



[J Child Adolesc Subst Abuse](#). Author manuscript; available in PMC 2016 Mar 6.

PMCID: PMC4393016

Published in final edited form as:

NIHMSID: NIHMS442797

[J Child Adolesc Subst Abuse](#). 2015; 24(3): 166–176.

PMID: [25870511](#)

Published online 2015 Mar 6. doi: [10.1080/1067828X.2013.777380](https://doi.org/10.1080/1067828X.2013.777380)

## What Can Parents Do? A Review of State Laws Regarding Decision Making for Adolescent Drug Abuse and Mental Health Treatment

[MaryLouise E. Kerwin](#),<sup>a,b,\*</sup> [Kimberly C. Kirby](#),<sup>a,c</sup> [Dominic Speziali](#),<sup>d</sup> [Morgan Duggan](#),<sup>b</sup> [Cynthia Mellitz](#),<sup>b</sup> [Brian Versek](#),<sup>a</sup> and [Ashley McNamara](#)<sup>a</sup>

<sup>a</sup>Treatment Research Institute

<sup>b</sup>Rowan University

<sup>c</sup>University of Pennsylvania School of Medicine

<sup>d</sup>Rutgers University

\*Correspondence should be directed to Dr. MaryLouise Kerwin, Department of Psychology, Rowan University, 201 Mullica Hill Road, Glassboro, NJ 08028. [kerwin@rowan.edu](mailto:kerwin@rowan.edu)

[Copyright notice](#)

### Abstract

This study examined US state laws regarding parental and adolescent decision-making for substance use and mental health inpatient and outpatient treatment. State statutes for requiring parental consent favored mental health over drug abuse treatment and inpatient over outpatient modalities. Parental consent was sufficient in 53%–61% of the states for inpatient treatment, but only for 39% – 46% of the states for outpatient treatment. State laws favored the rights of minors to access drug treatment without parental consent, and to do so at a younger age than for mental health treatment. Implications for how these laws may impact parents seeking help for their children are discussed.

**Keywords:** decision-making authority, consent, state laws, treatment

Parents and guardians are responsible for creating and fostering a safe, healthy, and stimulating environment to maximize their child's growth until the age of majority. Unfortunately, adolescents sometimes challenge this parental obligation by engaging in risky behaviors that compromise their health and well-being. As a result, parents of these adolescents are faced with the formidable task of trying to obtain treatment for their child at a time when many adolescents may not agree that they need treatment or may object to treatment. In 2010, about 1.8 million youths (12–17) in the United States needed treatment for an alcohol or illicit drug use problem ([SAMHSA, 2011](#)); however, rates of treatment for adolescent substance abusers are low (6%–10%) and have remained stable over the past 22 years ([Ilgen et al., 2011](#)). Explanations for this treatment gap include the pervasive stigma associated with substance use disorders (SUD), financial barriers, lack of confidence in the effectiveness of treatment, lack of motivation by the adolescent to seek treatment, and denial that problems associated with substance use in adolescence require treatment ([Ballon, Kirst, & Smith, 2004](#); [Mensingher, Diamond, Kaminer, & Wintersteen, 2006](#); [Owens et al., 2002](#); [Simmons et al., 2008](#)). However, one barrier that is not discussed often is the possible legal barrier confronting parents who

want to secure treatment for their adolescent's substance use. Whereas parents have the authority to consent for medical treatment for their children for most problems up to the age of majority in most states ([Committee on Bioethics, 1995](#), reaffirmed in 2007), it is unclear if state laws help or hinder parents who recognize that their children need substance abuse or mental health treatment.<sup>1</sup>

Starting in the late 1960s, the federal government and states began to recognize that the interests of minors, their parents, and the state were not always congruent with one another ([English, 2002](#); [Melton & Wilcox, 1989](#)). Health professionals recognized that adolescents might be discouraged from seeking help for personal problems if parents were told about the adolescent's concerns and behaviors ([Committee on Bioethics, 1995](#); [Council for Scientific Affairs, 1993](#); [Ford, Bearman, & Moody, 1999](#); [Marks, Malizio, Hoch, Brody, & Fisher, 1983](#); [Society for Adolescent Medicine, 1997](#)). Furthermore, it was thought that giving minors more control over their health care decisions might enhance their response to treatment ([Adleman, Kaser-Boyd, & Taylor, 1984](#)). As a result, many states began to accord minors limited autonomy to provide consent for treatment of sensitive and private issues, such as pregnancy, sexually transmitted diseases, and drug, alcohol or mental health problems ([English, 1990](#); [Holder, 1992](#); [Santelli et al., 1995](#)).

Since these laws permitting adolescents to seek help for reproductive health, substance use, and mental health concerns were enacted, the legal system has grappled with the competence of a minor to provide informed consent for treatment. The crux of the debate concerns the cognitive abilities of an adolescent to make decisions affecting their long-term welfare ([Committee on Bioethics, 1995](#)). Initial evidence for minor competence was based on Piaget's stages of cognitive development positing that children as young as twelve years old were capable of formal operational reasoning ([Grisso & Vierling, 1978](#)). Similarly, minors as young as 14 years of age did not differ significantly from adults in their reasoning and understanding of hypothetical medical treatment information ([Weithorn & Campbell, 1982](#)) or in their judgments about hypothetical situations involving risky behaviors ([Beyth-Marom, Austin, Fischhoff, Palmgren, & Jacobs-Quadrel, 1993](#); [Quadrel, Fischhoff, & Davis, 1993](#)). These findings bolstered the argument that minors may have more capacity for informed decision-making than had previously been allowed ([Lewis, Lewis, Lorimer, & Palmer, 1977](#); [Melton, 1983](#); [Poncz, 2008](#); [Scott & Steinberg, 2009](#)). However, one important element of informed consent that has largely been ignored is the minor's competence to understand and accurately assess the risks of not undergoing treatment ([Hickey, 2007](#)).

Placing high dependence on adolescent decision-making may pose problems when there is little incentive for the adolescent to seek treatment on his or her own. In contrast to most medical and mental health problems, drug and alcohol use has immediate positive effects that tend to overshadow the current and future negative consequences of use; therefore, teenagers are less likely to recognize problematic use ([Cho, Hallfors, & Iritani, 2007](#); [Stueve & O'Donnell, 2005](#)) and to seek treatment. Furthermore, peer pressure to use drugs and alcohol may mitigate any motivation an adolescent has to seek treatment ([Poulin, Kiesner, Pedersen, & Dishion, 2011](#)). Finally, adolescent decision-making may be impaired by use of alcohol or drugs.

