in need of treatment for substance use disorders or mental illness can be involved in the decision-making process regarding their care in a number of different ways. In some states, and for some purposes, adolescents are permitted to act as independent decision-makers, or to have the "final say."[251] In most circumstances, parents, juvenile justice officials, and/or other adults are accorded the ultimate decision-making authority.[252] Even in these instances, however, adolescents and other minors can still remain involved by being informed of the available choices and their relative costs and benefits, by being invited to express a view based upon their understanding of those options, and by being permitted to influence the decision-maker through the expression of their preferences.[253] As one writer has put it: "We should tell [adolescents] that their participation is important, that their voices should be heard and their values and preferences taken into account."[254]

When the law does not permit adolescents or other minors to exercise independent and final authority, it is crucial that parents and clinicians communicate openly and clearly both about the child's opportunities for participating in the decision-making process and about the limits of that participation.[255] The adolescent or other minor should be treated with respect, which means that his or her "preferred choices and values are [regarded as] important and may often, but not always, be decisive."[256] But respectful treatment also means that, when the minor's preferences are not followed, he or she is helped

250. *See* Howard A. Liddle et al., *Multidimensional Family Therapy: A Science-Based Treatment for Adolescent Drug Abuse*, *in* HANDBOOK OF CLINICAL FAMILY THERAPY 128, 134 (Jay L. Lebow ed., 2005), *available at* http://iftandcs.org/Family%20Therapy/Handbook%20of%20Clinical%20Family%20Therapy.pdf (noting the importance of promoting adolescent independence in individual sessions and including the adoloscent's parents in therapy sessions).

251. *See* Rosenbaum et al., *supra* note 235, at S116 (noting that minor children have autonomy over certain kinds of health care decisions). This is certainly the case in most states with respect to consenting to treatment for substance misuse. *See supra* text accompanying notes 116–26.

252. Paul, *supra* note 64, at 309. *See also* Nissen, *supra* note 231, at 301 (noting that the juvenile justice system accounts for a majority of adolescent substance abuse treatment referrals).

253. Paul, *supra* note 64, at 309.

254. *Id.*

255. *Id.*

256. *Id.*

to understand the interests—relating to his or her wellbeing and to the wellbeing of the family unit—that have led the adult decision-maker to a different outcome.[257]

In addition to making efforts to include the minor in the decision-making process, and communicating openly with him or her about the decision, adult decision-makers with final authority who determine to pursue an outcome at odds with a minor's expressed wishes should do so only under certain limited circumstances.[258] Authorizing a therapeutic intervention over the objections of an adolescent or other minor thus should be avoided when it would produce "too little harm-avoidance or benefit," would be "unlikely to succeed without cooperation," would not "respect the human dignity of the child," or would "require the child to be physically or emotionally 'dragged to the clinic'" in a way that would "impair family or therapeutic relationships."[259]

When the law grants the minor the authority to decide, those legal rights should be honored.[260] If the treatment provider determines that the child's judgment does not further either his or her basic or developmental interests, these concerns should become part of the therapeutic conversation. A carefully made decision whether to consent to treatment, or to authorize the disclosure of confidential information, may require the minor to weigh his or her options in light of the consequences likely to result from competing choices. Sometimes the consequences on both sides of a decision will be unattractive, as, for example, when an adolescent who does not wish to authorize a disclosure to his or her parents seeks treatment in a jurisdiction that requires parental consent.[261] In such cases, the fact that the adolescent has decision-making rights does not mean that he or she is entitled to exercise those rights in a vacuum. Moreover, even in circumstances in which the adolescent possesses significant decision-making rights,

257. *Id.*

258. *Id.* at 306 (noting that the minor's preferred health care decision should be followed except in "rare" instances, but even then the decision to overrule the minor's choice should be in the minor's best interests).

259. *Id.* at 305.

