Inconsistency Among American States on the Age at Which Minors Can Consent to Substance Abuse Treatment

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In a recent publication, the lack of consensus among U.S. laws regarding the age at which minors may consent to confidential treatment for abuse of illegal substances was highlighted. This article reports the results of an investigation of the information used by legislators to determine the age at which minors may consent to treatment. Evidence indicates that in four states lawmakers considered the advice of mental health professionals before making age determinations. In six states "consistency with other state laws" or "precedence" was the lawmakers' major consideration. In five states, the main concern was removing legal barriers to treatment access. Lawmakers from several states had no independent recollection regarding the motives behind age selection. When deciding on the age at which minors would be allowed to consent to substance abuse treatment, some state legislators based their decisions on clinical data or legal facts. Some, however, appear to have made decisions without a clear foundation.

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In a recent publication, the lack of consensus among U.S. laws as to the age at which a minor may consent to confidential treatment for alcohol and drug abuse was underscored.[1] Several states' statutes indicate that confidential treatment should be available to "any minor" (e.g., Arkansas, Iowa, and Ohio), while other states have clear age specifications (e.g., Illinois: 12 years; Delaware: 14 years; and Maryland: 16 years). Federal regulations support the concept of treatment confidentiality and set restrictions on information disclosure based on each state's regulations.[2] An examination of the differences among states' statutes prompts the question: What information was used by legislators to determine the age at which a minor may consent to confidential substance abuse treatment? One might theorize that lawmakers used Piagetian concepts of cognitive development,[3] as well as more recent data[4] that support the notion that 14-year-old minors demonstrate a level of competency equivalent to that of adults. Alternatively, lawmakers may have based their decisions on the English common law of colonial times.[1,5] Under those laws, 14 years was the legal age when a girl could marry, and that age carried over to the colonies. It is possible that consent statutes were paired with marriage statutes. A third possibility is that lawmakers adopted a particular age to remain consistent with other legislation regarding minors. Finally, there is always the possibility that age selection was based on political principles.

This article reports on the effort to find answers to the aforementioned question. To achieve this goal, secretaries of state, state law librarians, and nonpartisan legislative staff (referred to variously in different states by titles such as legislative council, legislative counsel, or legislative commissioner, among other names) of the 50 U.S. states were asked to assist in identifying the lawmakers who crafted each state's bill that allows minors to consent to confidential treatment for abuse of illegal substances. The lawmakers were contacted, given an explanation of the purpose of the research, and invited to participate in it. Their responses are discussed in the description that follows.

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Methods

The statutes, codes, or regulations of each American state and the District of Columbia (D.C.) were searched on the World Wide Web for subjects such as substance abuse services, treatment for use of illegal drugs, alcohol or drug abuse, treatment of substance abusers, capacity of minors to consent to treatment, consent by minors to treatment or services, and drug-dependent minors. With specific information on these laws, the office of each secretary of state was contacted and asked for the legislative history of the particular law: the written and spoken public record that details the stages in the passage of a bill or resolution as it goes through the legislative process. The names of lawmakers involved in creating the bill and information on documents used to craft the bill were also included. When available, contact information for the legislators was obtained from the aforementioned sources. Otherwise, the World Wide Web was searched to attempt to locate the lawmakers.

Once identified, legislators were contacted via e-mail, telephone, or letter. As part of the interaction, the role that the legislator had in crafting a bill regarding the right of minors to consent to confidential substance abuse treatment in their states was reviewed. After they acknowledged that they were indeed involved in crafting the bill, their recollection of the information used to make age-specific decisions for the bill was requested. In those instances in which the person(s) who crafted the bill could not be contacted due to death or lack of contact information, secretaries of state, state law librarians, and members of states' legislative staff were asked for assistance. All e-mail and letter responses were stored for analysis at a later time, and they are part of the permanent record of this research. The information obtained from legislators was compared with that contained in the bills' legislative histories.

This work was deemed exempt from formal evaluation by Duke University Medical Center's Office of Human Subject Protections. Furthermore, the information used to document the work was obtained from the legislative history of each bill, which is a matter of public record.

Results

The results of the investigation are displayed in Table 1, arranged alphabetically according to state. The columns contain the specific location in each state's statute or code where the laws that permit minors to consent to confidential treatment for abuse of illegal substances are found, the age at which minors may consent to treatment, and information as to whether the regulations specifically address treatment for substance abuse or if all mental health services are combined under the same heading.

