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NOTE

Protecting Minors with Substance Use Disorders: A Closer Look at the Relationship of Confidentiality with Treatment Options

Katherine Slisz*

INTRODUCTION

Cindy, fourteen, sits in the substance use disorder (SUD) treatment provider's office after having traveled there from her parents' middle-class suburban home. The provider asks Cindy if she would like to sign the information release form or keep her treatment information confidential. She thinks for a moment about her parents, whom she believes would be disappointed to learn of her SUD. She does not want to upset her parents or face their discipline, so she refuses to sign the paperwork that would allow the release of her information. This hypothetical situation provides one example of the lack of understanding many minors possess when it comes to confidentiality concerning SUD treatment.

SUD is classified as a mental health disorder that "occur[s] when the recurrent use of alcohol and/or substances causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home."¹ An SUD diagnosis is made based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.² In 2014, of United States adolescents ages 12 to 17, an estimated 5%, or about 1.3 million adolescents, had SUD.³ The 1.3 million adolescents suffering from this challenging disorder present vulnerabilities that require caution, care, and concern in treatment.

Adolescents may find a number of treatments for SUD helpful based on the individual's situation.⁴ Some adolescents receive treatments where providers work directly with the adolescent to help them cope with their environment and other providers take group therapy approaches, like family-based treatment.⁵ Treatment providers work to allow adolescents to better understand their interactions with

* Indiana University Maurer School of Law, J.D. 2020; Executive Editor, *Indiana Journal of Law & Social Equality*, Volume 8.

¹ *Mental Health and Substance Use Disorder*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/disorders/substance-use> (last updated Apr. 13, 2019).

² AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013).

³ *Age- and Gender-Based Populations*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Jan. 17, 2018), <https://www.samhsa.gov/specific-populations/age-gender-based> [<https://web.archive.org/web/20190306023430/https://www.samhsa.gov/specific-populations/age-gender-based>].

⁴ NAT'L INST. ON DRUG ABUSE, *PRINCIPLES OF ADOLESCENT SUBSTANCE USE DISORDER TREATMENT* 23 (2014).

⁵ *Id.* at 23–25.

their external environment and how they cope with their desire for substances in the future.⁶ Treatment providers also strive to build a system of social support around adolescents with SUD.⁷

Confidentiality requirements for substance use treatment were codified in 1975 in 42 CFR Part 2 (Part 2) as part of the Drug Abuse Office and Treatment Act.⁸ Within Part 2 of the regulation, 42 CFR 2.14 (Section 2.14) provides minors similar consent rights as adults, meaning that minors must give consent for their information to be released to outside parties.⁹ Individuals having the capacity to consent to treatment is always assumed under the regulation.¹⁰ The regulation depends on the assumption that minors are more likely to seek treatment when their SUD treatment provider can promise confidentiality.¹¹ To achieve Section 2.14's purpose, treatment providers must consider the harm that maintaining confidentiality will do to the parent-child relationship and the child themselves.¹²

An examination of SUD's psychological effect on adolescents is necessary to understand how Section 2.14 may work in conjunction with minors' desire for confidentiality. While confidentiality mandated under Section 2.14 provides important benefits for adolescents seeking privacy for SUD treatment, there are many treatment reasons why providers should be reporting care for serious SUD to parents absent extraordinary circumstances. Therefore, this Note argues that, based on Section 2.14(c), providers should have more guidance both to supply adolescents with adequate information about family-based treatment and to protect the well-being of vulnerable adolescents by sharing more information with parents and guardians.

Section I provides background surrounding the regulation Part 2, along with its purpose. Section II discusses minors' interactions with the health care system, how substance use affects minors' brains, and alternative treatments for SUD. Section III explores why some minors with SUD lack maturity to make the decision of whether or not to maintain confidentiality, including the importance of medical informed consent, both medical and legal capacity, traditional legal standards, and case law. Section IV then examines how these understandings may conflict with or change the meaning of Section 2.14(c)'s provisions. Finally, Section V proposes a solution to Section 2.14(c)'s vagueness: a process for providers and psychologists to

⁶ *Id.* at 21, 23, 25.

⁷ *Id.* at 17–23.

⁸ Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27,802 (July 1, 1975) (to be codified at 42 C.F.R. pt. 2). *See* Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, 86 Stat. 65 (1972); Comprehensive Alcohol Use and Alcoholism Prevention, Treatment, and Rehabilitative Act of 1970, Pub. L. No. 91-616, 84 Stat. 1848 (1970) (providing legislative authority to enact the 1975 regulation).