In fact, few adolescents enter drug treatment of their own accord. Parental pressure is positively associated with treatment entry ([Caldeira et al., 2009](#)) yet few referrals to adolescent drug treatment are from parents (see Kirby et al. this issue). In a study of adolescent drug treatment, only 10% of referrals were from family or the adolescent ([Simmons, et al., 2008](#)). In 2010, only about 16.5% of all admissions to drug treatment for youth ages 12–17 occurred by self-referral or referral by other individuals compared to nearly half (45.6%) occurring through the criminal justice system ([USDHHS, 2012](#)). These data indicate that many adolescents who need treatment for drug addiction are not seeking it, leaving open the question of what role parents can have in helping their child.

Legal requirements for minor consent vary widely by state ([English, 2002](#); [English, Bass, Boyle, & Esragh, 2010](#); [Lallemont, Mastroianni, & Wickizer, 2009](#); [Weisleder, 2004, 2007](#)). Most recently, [Lallemont et al. \(2009\)](#) conducted a thorough review of all 50 states' laws concerning decision-making authority regarding voluntary inpatient treatment for substance-abusing adolescents and noted that all states had applicable laws, some deferring to the decision of the parent and some to the child. Notably, the majority of the states failed to indicate what happens when a parent and child disagree about the need for treatment.

The purpose of this paper was to provide an up-to-date report examining consent and decision-making authority for adolescent drug treatment and to expand on [Lallemont et al. \(2009\)](#) by: 1) including laws for outpatient as well as inpatient treatment and mental health as well as drug abuse treatment; 2) comparing the laws for inpatient and outpatient modalities to see if parental consent was more likely to be required for inpatient settings that could remove the child from the parent's home; and 3) comparing the laws for the two types of treatment to see if there were differences in parental and adolescent consent in mental health versus drug abuse treatment. We were interested in comparing laws for substance abuse and mental health treatment because historically, parents have been underutilized in their child's substance abuse treatment ([SAMSHA, 2010a](#)), but may be more likely to be included in mental health treatment (e.g., [Alkhatib, Regan, & Jackson, 2008](#); [Tan, Passerini & Stewart, 2007](#)) and because we have noted significant differences between substance abuse and mental health treatment with respect to other policies ([Kerwin, Walker-Smith, & Kirby, 2006](#)).

## Method

---

### Procedure

Using LexisNexis, we searched for state requirements (i.e., laws, codes, rules, and regulations) regarding informed consent for both inpatient and outpatient substance abuse and mental health treatment in all 50 states and Washington, D.C. In identifying the state laws, we looked only at those laws pertaining to voluntary admission for treatment. Data were collected in June, 2012.

After the state laws were located, the laws regarding consent for a minor to receive drug and mental health treatment were first coded into the following categories: Parent Consent Only (i.e., only the parent could consent for the child's treatment), Either Parent or Minor Consent (i.e., either the minor or parent could consent for treatment), Both Parent and Minor Consent (i.e., both the parent and the child are required to provide consent for treatment), or Minor Consent Only (i.e., only the minor could consent for treatment). In addition, information regarding a specified age over which a minor could consent for treatment was also included in the data if it was specified by the state.<sup>2</sup> If a state specified an age cut-off for minor consent, the law was classified as minor consent; however, parents must provide consent for children younger than the age cut-off. For example, if a state allowed a minor 16 years and older to consent for outpatient drug treatment, parents will need to provide consent for treatment of children under the age of 16. It was assumed that all states allowing minors to consent for treatment would do so only if the minor was deemed competent to provide informed consent (i.e., not cognitively challenged).

The following decision rules were utilized to categorize the laws of each state. Those laws pertaining only to emancipated minors and minors considered to be the age of majority by virtue of their status (e.g., married, parents themselves) were not categorized because these "minors" were considered to be adults according to most state laws. Similarly, we excluded laws designed specifically for wards of the state. For the purposes of classification, we excluded laws pertaining to emergency situations only when parents would not provide consent or could not be found. Some state laws for consent to mental health or drug treatment did not specify modality (e.g., used terms such as "mental health agency"). In these instances, the law was assumed to apply to both inpatient and outpatient treatment. Finally, in

categorizing the laws, we attempted to capture the reasonable essence of the law in daily practice. In other words, we considered what would happen typically if a minor presented him/herself for treatment or a parent presented him/herself to a treatment program asking for treatment for his/her child. For example, if a state law specified that parents could petition the court to involuntarily commit their child to treatment, we decided that this required extraordinary effort and resources; therefore, this exception was not coded as parents having right to consent for their child's treatment.

Four types of restrictions could be placed on minor or parental consent. The limitation was noted in the results for the following three restrictions: 1) minor consent was allowed for treatment, but parental notification of the minor's admission was required; 2) minors consent for drug treatment was allowed but only for observation and diagnosis or for a specified period of time after which parental consent was required; and 3) minor or parent consent was allowed; however, if parents requested admission for their children, both the minor and parent had to consent for treatment. The fourth restriction specified that a minor could consent to treatment alone if the health care provider determined that involvement of the parents would be detrimental to treatment. These laws were coded as requiring either minor or parent consent and the restriction was noted.

Applying these decision rules to state laws was difficult in some cases. To ensure that we categorized the state law appropriately in every case that eluded clear interpretation and categorization, we contacted (telephone and email) officials or representatives within that state's court system, experts within state-based legal aid centers, and agents within the state's department of human service's mental health or substance abuse division. Oftentimes, those offering guidance referred us to other individuals in the agency with whom clarification was also requested. Following contact, we attempted to attain clarification and consensus amongst the majority of those contacted representing the state. Using this method, a categorical determination was then made. In the event that no law could be found that specifically mentioned type and modality of treatment, confirmation was requested primarily through employees at university and state court law libraries. If they verified that there was no specific law, the category was coded as "No Specific Law Found."

## Data Analysis

Although we explicitly noted when no law specific to drug or mental health treatment was found, for the purposes of secondary classification (described below) and data analysis, we assumed that in these states the laws governing consent for medical care would apply, in which case we assumed parental consent only was required.

Finally, because the purpose of the study was to examine the rights of parents, the laws were further classified into parent consent required (i.e., states that specified parent consent only or both parent and minor consent), parental consent sufficient (i.e., states that specified parent consent only for treatment plus those states that allowed either parent or minor consent), minor consent sufficient (i.e., states that specified minor consent only plus those states that allowed either parent or minor consent), and minor consent required (i.e., states that specified minor consent only or both parent and minor consent). We believe these categories best reflect a continuum of parental decision-making from most authority to least authority. We then used Chi Square analyses to compare the prevalence of consent laws by treatment modality and type for parent versus minor decision-making authority.

## Results

---

[Table 1](#) contains each state's statutes regarding the type of decision-making authority required for adolescents to enter inpatient or outpatient drug or mental health treatment. If the state specified an age at which the minor was capable of making this decision, the age is indicated in parenthesis in the table

after the type of consent required. Restrictions to minor or parental consent are indicated in the notes to the table.