260. Certainly, the rights accorded minors by the federal confidentiality law and regulations governing treatment for substance misuse disorders are an important example of this. *See supra* text accompanying notes 184–86; *see also, e.g.*, OFFICE FOR CIVIL RIGHTS, U.S. DEPT. OF HEALTH AND HUMAN SERV., THE HIPAA PRIVACY RULE AND ELECTRONIC HEALTH INFORMATION EXCHANGE IN A NETWORKED ENVIRONMENT 5. http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/healthit/individualchoice.pdf (last visited Nov. 18, 2011) (noting that a parent should not act on behalf of a child "when State or other law does not require the consent of a parent [to] . . . obtain a particular health care service" or a parent or guardian agrees "to a confidential relationship between the minor and . . . health care provider").

261. *See supra* text accompanying notes 176–82.

the law sometimes permits the treatment provider to disregard the minor's preferences if they pose a serious risk of harm either to the child or to others.[262]

With these principles in mind, we can now make some observations about Denise and Steve, the adolescents described in the case studies set out earlier. We know that in most states Denise's mother retains the legal right to authorize substance misuse treatment, even over Denise's objections, although many jurisdictions also require the independent judgment of either the treatment provider or a judge (or both).[263] It may be that Denise's basic and developmental interests require that she receive inpatient treatment for her substance misuse disorder and co-occurring mental disability, even though this will require a degree of coercion at odds with her autonomy interests and potentially at odds with maintaining a trusting therapeutic relationship with the treatment program. But whatever the relative weight of the costs and benefits associated with this decision, it is likely that Denise's chances for a favorable treatment outcome, as well as a healthy relationship with her mother, will be advanced if her mother and the treatment program are careful to undertake a decision-making process in which Denise is informed of the factors under consideration,[264] is permitted to participate by expressing her views, and is made aware that her views will be given weight in shaping the treatment that is authorized.

In Steve's case, it is clear that, absent Steve's written consent, the federal confidentiality law and regulations governing substance misuse treatment prohibit the counselors from sharing any patient-identifying information with Steve's parents, even for purposes of involving them in family-based treatment.[265] The

262. *See, e.g.*, 42 C.F.R. § 2.14(c)(2)(ii) (2010) (permitting a program director to contact a minor's parents to seek authorization to treat in circumstances where the minor lacks the capacity for rational choice).

263. *See supra* text accompanying notes 131–34.

264. At least to the extent that the information can be shared safely without undermining Denise's well-being. *See* Paul, *supra* note 64, at 309 (noting that explaining the decision-making process gives the child a sense of self-worth).

265. *See supra* text accompanying notes 183–92. As noted earlier, state laws governing the disclosure of mental health treatment information often are a good deal less restrictive than those governing substance misuse treatment. While substance misuse, like many mental disabilities, has the potential to impair a person's capacity for effective and rational decision making, the especially pronounced stigma associated with drug and alcohol misuse and the special concerns articulated by policy-makers decades ago that a rigorous system of patient confidentiality is necessary to encourage individuals, including adolescents, to seek substance misuse treatment, may be a sufficient basis for the legally distinct treatment that continues to be accorded to persons receiving drug and alcohol treatment. Under the federal Health Insurance Portability and Accountability Act of 1966 (HIPAA), Pub. L. No. 104-191 (1996), Steve's counselors also would be more likely to have authority to share information with his parents for purposes of involving them in his treatment for mental illness. 45 C.F.R. §§ 164.502(g)(1) and (3) (2010) deal with parents, guardians, or other persons acting in *loco parentis*. HIPAA approaches this as an adult serving in the capacity of a personal representative. Under § (g)(1), a personal representative is treated as if he or she is the individual to whom the health record pertains; i.e. stands in the patient's shoes for all use/disclosure decisions. In one respect, HIPAA provides a variation

exception in the federal regulations permitting a treatment program to contact parents to obtain authorization for treatment when the program director determines that the minor is incapable of making a rational choice would not apply in this instance,[266] because the proposed contact would not be for purposes of obtaining parental consent for treatment (assuming these events are taking place in a state in which minors are empowered under state law to consent to treatment on their own). An exception in the federal regulations for medical emergencies also would not provide a solution, both because these circumstances probably do not constitute a medical emergency for purposes of the federal law, and because that exception only allows disclosure to medical personnel.[267] Finally, the provisions governing court-ordered disclosures under Subpart E of the regulations are extremely restrictive and procedurally cumbersome. Their requirement of a judicial finding of "good cause"