In the United States, 48 states and the District of Columbia (D.C.) have laws that authorize minors to obtain confidential medical treatment for abuse of illegal substances. In 44 states, the laws are specific to the treatment of drug addiction. In D.C., Alaska, Arkansas, New Mexico, and South Carolina, laws regarding treatment for abuse of illegal substances are bundled under the heading of mental health. Two states, Utah and Wyoming, do not have laws that allow minors to receive confidential treatment for mental illness, addiction included.

In 24 states and D.C., the age at which a minor may seek confidential treatment for abuse of illegal substances is not specified. In four states, the age for outpatient treatment is not specified but that for inpatient treatment is. Four states and D.C. stipulate that a parent or guardian must be notified if the treatment is to be rendered in an inpatient setting. Significant disparity exists among the 20 states that stipulate the age at which minors may seek treatment for drug abuse (e.g., Arizona: 12 years; Florida: 13 years; Delaware: 14 years; Colorado: 15 years; and Tennessee: 16 years); the modal age is 14 years.

The main goal of this investigation was to learn from state legislators the information that was used to determine the age at which minors can consent to confidential substance abuse treatment. Answers were received from legislators in 31 states. There was variability in the depth and relevance of the information. This inconsistency is likely a result of the inability to find the bill's complete legislative history, the time that has elapsed since the bill became law, whether the sponsors could be located, and the readiness of government agencies to assist in the quest. Table 2 contains highlights of the information that was compiled.

Discussion

U.S. state lawmakers were asked to recall the information used to determine the age at which minors in their states are capable of consenting to confidential treatment for abuse of illegal substances. At the

Table 1 State Laws that Permit Minors to Consent to Treatment for Abuse of Illegal Substances, and Age at Which Confidential Treatment Is Allowed