Table 1

## Parent and Adolescent Decision-Making Authority for Inpatient and Outpatient Drug and Mental Health Treatment

Missouri	Either	Either	Parent	Parent
Montana	Minor	Minor	Either ( $\geq 16$ )	Either ( $\geq 16$ )
Nebraska	Either	Either	Either	Either
Nevada	Minor	Minor	Parent	Parent
New Hampshire	Minor ( $\geq 12$ )	Minor ( $\geq 12$ )	Either	Either
New Jersey	Minor	Minor	Parent	Parent
New Mexico	Minor ( $\geq 14$ )	Minor ( $\geq 14$ )	Minor ( $\geq 14$ )	Minor ( $\geq 14$ )
New York	Either <sup>e</sup>	Either <sup>e</sup>	Either ( $\geq 16$ )	Either <sup>e</sup>
North Carolina	Parent	Minor	Parent	Minor
North Dakota	Minor ( $\geq 14$ )	Minor ( $\geq 14$ )	Parent	Parent
Ohio	Minor	Minor	Parent	Minor ( $\geq 14$ )
Oklahoma	Minor ( $\geq 16$ )	Minor	Minor ( $\geq 16$ )	No Specific Law
Oregon	Minor <sup>a</sup>	Minor ( $\geq 14$ )	Parent	Minor ( $\geq 14$ )
Pennsylvania	Either	Either	Either ( $\geq 14$ )	Either ( $\geq 14$ )
Rhode Island	Either <sup>e</sup>	Either <sup>e</sup>	Both	Both
South Carolina	Minor ( $\geq 16$ )	Minor ( $\geq 16$ )	Minor ( $\geq 16$ )	Minor ( $\geq 16$ )
South Dakota	Either	Either	Both ( $\geq 16$ )	Both ( $\geq 16$ )
Tennessee	Either ( $\geq 16$ )	Either ( $\geq 16$ )	Minor ( $\geq 16$ )	Minor ( $\geq 16$ )
Texas	Either ( $\geq 16$ )	Either ( $\geq 16$ )	Either ( $\geq 16$ )	No Specific Law
Utah	Parent	Parent	No Specific Law	No Specific Law
Vermont	Minor ( $\geq 12$ )	Minor ( $\geq 12$ )	Minor ( $\geq 14$ )	Minor ( $\geq 14$ )
Virginia	Both ( $\geq 14$ )	Minor	Both ( $\geq 14$ )	Minor
Washington	Parent	Minor ( $\geq 13$ )	Minor ( $\geq 13$ )	Minor ( $\geq 13$ )
West Virginia	Minor	Minor	Both ( $\geq 12$ )	Both ( $\geq 12$ )
Wisconsin	Parent	Either ( $\geq 12$ ) <sup>b</sup>	Both ( $\geq 14$ ) <sup>g</sup>	Both ( $\geq 14$ )
Wyoming	No Specific Law	No Specific Law	No Specific Law	No Specific Law

[Open in a separate window](#)

*Note.* Parent = Parental consent only required; Minor = Minor consent only required; Either= Either parental or minor consent; Both= Both parental and minor consent required; No Law Found = No specific law was found addressing that particular form of treatment. If a state specified an age at which a minor was considered mature, it is indicated in parenthesis after the type of consent required.

<sup>a</sup>Parents are notified if minor is only one to provide consent.

<sup>b</sup>Parents need to consent for treatment; minor may consent for observation/diagnosis (in some cases may be for limited periods of time (e.g., < 72 hours).

<sup>c</sup>Minor may consent alone; however, if parent wants child in treatment, both parent and minor need to consent.

<sup>d</sup>Iowa General Assembly Senate File 2016 states that minor may consent without consent of parent. Although this is not a law, we assumed this would apply in practice.

<sup>e</sup>A minor may consent for treatment if practitioner determines that requiring parental consent would have detrimental effect on course of therapy.

<sup>f</sup>Only for assessment and diagnosis; law is unclear regarding treatment

<sup>g</sup>Parent only if minor refuses to consent.

## Consistency in Consent Laws

Only 18 states (35%) were consistent in consent requirements across treatment type and modality (i.e., inpatient drug, outpatient drug, inpatient mental health, outpatient mental health). In three of the 18 states (AK, AR, WY), the consistency was represented by no specific laws for any of the four categories of treatment. When laws specified consent requirements, in nine states only minor consent was required (AL, CO, IN, LA, MN, NM, OK, SC, VT) and in five states either minor or parental consent was acceptable (ID, NE, NY, PA, TX). In one state (UT), parental consent was required for drug treatment, but there were no specific laws for mental health treatment.

In 15 states (29%), there was a difference in consent requirements across treatment type (drug abuse vs. mental health), with 7 states being more restrictive of parental authority by specifying that only minor consent was acceptable for drug abuse treatment, while allowing parental (NV, NJ, ND) or either parental or minor consent (KS, MA, MT, NH) for mental health treatment. Only 3 states (CA, IA, TN) were more restrictive of parental authority for mental health treatment requiring minor consent for mental health services while allowing either parents or minors to consent to drug abuse treatment. In 2 states (AZ, MO), parental consent was required for mental health treatment, but either parents or minors could consent to drug abuse treatment. In 2 states (RI, SD), both parents and minors needed to consent for mental health treatment while either the parent or minor could consent to drug treatment. In one state (WV), minor consent was sufficient for drug abuse treatment, while both parents and minors had to consent to mental health treatment.

Only 3 states (6%) had different consent requirements across treatment modality (inpatient vs. outpatient). Two states (MS, NC) required parental consent only and one state (VA) required both parental and minor consent for inpatient treatment, while minor consent only was required for outpatient treatment; MS had no specific law for mental health outpatient treatment.

In 15 states (29%), there was no consistent pattern in consent requirements. In 12 states, the consent requirement was consistent except in one category. In 8 of these 12 states (DC, HI, KY, ME, OH, OR, WA), the exception was making parent consent sufficient or required for one of the inpatient treatments (3 drug, 5 mental health) while only minor consent was required for the other three settings. In the other 4 of the 12 states (CT, DE, MD, MI), the exception was for one of the outpatient treatment settings (2 drug, 2 mental health) which allowed or required minor consent when parental consent or either parental or minor consent was specified in the other three settings. For the remaining 3 of the 15 states (FL, GA, WI), the consent requirement was consistent across only two of the four treatment categories and there was no clear pattern. In one state, there was consistency across the outpatient modality (FL), in another the consistency was within mental health treatment (WI), and in the last state (GA), inpatient drug abuse treatment and outpatient mental health treatment were consistent.