⁹ *See* 42 C.F.R. § 2.14(a) (2018).

¹⁰ *Id.*

¹¹ *See infra* note 46 and accompanying text.

¹² *See* Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27,802.

determine if minors with SUD have been fully informed of the importance of social support and have the maturity to consent to treatment.

I. BACKGROUND AND PURPOSE OF 42 CFR PART 2

Federal privacy regulations exist in the current healthcare system to protect individuals from unwanted information sharing.¹³ Part 2 was created to allow individuals with SUD to seek treatment with confidentiality, therefore decreasing stigmatization.¹⁴ As substance use was on the rise in the 1960s, law enforcement attempted to control illegal substance use through punitive measures; however, by the late 60s and early 70s, they realized this punitive method was ineffective.¹⁵ Furthermore, fear of discrimination deterred people from entering substance use treatment programs.¹⁶ To move away from punishment and towards treatment, the federal government first enacted the Comprehensive Alcohol Use and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.¹⁷ This Act encouraged people to view SUD as a medical problem, rather than a moral problem.¹⁸ The government next enacted the Substance Use Office and Treatment Act of 1972, aimed at supporting treatment and rehabilitation programs.¹⁹

Title 42 Part 2 was then enacted in 1975 pursuant to authority given in the previous Acts.²⁰ A joint action of the Special Action Office for Substance Use Prevention and the Department of Health, Education, and Welfare (later renamed The Department of Health and Human Services (HHS)) enacted Part 2 due to a transfer of authority from the Director of the Special Action Office for Substance Use Prevention, to the Secretary of the Department of Health, Education, and

¹³ 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines> [<https://web.archive.org/web/20190109052630/https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines>] (last updated Oct. 12, 2018).

¹⁴ See Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27,802.

¹⁵ David F. Musto, *Drug Abuse Research in Historical Perspective*, in INST. MED., PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH app. B, at 284, 290 (1996).

¹⁶ Mitchell Berger, *Confidentiality of Substance Use Disorder Patient Records Final Rule (42 CFR Part 2)*, RESIDENTIAL SUBSTANCE ABUSE TREATMENT—TRAINING & TECHNICAL ASSISTANCE 1, 3 (2017), [http://www.rsat-tta.com/Files/Confidentiality-Rules-and-Regulations_BERGER-\(1\)](http://www.rsat-tta.com/Files/Confidentiality-Rules-and-Regulations_BERGER-(1)).

¹⁷ *Id.*

¹⁸ *History of NIAAA*, NAT'L INST. ALCOHOL ABUSE & ALCOHOLISM, <https://www.niaaa.nih.gov/our-work/history-niaaa> (last visited Oct. 1, 2018).

¹⁹ See Berger, *supra* note 16; Richard Nixon, *Statement About the Substance Use Office and Treatment Act of 1972*, AM. PRESIDENCY PROJECT (Mar. 21, 1972), <https://www.presidency.ucsb.edu/node/255218> (including information about the “balanced attack” to prosecute the “heroin pusher” in order to protect the “pusher’s victim”).

²⁰ Drug Abuse Office and Treatment Act of 1972, Pub. L. No. 92-255, 86 Stat. 65 (1972); Comprehensive Alcohol Use and Alcoholism Prevention, Treatment, and Rehabilitative Act of 1970, Pub. L. No. 91-616, 84 Stat. 1848 (1970) (providing legislative authority to enact the 1975 regulation).

Welfare.²¹ Part 2 governs confidentiality in federally-assisted SUD treatment programs.²² In most circumstances, the regulation requires that providers obtain patients' consent before releasing information to others.²³ This regulation furthers the purpose of protecting those with SUD from stigmatization.²⁴

The 1975 version of Part 2 was the first legislation to give minors confidentiality rights in SUD treatment.²⁵ Its purpose was to allow minors confidentiality without interfering in parent-child relationships, and to be consistent with local policy and reinforce the importance that states placed on family relationships.²⁶ The rule states disclosures may be made if in the patient's best interest,²⁷ but it does not explicitly define capacity to give consent to confidentiality and how to assess it. The regulation was written so treatment providers would not be torn between violating Part 2 and acting in the minor patient's best interests: "[O]ther rule(s) could subject clinicians to an intolerable choice between violating the provisions of this part . . . , or failing to take action to avoid a preventable tragedy involving a minor. . . . The statutes . . . should not be read as requiring such a choice."²⁸