State	Statute or Code*	Consent Age*	Law Specific to Substance Abuse
Alabama	Code of Alabama 22-8-4	14	Yes
Alaska	Alaska Statutes 25.20.025	Not specified	No
Arizona	Arizona Revised Statutes 44-133.01	12	Yes
Arkansas	Arkansas Code 20-9-602-7	Not specified	No
California	California Family Code § 6929	12	Yes
Colorado	Colorado Revised Statutes 13-22-102	15	Yes
Connecticut	General Statutes of Connecticut Ch 319 § 17a-79 (in); 688 (out)	Out: not specified; in: 14	Yes
Delaware	Delaware Code 16-22 § 2210	14 (parental consent for in)	Yes
D.C.	DC Statutes § 7-1231.14	Not specified (parental consent for in)	No
Florida	Florida Statutes XXIX 397.601	Not specified	Yes
Georgia	Georgia Code 37-7-8	Out: not specified; in:12	Yes
Hawaii	Hawaii, Revised Statutes Ti 31 Chap 577.26	Not specified	Yes
Idaho	Idaho Statutes Ti 37 Chap 3102	16	Yes
Illinois	Illinois Compiled Statutes 405 ILCS § 5/3-501 (out); 5/3-502 (in)	Out: 12; in: 16 (parental consent for in)	Yes
Indiana	Indiana Code 12-23-12-1	Not specified	Yes
Iowa	Iowa Statutes Ti IV Ch 125.33	Not specified	Yes
Kansas	Kansas Statutes Ti 59 Art 2949	14; if inpatient, custodian to be notified	Yes
Kentucky	Kentucky Revised Statutes Ti XVIII Ch 222	Not specified	Yes
Louisiana	Louisiana Revised Statutes RS 40: § 1095	Not specified	Yes
Maine	Maine Revised Statutes Ti 22 Ch 260 § 1502	Not specified	Yes
Maryland	Code of Maryland regulations 10.21.06.03	16	Yes
Massachusetts	General Laws of Massachusetts Part I, Ti XVI, Ch 112, S12e	12	Yes
Michigan	Michigan Public Health Code Act 368 of 1978 333.6121	Not specified	Yes
Minnesota	Minnesota Statutes Ch 144.343	Not specified	Yes
Mississippi	Mississippi Code Ti 41 Ch 41 § 14	15	Yes
Missouri	Missouri Revised Statutes Ch 431 § 061	Not specified	Yes
Montana	Montana Code Annotated 41-1-402	Not specified	Yes
Nebraska	Nebraska Statutes 71-5041	Not specified	Yes
Nevada	Nevada Revised Statutes 129.050	Not specified	Yes
New Hampshire	New Hampshire Revised Statutes Ti XXX Ch 318-B: 12-a	12	Yes
New Jersey	New Jersey Statutes Ti 9:17A-4	Not specified	Yes
New Mexico	New Mexico Statutes Ch 32A-6-12 and 15	14; if inpatient, custodian to be notified	No
New York	New York State Consolidated Laws Ti Mental Hygiene Law Ti D Ar 22.11 and Ti E Ar 33.21	Not specified	Yes
North Carolina	North Carolina General Statutes § 90-21.5	Not specified	Yes
North Dakota	North Dakota Century Code 14-10-17	14	Yes
Ohio	Ohio Revised Statutes § 3719.01.02	Not specified	Yes
Oklahoma	Oklahoma Statutes § 63-26Q2	Not specified	Yes
Oregon	Oregon Revised Statutes Chapter 109.675	Out: 14; in: 15	Yes
Pennsylvania	Pennsylvania Statutes 71 PS § 1690.112	Not specified	Yes
Rhode Island	General Laws of Rhode Island Ti 14, Chapter 14-5 § 14-5-3	Not specified	Yes
South Carolina	South Carolina Code of Laws § 20-7-280/20-7-290	16/any age when deemed "necessary"	No
South Dakota	South Dakota Statutes Ti 34 Chap 20A, § 50	Not specified	Yes
Tennessee	Ti 33 Chap 8 § 202	16	Yes
Texas	Texas Statutes Family Code Chap 32 § 32.004/Health and Safety Code Ch 462 § 462.022	Out: not specified; in: 16	Yes
Utah	No law	No law	No
Vermont	Vermont Statutes Title 18 Part 5 Chapter 84 § 4226	12	Yes
Virginia	Code of Virginia Ti 54.1-2969E.3	14	Yes
Washington	Revised Code of Washington 70.96A.095	13	Yes
West Virginia	West Virginia Code § 60A-5-504E	12	Yes
Wisconsin	Wisconsin Statutes Ch 51.47/51.13(1)[c]1.	Out: 12; in 14 and guardian must consent	Yes
Wyoming	No law	No law	No

*Ti, title; Out, outpatient treatment; in, inpatient treatment.

Table 2 Highlights of Information Obtained Directly From the Legislators Who Crafted the Bills or From the Bills' Legislative Histories