## Parent versus Minor Decision-Making Authority

[Table 2](#) presents a summary of the number of states with each of the four primary categories of decision-making (i.e., Parent Consent Only, Either Parent and Minor Consent, Both Parent and Minor Consent, and Minor Consent Only) as a function of the four treatment categories. These four categories represent a continuum of parental authority. Parent consent only (Parent consent required and sufficient) represents the greatest degree of authority, as it allows the parent to place their child in treatment with or without their agreement, but does not allow the child to receive treatment without the parent's knowledge. The next level is either parent or minor consent (Parent consent sufficient, but not required), which affords the parent the same degree of authority for placing their child in treatment, but allows the child to access treatment independent of the parent. Laws requiring the consent of both the parent and child restrict the parent's ability to place their child in treatment if the child does not consent (Parent consent required, but insufficient). Finally minor consent only places the decision-making authority wholly and completely with the minor (Parent consent is not sufficient or required). [Table 3](#) presents the secondary classification of these four categories into parental consent required, parental consent sufficient, minor consent sufficient, and minor consent required.

**Table 2**

Number of states with each of four types of decision-making authority for inpatient and outpatient drug and mental health treatment

Type of Authority	Drug Treatment		Mental Health Treatment	
	Inpatient	Outpatient	Inpatient	Outpatient
Parent Consent Only <sup>a</sup>	9	4	18	13
Either Parent or Minor Consent	18	16	13	10
Both Parent and Minor Consent	2	0	6	4
Minor Consent Only	22	31	15	24
Total Number of States	51	51	52 <sup>b</sup>	51

<sup>a</sup>States with No Specified Law were counted in the Parent Consent Only category.

<sup>b</sup>Iowa is counted twice because of their law regarding both parent and minor consent for treatment.

**Table 3**

Percent (and number) of states where parental or minor consent is required or sufficient and minimum age for minor consent by treatment type and treatment modality

	Drug Abuse		Mental Health	
	Inpatient	Outpatient	Inpatient	Outpatient
Parent Consent Required <sup>a</sup>	22(11)	8(4)	47(24)	33(17)
Parent Consent Sufficient <sup>b</sup>	53 (27)	39 (20)	61 (31)	46 (23)
Minor Consent Sufficient <sup>c</sup>	78(40)	92 (47)	55 (28)	67 (34)
Minor Consent Required <sup>d</sup>	47(24)	61 (31)	41(21)	55(28)
Minor Consent Allowed <sup>e</sup>	82(42)	92(47)	67(34)	75(38)
No Age Specified <sup>f</sup>	62(26)	62(29)	24 (8)	36 (14)
Age Specified <sup>g</sup>	38(16)	38 (18)	76 (26)	63(24)
Minimum Age ≥ 12	44 (7)	39 (7)	8(2)	17(4)
Minimum Age ≥ 13	44 (7)	44 (8)	12(3)	25(6)
Minimum Age ≥ 14	69(11)	72 (13)	50(13)	63(15)
Minimum Age ≥ 15	69(11)	78 (14)	54(14)	67(16)
Minimum Age ≥ 16	100 (16)	100 (18)	100 (26)	100 (24)

<sup>a</sup>Parent consent considered to be required when the state law was coded as parent consent only or both parent and minor consent

<sup>b</sup>Parental consent was considered sufficient when the state law was coded as parent consent only or as either parent or minor consent

<sup>c</sup>Minor consent was considered sufficient when the state law was coded as minor consent only or as either parent or minor consent

<sup>d</sup>Minor consent was considered to be required when the state law was coded as minor consent only or both parent and minor consent

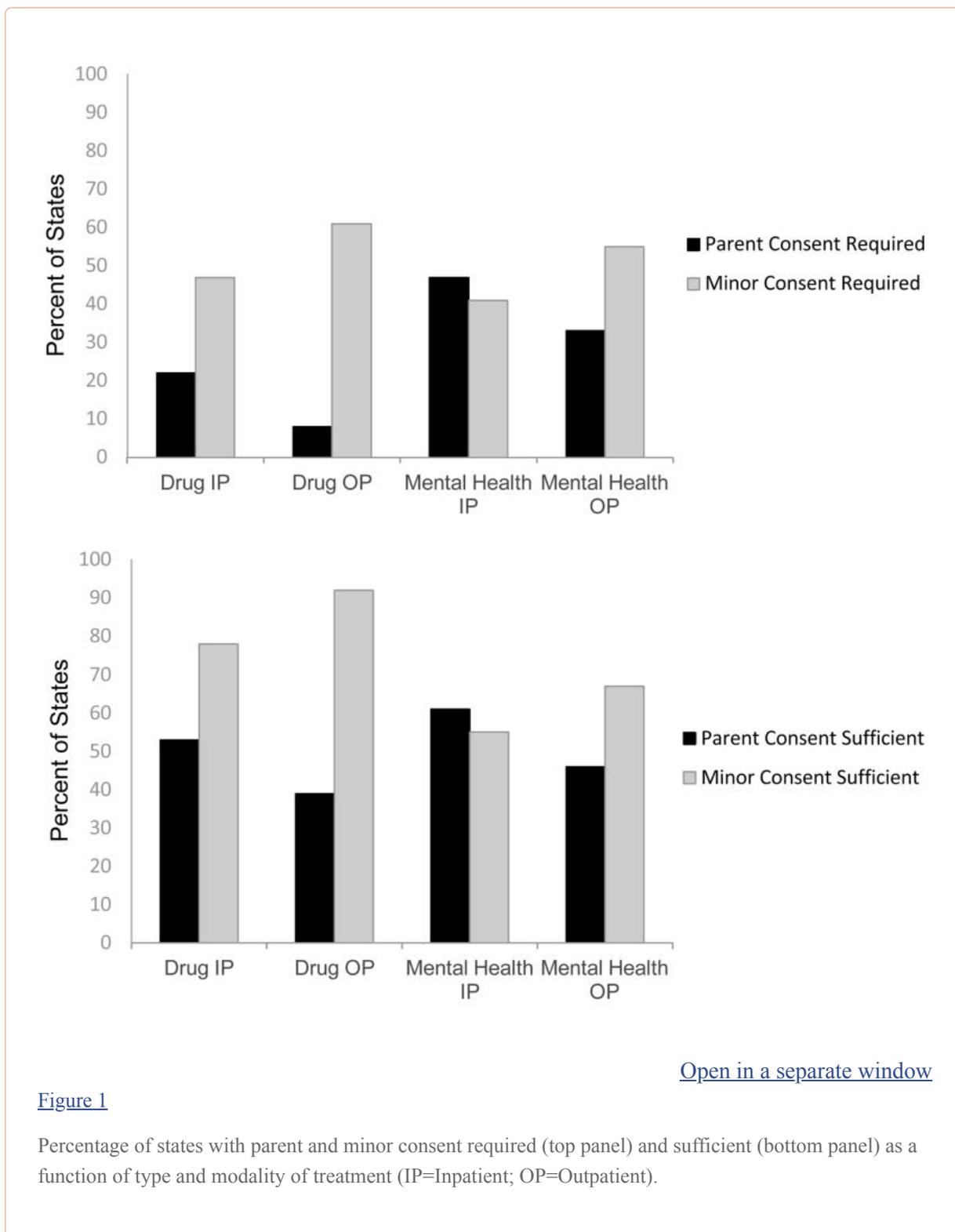
<sup>e</sup>Minor consent was considered to be allowed when the state law was coded as minor consent only, either parent or minor consent, or both parent and minor consent

<sup>f</sup>Denominator is the number of states that allowed minors to consent

<sup>g</sup>For each age, the cumulative percent (and number) of states specifying that age are presented.