on the approach of the federal substance misuse treatment confidentiality regulations: if the parent has authority to act on the minor's behalf for health care decisions, then the health provider is required to treat the parent as the personal representative, resulting in disclosure to the parent. *Id.* § (g)(3)(i). On the other hand, the parent is not treated as a personal representative to the extent the minor has consented to the health care and no other consent is needed, and the minor has not requested that the parent act as the personal representative. *Id.* § (g)(3)(i)(A). 45 C.F.R. § 164.502(g)(1) also contains a separate standard that governs the disclosure of information about an unemancipated minor to parents who are not acting as the personal representative. Under § 164.524, a patient generally is entitled to gain access to his or her own records. The provision related to unemancipated minors states that to the extent state law permits or requires disclosure of health information to a parent, the health provider may disclose that information (which would be given to the minor under § 164.524) to the parent. *Id.* § (g)(3)(ii)(A). Similarly, to the extent state law prohibits access of the minor's health information to parents, it cannot be released to the parent under § 164.524. *Id.* § (g)(3)(ii)(B). If there are no provisions in state law related to parental access to a minor's health information when the parent is not acting as a personal representative, then the provider may provide or deny access to a parent/guardian, provided the decision is made by a licensed care professional in the exercise of professional judgment. *Id.* § (g)(3)(ii)(C). A final provision that relates to a family's access to health information is 45 C.F.R. § 164.510 (2010). This section deals with disclosures of personal health information in a number of circumstances in which the patient is informed in advance of the use or disclosure and is given the opportunity to agree to, prohibit, or restrict the use or disclosure of protected health information. (The patient's oral agreement or objection to use/disclose is sufficient.) One of the circumstances deals with family members who are directly involved in the patient's care or payment related to that care. *Id.* § 164.510(b). The provider can disclose information (1) directly relevant to the family member's involvement in the patient's care or payment or (2) that informs the parent of the patient's location, general condition or death. *Id.* Before making either of these disclosures, however, the provider must obtain the patient's agreement; give the patient an opportunity to object and not get an objection; or reasonably infer that the individual does not object. *Id.* If the patient is deemed to be "not present" because of incapacity or an emergency situation, this section permits disclosures that the provider considers to be in the best interest of the patient, but limits the information to that which is directly relevant to the person's involvement in the patient's health care. *Id.* § 164.510(b)(3).

266. 42 C.F.R. § 2.14(c)(2)(ii) (2010).

267. *See id.* § 2.51 (noting that patient information can be disclosed to medical personnel to treat a condition that poses an immediate threat to the patient's health and requires immediate medical intervention).

to disclose would likely prevent the issuance of an authorizing court order to contact Steve's parents, absent other more compelling circumstances.[268]

In the end, the decision to contact Steve's parents would require the adolescent's written consent.[269] Of course, the treatment provider could make the provision of further counseling contingent on its receiving Steve's written permission to contact his parents.[270] In any event, Steve's exercise of his confidentiality rights, and his plan for dealing with his father's intolerance with respect to alcohol or drug use, ought to be an integrated part of the counseling agenda itself. While there is considerable legal regulation of these issues at both the federal and state level,[271] in the final analysis these questions more properly are framed as clinical issues that require the sound judgment of treatment professionals. Important legal obligations certainly are present, but they should not serve as the sole basis for decision making in these cases.

268. *See id.* § 2.64(d) (noting that "good cause" exists where the court finds that other ways of obtaining the information would be unavailable or ineffective and that the interests in disclosure outweigh the potential negative results for the patient); *id.* §§ 2.61–.67 (outlining the procedures that must be taken before an order may be issued).

269. *See id.* § 2.31(a) (outlining the requirements for written consent).

270. *See, e.g.*, Margaret K. Brooks, *Legal and Ethical Issues*, *in* TIP 32: TREATMENT OF ADOLESCENTS WITH SUBSTANCE ABUSE (Y-Lang Nguyen ed., 1999), *available at http://www.ncbi.nlm.nih.gov/books/NBK26046/?report=printable/* (noting that a provider could limit the period of the treatment for adolescents who refuse parental notification). This assumes that there is no other state law that provides Steve with an enforceable right to receive substance misuse services. *See supra* notes 116–26 and accompanying text.

271. *See supra* Part II.