State	Commentary
Arizona	The bill was sponsored by the late Douglas Holsclaw (R, Tucson) and former United States Supreme Court Associate Justice Sandra Day O'Connor (formerly R, Paradise Valley). In her reply letter, Justice O'Connor wrote "In response to your letter. . . . I have kept no records of my legislative activity in 1971 and have no information to offer in response to your question."
California	The bill was introduced by Assemblywoman Leona Egeland in 1977 and was approved, with amendments, by the California House and Senate the same year. The legislative history indicates that 12 years was selected, to be ". . . . consistent with minor consent rights for other types of care in California."
Colorado	One legislator involved in crafting the bill did not recall specific details. He proceeded to say, "If you ask me, we probably pulled the number out of thin air." A member of the Behavioral Health Network that provides services to the State of Colorado stated, "Many treatment providers do have a policy that adolescents younger than 16 will only be admitted with parental consent. This is partially a clinical decision based on the belief that treatment cannot be successful for such individuals without family involvement, partially a concern for parental rights and potential liability, and partially due to licensing issues."
Connecticut	The legislative history indicates that the statute was intended to establish an opportunity for minors to seek and enter into substance abuse treatment programs without parental consent, in an effort to remove barriers for young people to receive treatment.
Florida	The information available indicates that Florida does not have a consistent public policy governing health care for minors. An official with Florida's Department of Children and Families indicated, "In my many years with the system, each of these laws reflects decisions made at the time of passage over a span of many years. The decisions derive from political, financial, and precedent origins, not necessarily on the developmental needs or maturity level of a person to make such decisions."
Idaho	Upon review of the legislative history, a member of the state librarian's office said, "In the original bill, the age was 18. In 1972 they tried to change it to 12 years old; it ended at 16 years old. The minutes don't really discuss why."
Indiana	An attorney with the Indiana Family and Social Services Administration indicated that no legislative history was available for review, as ". . . . Indiana is not a legislative history state, in some jurisdictions the legislative hearings are recorded and carry some legal weight in interpreting statutes the way the legislators intended them. Indiana is not such a jurisdiction, and legislative history has absolutely no legal significance, and so it's not preserved except by memory of those involved."
Kansas	Interpreting the legislative history, an attorney with the Kansas Department of Social and Rehabilitation Services indicated his recollection was that ". . . [14 years] was the age that legislators thought might show the most promise for treatment."
Kentucky	An individual in the Attorney General's office indicated that the age was set at 16 for purposes of uniformity, given that in Kentucky ". . . . minors can consent to medical treatment, mental health services, and sex at age 16. . . . the age at which a minor can consent to sex was lowered to 16 in 1976."
Maryland	After reviewing the legislative history, an individual with the Attorney General's office indicated that before 1981, the age was 18 years. Then, the Special Committee on Mental Health Laws began working on a revision that among other things would lower the age from 18 to 14. The change received support from the state's Department of Health and Mental Hygiene, as "lowering the age for voluntary admissions to 14 is in accordance with the developmental guidelines of when children reach adult-type abstract thinking capacity. According to developmental psychologists, this capacity is attained at age 14." For unclear reasons, at the last minute the age was raised to 16 years, and the bill was signed into law.
New Hampshire	Interpretation of the bill's legislative history revealed that 12 years of age had been selected, as ". . . . the age of individuals involved with drugs [had been] decreasing and the legislators wanted children to be able to come forward and ask for help."
New Mexico	In his reply, an attorney with Child Protective Services wrote, "In the mid-1990s, a task force was convened to do a major rewrite of the Children's Mental Health Code. I sat on that task force. We debated the age of consent for hours, possibly days. We looked at other states' laws. We looked at New Mexico laws that set ages for different processes (the age at which delinquents could be tried as adults, 14). There was psychological information that was presented about child development and brain development. Many on the task force wanted a younger age and some wanted an older age. In the end we compromised on the age 14."
North Dakota	The legislative history revealed that "mental health professionals" advising the 1977 North Dakota Legislative Council testified that ". . . . there is a need to be able to treat juveniles in life-threatening situations. This help cannot now be given without the permission of the jiveniles' parents. . . . [J]uveniles are often in trouble and need the help precisely because they cannot or will not talk to their parents. . . . [M]ost adolescents who come in [for treatment] are in conflict with society, especially their family. . . . [T]hey do not trust adults. If we tell them that we will provide them with care and respect their need for confidentiality, this instills a trust within them for us." ND representatives discussed using 14 as the age, then agreed to eliminate a specific age and insert the word "minors" in the bill. The next day, after a meeting with the state's Attorney General (AG) and the Legislative Research Council, the AG asked that 14 years be reinserted. The argument was that 14 years was a '"point of reference' in federal and state law."

Table 2 Continued.

State	Commentary
Oregon	The legislative history of the bill revealed that its passage was not driven by access to substance abuse treatment as much as it was related to abused children who were seeking care. Treatment providers who received service requests from children were concerned about the confidentiality of adolescents who were victims of abuse or were afraid of parental retaliation if the children reported abusive behavior to others. Specific discussions regarding age were not found.
Tennessee	Tennessee's legislators selected this age to be consistent with federal laws that authorize 16-year-olds to consent to inpatient treatment without parental consent.
Utah	An attorney from the Utah Medical Association indicated that arguments are evaluated on a case-by-case basis. ". . . . [W]e tend to encourage people to look at the AMA code of ethics on the issue. . . . and to the extent we need to have legislative backing on that, we look to the provisions in Utah's professional licensing code. Finally, the state looks to nationally recognize[d] standards to fill in the blanks for whatever isn't specifically regulated by the state."
Virginia	An individual with the office of Mental Health Planning of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services indicated that ". . . . the age of 14 is consistent with the age [at which minors may consent] for several things: substance abuse treatment, seeking treatment for STDs, medical care for reproductive health (except for surgical sterilization), mental health services for outpatient mental health treatment, involuntary commitment proceedings, and with other states' laws."
Washington	An individual in the office of the Director of Washington State's Division of Alcohol and Substance Abuse indicated that . . . . 14 was selected [initially] as the age, given that it was the age of the youngest kids who were seeking, or showing up, for treatment and seemed to have the maturity to follow through. Then later we decided to be consistent with mental health for no reason other than consistency and the age was lowered to 13 years."
West Virginia	An individual in the Attorney General's office for the Bureau for Behavioral Health and Health Facilities stated, ". . . . I suspect that 12 years was selected based upon family and domestic laws, where a child 12 years or older must consent to various living arrangements, such as foster parents, group homes, etc."