[Figure 1](#) presents a comparison of the number of states in which parent versus minor consent is required (top panel) and the number of states in which parent versus minor consent is sufficient (bottom panel). Examined in this way, several patterns emerge in the data. Minor consent was more frequently required for inpatient and outpatient drug abuse and outpatient mental health treatment relative to parent consent. Parent consent was more frequently required for mental health inpatient treatment than minor consent. Also, parent consent was more frequently required for mental health treatment than for drug abuse treatment regardless of modality. Finally parental consent was more

frequently required for inpatient versus outpatient treatment regardless of treatment type. A chi-square analysis across the four combinations of treatment and modality was statistically significant when parent or minor consent was required ( $\chi^2(3) = 15.5, p = 0.001$ ).



State laws favored the consent of the minor as sufficient for inpatient and outpatient drug treatment and outpatient mental health treatment relative to the consent of the parent. The laws were approximately evenly split between minor and parent consent being sufficient for inpatient mental health treatment. Within type of treatment, minor consent was more frequently sufficient for outpatient versus inpatient

care regardless of whether it was drug or mental health treatment. A chi-square analysis across the four combinations of treatment and modality approached statistical significance ( $\chi^2(3) = 7.71, p = 0.082$ ) when parent or minor consent was sufficient.

### Age for Minor Consent

[Table 3](#) also depicts the minimum age specified by states for minors to consent (including minor consent only, either parent or minor consent, and both parent and minor consent categories) for drug and mental health treatment. The majority of states (62%) did not specify a minimum age required to consent for inpatient or outpatient drug treatment. In contrast, for states allowing minor consent to mental health inpatient and outpatient treatment, only 24% and 36%, respectively, failed to specify a minimum age. For drug treatment, 16 (38%) states specified a minimum age at which a minor could consent to inpatient and 18 (38%) states specified a minimum age for outpatient drug treatment, compared to 26 (76%) and 24 (63%) states for inpatient and outpatient mental health treatment, respectively.

When states did specify a minimum age for consent for treatment, more states allowed younger minors to consent for drug treatment compared to mental health treatment. About 44% of the states that specified a minimum age for minor consent for inpatient (7 out of 16) and/or outpatient (8 out of 18) drug treatment specified a minimum age of 13 years old or less. Conversely, for mental health treatment, of the 26 and 24 states that specified a minimum age for minor consent for mental health treatment, 3 (12%) and 6 (25%) states specified a minimum age of 13 years old or less for inpatient and outpatient treatment, respectively. For states specifying a minimum age for minor consent, the modal age for drug abuse treatment regardless of modality was 12 years old while the modal age for mental health treatment was 15 and 14 years old for inpatient and outpatient treatment, respectively.

### Discussion

---

This study extends the work of [Lallemont et al. \(2009\)](#) by reporting and comparing laws for both drug abuse and mental health inpatient and outpatient treatment. Our results revealed that just over one third of the states had consistent consent laws across treatment types and modalities. More states differed across treatment type than treatment modality, but there was no consistent pattern in the way that they differed. The rationale for the differences in consent requirements between inpatient and outpatient modalities and drug abuse and mental health treatment types is not clear.

As we hypothesized, when parental consent was required for a minor to be admitted to either drug or mental health treatment, more states required parental consent for inpatient modalities compared to outpatient modalities. However, across treatment type, more than twice as many states required parental consent for mental health treatment compared to drug treatment. Also, while parental consent was more likely to be required for inpatient treatment, it was still infrequently required for drug abuse treatment, regardless of modality, and required in fewer than half of the states for mental health treatment regardless of modality. Clearly most states do not require parental consent for treatment of their minor child. In three of the four treatment categories, a greater number of states required minor consent than required parental consent. The only exception was in mental health inpatient treatment where parental consent was required in 47% of the states and minor consent was required in 41%.

Fortunately, parental consent need only be sufficient for parents to request and receive assistance for their child who may need treatment. Parental consent was sufficient to admit a minor to inpatient drug and mental health treatment in just over half of the states and in about half of the states for outpatient mental health treatment; however, it was sufficient in only twenty states for admission to outpatient drug treatment. State laws clearly favored the rights of minors to independently access drug treatment compared to mental health treatment.

For those states that allowed a minor to consent for treatment, the minimum age required for this consent was unspecified for nearly two-thirds of the states for drug treatment compared to a quarter to one-third of the states for mental health treatment. When a minimum age for minor consent was specified, the modal minimum age for minor consent to drug treatment was 12 years old compared to 14 or 15 years old for mental health treatment.

The rationale for why states afford more decision-making authority at a younger age to minors seeking drug treatment compared to mental health treatment is unclear. State laws may reflect professional association policies asserting that adolescents should have the right to seek confidential and private care for sensitive health issues ([Council for Scientific Affairs, 1993](#); [Ford, English, & Sigman, 2004](#); [Society for Adolescent Medicine, 1997](#)). Alcohol and drug use by adolescents is illegal; therefore, any breach of confidentiality may result in legal consequences for the minor. In addition, parents may punish their child for drug use, whereas, this is less likely to be the case with mental health problems. Perhaps this preference towards minor consent for drug treatment reflects a perception that mental health treatment is more similar to general medical treatment than drug treatment. Alternatively, these results may simply reflect differences in education, training, and licensure between mental health and addiction professionals. In a review of state laws comparing licensing requirements for drug and alcohol counselors to mental health counselors, state requirements for training and experience differed substantially for these two types of counselors ([Kerwin et al., 2006](#)). An exploration of the legislative history of each state's minor consent law for drug treatment revealed no consistent pattern in the rationale for choosing one age over another age ([Weisleder, 2007](#)). Furthermore, the variations in minimum age for minor consent for drug treatment and mental health treatment do not appear to reflect scientific findings regarding adolescent decision-making capacity. These public policy considerations are the mutual responsibility of both scientists and policymakers; scientists should seek to inform policymakers and policymakers should seek relevant empirical evidence when crafting laws ([Meyer, 2007](#); [Sullivan, 2008](#)).