Part 2 was last substantially updated in 1987 with respect to payment information and criminal justice system referrals.²⁹ With the widespread advancement of technology since 1987, the regulation desperately needed updates, including the integration of information sharing with electronic health records (EHRs)³⁰ which risk breaching confidentiality and could deter fearful patients from seeking SUD treatment due to the stigma.³¹ The former director of the Center for Substance Use Treatment at Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. H. Westley Clark, was responsible for interpreting the previous version of Part 2.³² Clark believed that some EHR sellers who

²¹ Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 20,522 (proposed May 9, 1975) (to be codified at 42 C.F.R. pt. 2); Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27,802. *See also* Comprehensive Alcohol Use and Alcoholism Prevention, Treatment, and Rehabilitative Act of 1970, Pub. L. No. 93-282, 88 Stat. 138.

²² *42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records*, *supra* note 13.

²³ *Id.*

²⁴ *See id.*

²⁵ *See* Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27,802 (July 1, 1975) (to be codified at 42 C.F.R. pt. 2).

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records*, *supra* note 13; *see also* Confidentiality of Alcohol and Drug Abuse Patient Records, 52 Fed. Reg. 21,796 (June 9, 1987) (to be codified at 42 C.F.R. pt. 2) (changing "Minor patients." from Section 2.15 to 2.14 with minimal changes to the text).

³⁰ Alison Knopf, *Upcoming Rule on 42 CFR Part 2 Could Harm SUD Patients*, 29 ALCOHOLISM & DRUG ABUSE WEEKLY 3, 4 (2017).

³¹ *Id.*

³² *Id.*

previously struggled with Part 2 compliance simply wished to update the regulation for business interests, particularly because of the opioid epidemic and the nation's concern surrounding substance use.³³ Based on this national issues some EHR system vendors hoped that their products would see increased sales.³⁴ Around 2010, prior to the current updates, SAMHSA worked to help health providers integrate technology into their Part 2 compliance efforts.³⁵ Despite these efforts, stakeholders were still requesting regulatory updates.³⁶

In February of 2016, HHS published new proposed rule changes to Part 2.³⁷ SAMHSA published the final rule, and in February 2017, the rule went into effect.³⁸ The regulation was renamed from "Confidentiality of Alcohol and Substance Use Patient Records" to "Confidentiality of Substance Use Disorder Patient Records."³⁹ Section 2.14 currently states, "If a minor patient acting alone has the legal capacity under the applicable state law to apply for and obtain substance use disorder treatment, any written consent for disclosure . . . may be given only by the minor patient."⁴⁰ The updates to Part 2 should ultimately help treatment providers incorporate health care delivery systems, including electronic information sharing.⁴¹

Changes to Part 2 will ultimately allow SUD treatment information to be shared with others in the same healthcare system with consent, while leaving in place existing confidentiality provisions for all communications outside the healthcare system.⁴² Compared to different health information privacy laws like the Health Insurance Portability and Accountability Act (HIPAA), Part 2 contains the strictest health privacy standards because disclosure of SUD may subject patients to discrimination or legal consequences.⁴³

The purpose of these updates applies to minors as well. One of the issues with Section 2.14 is that although there were no changes to this "Minor patients" section, comments were made with "specific suggestions or requested

³³ *Id.*

³⁴ *Id.*

³⁵ Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2).

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ 42 C.F.R. § 2.14(a) (2018).

⁴¹ *Id.* See Confidentiality of Substance Use Disorder Patient Records, 81 Fed. Reg. 6988 (proposed Feb. 9, 2016) (to be codified at 42 C.F.R. pt. 2).

⁴² *Setting the Record Straight: ASAM's Position in 42 CFR Part 2*, AM. SOC'Y ADDICTION MED. (Aug. 11, 2017), [https://www.asam.org/advocacy/issues/confidentiality-\(42-cfr-part-2\)](https://www.asam.org/advocacy/issues/confidentiality-(42-cfr-part-2)).