outset, four theories were considered: Piagetian concepts of cognitive development, the English common law of colonial times, consistency with other state laws, and other practical matters.

Convincing evidence was found that, in four states (Maryland, New Mexico, North Dakota, and Washington), lawmakers considered the advice of mental health professionals before determining the age at which minors would be able to consent to confidential treatment for substance abuse. As previously mentioned, Piagetian concepts of cognitive development as well as more recent data support the notion that a 14-year-old minor can demonstrate a level of competency equivalent to that of an adult.[3,4] For example, 14-year-old minors asked to select from a list of proposed treatments after evaluating four hypothetical treatment dilemmas demonstrated an ability equivalent to that of adults to make a reasonable choice and to understand the risks and benefits of their choices and of the treatment alternatives.[3] Similarly, in evaluating hypothetical medical scenarios, 15-year-olds have been shown to possess the ability to make choices and comprehend risks and benefits at a level parallel to that of young adults.[6] It remains unclear why legislators in both Maryland and Washington, after considering the advice of mental health professionals, set aside such evidence when making a final determination.

No evidence was found that legislators in any state utilized English common law to distinguish between minors and adults. Under those laws, individuals 14 to 21 years of age were presumed to be competent unless there was evidence to the contrary.[4] In today's England, minors 16 years of age and older can consent to ". . .any medical treatment without the consent of a parent or guardian" as long as the child is deemed to be "Gillick competent."[7] Gillick competence is a term used to describe when a minor possesses the intelligence and understanding to consent to his or her own medical treatment despite young age. The standard is based on a decision of the House of Lords in the case *Gillick v. West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security*.[7] This criterion is binding in England and has been approved in Australia, Canada, and New Zealand.

Evidence was found that legislators in six states (California, Florida, Kentucky, Tennessee, Virginia, and West Virginia) considered consistency with other state laws or precedence before deciding on the age at which minors could consent to substance abuse treatment. The concept of precedence establishes that an earlier opinion determines legal rules for future judgments on the same question. This notion is well entrenched in the legal system.

Lawmakers from several states had no recollection regarding the motives behind selection of a particular age for the bill that eventually became part of their states' statutes. Some indicated, for example, that the legislative history was unclear, that records were not kept, or that minutes of the sessions had no details. However, no one expressed his opinion more eloquently than the Colorado legislator who stated that ". . . we probably pulled the number out of thin air."

Finally, a rationale not considered at the outset of this work was used by legislators in five states (Connecticut, Kansas, New Hampshire, Oregon, and Washington) to determine the age at which minors would be considered competent to consent to confidential treatment for substance abuse. In these states, the main concern of legislators was to remove legal barriers to access to treatment. Availability of confidential health care for minors is a guiding principle of adolescent medicine supported by many medical associations.[1] Specifically, the Society for Adolescent Medicine has stated that private and confidential health services are essential for adolescents.[8] Several studies have demonstrated that youngsters are more likely to seek medical treatment when privacy is assured.[9] Conversely, fear of disclosure has been cited as a deterrent to seeking care for serious conditions.[9–11] Thus, the decisions of the legislators in the five aforementioned states were in line with the recommendations of major medical organizations.

Information used by legislators in the United States to determine the age at which minors may consent to substance abuse treatment was sought. The answers revealed that in some instances decisions were based on clinically or legally sound foundations. Some decisions, however, appear to have been made based on last-minute political negotiations, or without clear scientific basis. The author recognizes that answers from every state of the Union were not available and that, as indicated by one legislator, in some cases ". . . the answer is probably lost in antiquity."

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