Allowing adolescents to access care privately and without parental consent probably removes important barriers to care for adolescents who wish to receive help without suffering potentially negative consequences that would come with the parent's knowledge of the problem. This is likely a significant advantage for teens who are motivated to receive help; however, it appears that very few adolescents initiate substance abuse treatment of their own accord. In most cases, adolescents have to be court mandated to treatment ([SAMHSA, 2010b](#)). Drug use interferes with attention, memory and executive functioning ([Thoma, et al., 2011](#); [Witt, 2010](#)), making it less likely that adolescents will identify and/or recognize the negative consequences of use and seek treatment independently. State laws making minor consent sufficient for treatment pose no barrier for parents seeking help for their children, but laws that require minor consent may present a barrier to treatment for adolescents. More research is needed to understand the decision-making abilities of adolescents about seeking treatment, especially when they themselves are using drugs.

When families live in a state that requires a minor to consent to treatment, what happens when these minors refuse and/or won't seek treatment? Parents may have only a few options available. They can: (a) try to "force" their unwilling child into treatment; however, even if they succeed in getting the child in the treatment door, minors in these states would be allowed legally to refuse the treatment and to discharge themselves at any point during treatment, (b) involve extended family and friends to help influence the adolescent (for a discussion of these strategies, (see Kirby et al., this issue), (c) call upon other systems (e.g., legal, religious) to help them compel their child into treatment, (d) transport their child across state lines to a state where minor consent is not necessary, providing they have the resources, and (e) parents may give up and hope that the problem resolves itself without too much damage to their child.

Although the legal system is involved in just under half of adolescent treatment admissions ([SAMHSA, 2010b](#)), little research has investigated the strategy of involving other systems to compel a minor into treatment. In a study exploring barriers to drug treatment, 20% of parents whose teens were in a residential treatment program reported that they had been told by a treatment program that the child must be in the legal system to be admitted to treatment ([Wisdom, Cavaleri, Gogel, & Nacht, 2011](#)). The authors report that the parents experienced “a large amount of frustration.” (p. 182). “One parent shared in detail the uphill battle she faced in finding treatment. After a psychiatrist refused to admit her son to a residential treatment facility because the son refused treatment, she resorted to legal action. Here, too, she found significant resistance. ‘I called the police six times, [and] every time they refused to have him.... They didn’t want to waste their time.’ She concluded, ‘Getting him [into residential treatment] was a miracle.’” (p. 182). It is unclear how representative this parent’s experience is with respect to seeking help for her child; however, there may be a variety of avenues of legal influence that could potentially be a fruitful area for future research.

Another option for a parent may be to transport their child to a state that allows parental consent only so that the minor does not need to consent and cannot refuse treatment. In a review of [The National Association for Therapeutic Schools and Programs \(2012\)](#), 112 of 131 (85%) programs are in states with parent consent sufficient for either drug or mental health treatment. Interestingly, 40 of the 131 (31%) programs are located in Utah, a state in which a parent may submit a non-consenting minor for treatment if a neutral and detached fact finder determines that the minor needs treatment and the non-consenting minor will not be discharged upon request if s/he continues to meet admission requirements ([Lallemont, et al., 2009](#)). Unfortunately, there are a number of noted problems with these types of programs ([Friedman et al., 2006](#)) and a lack of methodologically controlled outcome studies ([Scott & Duerson, 2010](#); [Wilson & Lipsey, 2000](#)). In addition, the effect of this type of coercion on the parent-adolescent relationship is unknown.

A final option is for parents to become frustrated in the face of their child’s drug use. Compared to investigating how parents might contribute to their teen’s problems, relatively little attention has focused on how parents are affected by their teen’s substance use. It is possible that stress and ineffective parental coping strategies may contribute to poorer parental functioning, which in turn might result in a maintenance of, or increase in, the adolescent’s substance use ([McGillicuddy, Rychtarik, Duquette, & Morsheimer, 2001](#); [Stice & Barrera, 1995](#)). Furthermore, health care professionals may interpret parental frustration and stress associated with adolescent substance use as lack of awareness or denial of their child’s drug use ([Wisdom, et al., 2011](#)). In summary, more research is needed on what obstacles confront parents and how best to address these obstacles. In addition, adolescents apparently are not motivated to seek existing treatments. Another future area for research is how to design and create treatment options that are effective and appealing to adolescents.

An important point that cannot be emphasized enough is that parental consent for treatment should be considered independently from the adolescent’s right to confidentiality during treatment. In other words, parental consent for treatment should be considered separately from the adolescent’s right to confidentiality during the treatment process ([Dyer & MacIntyre, 1992](#); [Fortunati & Zonana, 2003](#)). Those states that require parents to be notified that their adolescent has consented for treatment recognize the parent’s right to know what is happening with their minor child. Although these states include parents, the minor’s confidentiality in the treatment process is protected. Exactly how parental notification influences minors seeking of treatment is unknown, however.

The interpretation of the results of this study needs to be tempered by several limitations. These data reflect state statutes only, not practice in the field. We know that there are gaps between laws on paper and laws in practice ([Melton, 1981](#); [Poncz, 2008](#)). Another fruitful area for research is to assess if this gap exists for decision-making authority for treatment. For example, in a state in which either a parent or minor may consent for treatment, do health care professionals require a minor to consent because

this consent indicates recognition of a problem and motivation to change? Conversely, states that allow for either parental consent or minor consent appear to be striving towards a model of inclusiveness in which either the parent or the child can seek treatment for an adolescent's problem; however, this situation may result in conflict between the parent who wants treatment for the minor and the minor who does not recognize the problem and/or who does not want to participate in treatment. In these states, drug and mental health treatment programs may experience the proverbial dilemma of leading a horse to water, but not being able to make it drink. Another limitation may lie in the coding of the statutes. State statutes are complicated and are often very dense. It is possible that while our coding scheme simplifies classification of the various state statutes, some exceptions and nuances of a law were missed. Furthermore, it is important to note that we only coded laws that were specific to drug and mental health treatment. It is possible that when classifying a law as minor consent only, a parent would be able to consent in that state under laws for general medical care.

State laws reflect the tension between protecting the right of a minor to seek confidential treatment for substance use or mental health concerns, and the right of parents to protect the health and welfare of their children as their parental responsibilities. This tension results in complex state laws that specify that consent is sufficient or required from the minor alone, the parent alone, either the parent or the minor, or both parent and minor. The issue addressed in this paper is not what happens when the adolescents seek treatment for themselves, but what happens when the adolescent does not seek treatment and parents recognize a problem. Parents have less authority and lose it sooner when their child needs drug abuse as compared to mental health treatment. For parents who live in states that do not allow them any authority to consent for treatment of their adolescent, their options are more limited (irrespective of cost and other logistical aspects of treatment) and the laws may sometimes work against the best interests of their child.

## Acknowledgments

---

This research is supported in part by a grant (P50-DA027841) from National Institute on Drug Abuse. We gratefully acknowledge the help and assistance of Bianca Coleman.

## Footnotes

---

<sup>1</sup>For ease of presentation, drug treatment was used for drug and alcohol treatment and parent(s) was used to represent parents and guardians.

<sup>2</sup>Specific statutes are available upon request.