⁴³ *HHS Publishes Final Rule on Confidentiality of Substance Use Disorder Patient Records*, HIPAA J. (Jan. 3, 2018), <https://www.hipaajournal.com/final-rule-confidentiality-of-substance-use-disorder-patient-records>.

clarification.”⁴⁴ Commenters ranged from health insurance management associations to behavioral health management organizations.⁴⁵

II. PSYCHOLOGICAL EFFECTS OF MEDICAL CARE FOR MINORS

A. *Minors’ Desire for Confidentiality in Health Care*

Many minors prioritize confidentiality and autonomy in their medical decision making. One study found that one-fourth of participating adolescents would not seek general health care if they believed that their parents, friends, or teachers could find out.⁴⁶ These findings confirmed that a lack of confidentiality may create a barrier to health care.⁴⁷ A later study noted that 76% of teens wanted to obtain health care without parental knowledge,⁴⁸ and 8% of teens wanted health care in the previous twelve months, but did not seek it, fearing that their parents would be notified.⁴⁹ However, confidentiality may not be enough; 7% of teens who believed their provider would keep information confidential still did not seek healthcare out of fear that their parents would find out.⁵⁰ Therefore, although minors desire confidentiality and it is an important predictor of whether adolescents will seek health care, its presence does not guarantee that adolescents will seek health care.⁵¹

B. *Current Substance Use Trends Among Minors*

SUD affects adolescents of all populations. When compared to Caucasian adolescents, African-American students reported less substance use, and Hispanic

⁴⁴ Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6105 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2).

⁴⁵ Rhode Island Quality Health Institute, Comment Letter on Proposed Rule to Confidentiality of Substance Use Disorder Patient Records (Apr. 11, 2016), <https://www.regulations.gov/document?D=HHS-OS-2016-0005-0222>; Beacon Health Options, Comment Letter on Proposed Rule to Confidentiality of Substance Use Disorder Patient Records (Apr. 11, 2016), <https://www.regulations.gov/document?D=HHS-OS-2016-0005-0292>; Association for Behavioral Health and Wellness, Comment Letter on Proposed Rule to Confidentiality of Substance Use Disorder Patient Records (Feb. 17, 2017), <https://www.regulations.gov/document?D=HHS-OS-2016-0005-0402>.

⁴⁶ Tina L. Cheng, Judith A. Savageau, Ann L. Sattler & Thomas G. DeWitt, *Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes Among High School Students*, 269 JAMA 1404, 1406 (1993) (study conducted by Cheng et al.).

⁴⁷ *Id.*

⁴⁸ Jeannie S. Thrall, Lois McCloskey, Susan L. Ettner, Edward Rothman, Joan E. Tighe & S. Jean Emans, *Confidentiality and Adolescents’ Use of Providers for Health Information and for Pelvic Examinations*, 154 ARCHIVES PEDIATRICS & ADOLESCENT MED. 885, 886 (2000) (study conducted by Thrall et al.).

⁴⁹ *Id.* at 888.

⁵⁰ *Id.* at 886, 889 (finding 45% believed their regular provider could keep health services confidential).

⁵¹ *Id.*

adolescents reported more substance use.⁵² Maternal and paternal knowledge of adolescent substance use led to a lower likelihood that adolescents will use substances.⁵³ Open communication between parents and adolescents about alcohol use and its effects was a significant predictor for lower levels of drinking.⁵⁴ Furthermore, parent permissiveness of substance use, or parental substance use itself, increased the likelihood that adolescents would engage in substance use.⁵⁵ Studies confirmed that alcohol and marijuana use were higher in the middle- to upper-class communities of adolescents, possibly because these adolescents have the funds to obtain substances and fake identification.⁵⁶

Reducing risk factors and enhancing protective factors have also been linked to protecting adolescents from SUD.⁵⁷ Risk factors include external elements like permissive parenting, bullying, and living in a community with high drug tolerance.⁵⁸ Protective factors look to combat these risks by giving adolescents a strong bond with parents, spending time around positive role models, and promoting the belief that substance use can be dangerous.⁵⁹ Environmental factors are prevalent throughout research because, when compared to genetic factors, environmental factors may be more easily addressed.

On the whole, substance use among minors is currently on the decline.⁶⁰ Adolescents' use of illicit substances, other than marijuana, has decreased, this overall includes a decrease in prescription opioid use, and researchers have also identified a decrease in binge alcohol use.⁶¹ However, harmful substances are still a problem among teens, with alcohol and tobacco as the most frequently used substances and marijuana a close third.⁶² Teens are more accepting of marijuana;

⁵² Jing Wang, Bruce G. Simons-Morton, Tilda Farhart & Jeremy W. Luk, *Socio-Demographic Variability in Adolescent Substance Use: Mediation by Parents and Peer*, PUBMED CENT. 1, 6 (2011) (study conducted by Wang et al.).