## References

---

1. Adleman HS, Kaser-Boyd N, Taylor L. Children's participation in consent for psychotherapy and their subsequent response to treatment. *Journal of Clinical Child Psychology*. 1984;13:170–178. [[Google Scholar](#)]
2. Alkhatib A, Regan J, Jackson J. Informed assent and informed consent in the child and adolescent. *Psychiatric Annals*. 2008;38(5):337–339. [[Google Scholar](#)]
3. Ballon B, Kirst M, Smith P. Youth help-seeking expectancies and their relation to help-seeking behaviours for substance use problems. *Addiction Research & Theory*. 2004;12(3):241–260. doi: 10.1080/16066350942000193202. [[CrossRef](#)] [[Google Scholar](#)]
4. Beyth-Marom R, Austin L, Fischhoff B, Palmgren C, Jacobs-Quadrel M. Perceived consequences of risky behaviors: Adults and adolescents. *Developmental Psychology*. 1993;29:549–563. doi: 10.1037/0012-1649.29.3.549. [[CrossRef](#)] [[Google Scholar](#)]

5. Caldeira KM, Kasperski SJ, Sharma E, Vincent KB, O'Grady KE, Wish ED, Arria AM. College students rarely seek help despite serious substance use problems. *Journal of Substance Abuse Treatment*. 2009;37(4):368–378. doi: 10.1016/j.jsat.2009.04.005. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
6. Cho H, Hallfors D, Iritani B. Early initiation of substance abuse and subsequent risk factors related to suicide among urban high school students. *Addictive Behaviors*. 2007;32:1628–1639. doi: 10.1016/j.addbeh.2006.11.017. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
7. Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. *Pediatrics*. 1995;95:314–317. [[PubMed](#)] [[Google Scholar](#)]
8. Council for Scientific Affairs, American Medical Association. Confidential health care for adolescents. *Journal of the American Medical Association*. 1993;269:1420–1424. [[PubMed](#)] [[Google Scholar](#)]
9. Dyer AR, MacIntyre JC. Utilization of private child and adolescent services: Ethical considerations. *Administration and Policy in Mental Health*. 1992;19:139–149. [[Google Scholar](#)]
10. English A. Treating adolescents: Legal and ethical considerations. *Medical Clinics of North America*. 1990;74:1097. [[PubMed](#)] [[Google Scholar](#)]
11. English A. Understanding legal aspects of care. In: Neinstein LS, editor. *Adolescent health care: A practical guide*. 5. Philadelphia, PA: Wolters & Kluwer/Lippincott, Williams & Wilkins; 2002. pp. 124–132. [[Google Scholar](#)]
12. English A, Bass L, Boyle AD, Eshragh F. *State minor consent laws: A summary*. 3. Chapel Hill, NC: Center for Adolescent Health & Law; 2010. [[Google Scholar](#)]
13. Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *Journal of the American Medical Association*. 1999;282:2227–2234. doi: 10.1001/jama.282.23.2227. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
14. Ford CA, English A, Sigman G. Confidential health care for adolescents: Position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*. 2004;35:160–167. doi: 10.1016/j.jadohealth.2004.03.002. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
15. Fortunati FG, Jr, Zonana HV. Cultural considerations in child and adolescent psychiatric emergencies and crises. *Child and Adolescent Psychiatric Clinics of North America*. 2003;12:745–761. [[PubMed](#)] [[Google Scholar](#)]
16. Friedman RM, Pinto A, Behar L, Bush N, Chirolla A, Epstein M, Green A, Hawkins P, Huff B, Huffine C, Mohr W, Seltzer T, Vaughn C, Whitehead K, Young CK. Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry*. 2006;76(3):295–303. doi: 10.1037/0002-9432.76.3.295. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
17. Grisso T, Vierling L. Minors' consent to treatment: A developmental perspective. *Professional Psychology: Research and Practice*. 1978;9:412–427. doi: 10.1037/0735-7028.9.3.412. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
18. Hickey K. Minors' rights in medical decision making. *JONA's Healthcare Law, Ethics, and Regulation*. 2007;9(3):100–104. doi: 10.1097/01.NHL.0000287968.36429.a9. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
19. Holder AR. Legal issues in adolescent sexual health. *Adolescent Medicine*. 1992;3:257–267. [[PubMed](#)] [[Google Scholar](#)]
20. Ilgen MA, Schulenberg JE, Kloska DD, Czyz E, Johnston L, O'Malley P. Prevalence and characteristics of substance abuse treatment utilization by US adolescents: National data from 1987 to 2008. *Addictive Behaviors*. 2011;36:1349–1352. doi: 10.1016/j.addbeh.2011.07.036. [[PMC free article](#)] [[PubMed](#)] [[Google Scholar](#)]
21. Kerwin ME, Walker-Smith K, Kirby KC. Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment*. 2006;30(3):173–181. doi: 10.1016/j.jsat.2005.11.004. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]

22. Kirby KK, Versek B, Kerwin ME, Meyers K, Benishek LA, Bresani E, Washio Y, Arria A, Meyers RJ. Developing Community Reinforcement and Family Training (CRAFT) for Parents of Treatment-Resistant Adolescents. *Journal of Child and Adolescent Substance Abuse*. in press. [[PMC free article](#)] [[PubMed](#)] [[Google Scholar](#)]
23. Lallemond T, Mastroianni A, Wickizer TM. Decision-making authority and substance abuse treatment for adolescents: A survey of state laws. *Journal of Adolescent Health*. 2009;44:323–334. doi: 10.1016/j.jadohealth.2008.12.008. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
24. Lewis CE, Lewis MA, Lorimer A, Palmer BB. Child-initiated care: The use of school nursing services in an “adult-free” system. *Pediatrics*. 1977;60:499–507. [[PubMed](#)] [[Google Scholar](#)]
25. Marks A, Malizio J, Hoch J, Brody R, Fisher M. Assessment of health needs and willingness to utilize health care resources of adolescents in a suburban population. *Journal of Pediatrics*. 1983;102:456–460. [[PubMed](#)] [[Google Scholar](#)]
26. McGillicuddy NB, Rychtarik RG, Duquette JA, Morsheimer ET. Development of a skill training program for parents of substance-abusing adolescents. *Journal of Substance Abuse Treatment*. 2001;20(1):59–68. doi: 10.1016/S0740-5472(00)00149-5. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
27. Melton GB. Effects of a state law permitting minors to consent to psychotherapy. *Professional Psychology*. 1981;12(5):647–654. doi: 10.1037/0735-7028.12.5.647. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
28. Melton GB. Children’s competence to consent: A problem in law and social sciences. In: Melton GB, Koocher GP, Saks MJ, editors. *Children’s competence to consent*. New York: Plenum; 1983. pp. 1–18. [[Google Scholar](#)]
29. Melton GB, Wilcox B. Changes in family law and family life: Challenges for psychology. *American Psychologist*. 1989;44:1213–1216. doi: 10.1037/0003-066X.44.9.1213. [[CrossRef](#)] [[Google Scholar](#)]
30. Mensinger JL, Diamond GS, Kaminer Y, Wintersteen MB. Adolescent and therapist perception of barriers to outpatient substance abuse treatment. *The American Journal on Addictions*. 2006;15(Suppl 1):16–25. doi: 10.1080/10550490601003631. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
31. Meyer DJ. Commentary: Legislators--How did the deciders decide? Who shall serve as their experts? *Journal of the American Academy of Psychiatry and the Law*. 2007;35(3):323–324. [[PubMed](#)] [[Google Scholar](#)]
32. National Association of Therapeutic Schools and Programs. *NATSAP 2011–2012 Online Directory*. 2012 Retrieved May 28, 2012, from <http://natsap.org/wp-content/uploads/2012/05/2011-2012-NATSAP-Online-Directory-.pdf>.
33. Owens PL, Hoagwood K, Horwitz SM, Leaf PJ, Poduska JM, Kellam SG, Ialongo NS. Barriers to children’s mental health services. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2002;41:731–738. doi: 10.1097/00004583-200206000-00013. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
34. Poncz E. Rethinking child advocacy after Roper v. Simmons: “Kids are just different” and “kids are like adults” advocacy strategies. *Cardoza Public Law, Policy, and Ethics Journal*. 2008;6(2):273–343. [[Google Scholar](#)]
35. Poulin F, Kiesner J, Pedersen S, Dishion TJ. A short-term longitudinal analysis of friendship selection on early adolescent substance use. *Journal of Adolescence*. 2011;34(2):249–256. doi: 10.1016/j.adolescence.2010.05.006. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
36. Quadrel MJ, Fischhoff B, Davis W. Adolescent (in)vulnerability. *American Psychologist*. 1993;48:102–116. doi: 10.1037/0003-066X.48.2.102. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
37. Santelli JS, Rosenfeld WD, DuRant RH, Dubler N, Morreale M, English A, Rogers AR. Guidelines for adolescent health research: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*. 1995;17:270–276. [[PubMed](#)] [[Google Scholar](#)]

38. Scott DA, Duerson LM. Continuing the discussion: A commentary on “Wilderness therapy: Ethical considerations for mental health professionals” *Child & Youth Care Forum*. 2010;39(1):63–68. doi: 10.1007/s10566-009-9090-x. [[CrossRef](#)] [[Google Scholar](#)]
39. Scott ES, Steinberg L. *Rethinking juvenile justice*. Cambridge, MA: Harvard University Press; 2009. [[Google Scholar](#)]
40. Simmons R, Ungemack J, Sussman J, Anderson R, Adorno S, Aguayo J, Black K, Hodge S, Tirnady R. Bringing adolescents into substance abuse treatment through community outreach and engagement: The Hartford Youth Project. *Journal of Psychoactive Drugs*. 2008;40(1):41–54. doi: 10.1080/02791072.2008.10399760. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
41. Society for Adolescent Medicine. Confidential health care for adolescents: Position paper of the Society of Adolescent Medicine. *Journal of Adolescent Health*. 1997;21:408–415. [[PubMed](#)] [[Google Scholar](#)]
42. Stice E, Barrera M. A longitudinal examination of the reciprocal relations between perceived parenting and adolescents’ substance use and externalizing behaviors. *Developmental Psychology*. 1995;31(2):322–334. doi: 10.1037/0012-1649.31.2.322. [[CrossRef](#)] [[Google Scholar](#)]
43. Stueve A, O’Donnell L. Early alcohol initiation and subsequent sexual and alcohol risk behaviors among young adolescents. *American Journal of Public Health*. 2005;95:887–893. doi: 10.2105/AJPH.2003.026567. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
44. Substance Abuse and Mental Health Services Administration. *Families of Youth with Substance Use Addiction: A National Dialogue*. Rockville, MD: U.S. Department of Health and Human Services; 2010a. [[Google Scholar](#)]
45. Substance Abuse and Mental Health Services Administration. *NSDUH Series H-38A, HHS Publication No SMA 10-4856*. Rockville, MD: 2010b. Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings. Retrieved from <http://oas.samhsa.gov/2k10/185/185TypicalDayHTML.pdf>. [[Google Scholar](#)]
46. Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2011. [[Google Scholar](#)]
47. Sullivan KB. A public policymaker’s response: Weisleder and Meyer on legislator decision-making. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2008;36:10–12. [[PubMed](#)] [[Google Scholar](#)]
48. Tan JOA, Passerini GE, Stewart A. Consent and confidentiality in clinical work with young people. *Child Clinical Psychology and Psychiatry*. 2007;12(2):191–210. [[PubMed](#)] [[Google Scholar](#)]
49. Thoma RJ, Monnig MA, Lysne PA, Ruhl DA, Pommy JA, Bogenschutz M, Tonigan JS, Yeo RA. Adolescent substance abuse: The effects of alcohol and marijuana on neuropsychological performance. *Alcoholism: Clinical and Experimental Research*. 2011;35(1):39–46. doi: 10.1111/j.1530-0277.2010.01320.x. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
50. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set -- Admissions (TEDS-A), 2010*. [Data file] 2012 Available from Substance Abuse and Mental Health Data Archive (SAMHD), <http://www.icpsr.umich.edu/icpsrweb/SAMHDA/sda>.
51. Weisleder P. The rights of minors to confidentiality and informed consent. *Journal of Child Neurology*. 2004;19:145–148. [[PubMed](#)] [[Google Scholar](#)]
52. Weisleder P. Inconsistency among American states on the age at which minors can consent to substance abuse treatment. *Journal of the American Academy of Psychiatry and the Law*. 2007;35:317–322. [[PubMed](#)] [[Google Scholar](#)]

53. Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. *Child Development*. 1982;53(6):1589–1598. doi: 10.2307/1130087. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]
54. Wilson SJ, Lipsey MW. Wilderness challenge programs for delinquent youth: A metaanalysis of outcome evaluations. *Evaluation and Program Planning*. 2000;23(1):1–12. doi: 10.1016/S0149-7189(99)00040-3. [[CrossRef](#)] [[Google Scholar](#)]
55. Wisdom JP, Cavaleri M, Gogel L, Nacht M. Barriers and facilitators to adolescent drug treatment: Youth, family, and staff reports. *Addiction Research & Theory*. 2011;19(2):179–188. doi: 10.3109/16066359.2010.530711. [[CrossRef](#)] [[Google Scholar](#)]
56. Witt ED. Research on alcohol and adolescent brain development: Opportunities and future directions. *Alcohol*. 2010;44(1):119–124. doi: 10.1016/j.alcohol.2009.08.011. [[PubMed](#)] [[CrossRef](#)] [[Google Scholar](#)]