⁵³ *Id.* at 10.

⁵⁴ *Does Socioeconomic Advantage Lessen the Risk of Adolescent Substance Use?*, HAZELDEN BETTY FORD FOUND., <https://www.hazeldenbettyford.org/education/bcr/addiction-research/socioeconomic-advantage-edt-818> (last visited Nov. 17, 2018) (findings based on a 2016 study from Hausheer, Doumas, Esp & Cuffee).

⁵⁵ *Id.* (findings based on a 2017 study from Cambron, Kosterman, Catalano, Guttmanova & Hawkins).

⁵⁶ *Id.* (study conducted by Luthar and Milliren et al.).

⁵⁷ *Why Do Teens Use Drugs?*, GET SMART ABOUT DRUGS (Aug. 14, 2018), <https://www.getsmartaboutdrugs.gov/family/why-do-teens-use-drugs>.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *See Monitoring the Future Survey: High School and Youth Trends*, NAT'L INST. ON DRUG USE (Dec. 2019), <https://www.drugabuse.gov/publications/drugfacts/monitoring-future-survey-high-school-youth-trends>.

⁶¹ *Id.* (conducting a study of 8th, 10th, and 12th graders).

⁶² *What Drugs are Most Frequently Used by Adolescents?*, NAT'L INST. ON DRUG USE (Jan. 2014), <https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment->

only 29% of twelfth graders believe that “regular marijuana use poses a great risk,” and daily marijuana use among twelfth graders is currently higher than cigarette use.⁶³ The National Institute for Substance Use for Teens noted that twelfth graders’ use of marijuana has risen from 5.1% in 2007 to 5.9% in 2017.⁶⁴

Additionally, adolescents’ opioid use is increasing. According to data from a 2002–2006 Monitoring the Future survey, “1 out of 8 high school seniors reported having used prescription opioids nonmedically [and] 7 out of 10 nonmedical users reported combining prescription opioids with at least one other substance in the past year.”⁶⁵ According to a study by Dr. Marcel Casavant, 30% of calls to U.S. poison control centers for children ingesting prescription opioids were for teenagers who had taken the opioids intentionally to get high or for self-harm.⁶⁶ Of the 175 children who died from ingesting opioids, 55% were teenagers; however, the rate of calls per 100,000 adolescents decreased from 80% in 2009 to 50% by 2015.⁶⁷ The excessive use of substances by adolescents may create larger repercussions on their mental states.

C. *Effects of Substance Use on Minors*

Adolescents’ substance use presents physical and psychological health issues. A substantial amount of brain growth happens during the adolescent and teen years. The prefrontal cortex, which makes decisions, continues to develop until the mid-20s.⁶⁸ The prefrontal cortex regulates decision-making, reasoning, personality expression, and social behavior.⁶⁹ The development in the prefrontal cortex, or “frontalization,” may underlie adolescents’ growing ability to think about how they are perceived by others, leading to increased feelings that they are constantly being judged.⁷⁰ According to Harvard University’s Isabelle Rosso, PhD, as abstract

research-based-guide/frequently-asked-questions/what-drugs-are-most-frequently-used-by-adolescents.

⁶³ *Id.* See *Teens Mix Prescription Opioids with Other Substances*, NAT’L INST. ON SUBSTANCE USE (Apr. 2013), <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/teens-mix-prescription-opioids-other-substances> (finding most common combination of substances among youths in a 2002–2006 study was marijuana and alcohol (58.5% and 52.1%)).

⁶⁴ Shamard Charles, *Marijuana Worse for Teen Brains than Alcohol, Study Finds*, NBC NEWS (Oct. 3, 2018), <https://www.nbcnews.com/health/kids-health/marijuana-may-be-worse-teen-brains-alcohol-study-finds-n916296>.

⁶⁵ *Teens Mix Prescription Opioids with Other Substances*, *supra* note 63.

⁶⁶ Amy Norton, *Fewer U.S. Kids Overdosing on Opioids*, WEBMD (Mar. 20, 2017), <https://www.webmd.com/mental-health/addiction/news/20170320/fewer-us-kids-overdosing-on-opioids>.

⁶⁷ *Id.* (“This study can’t show why.”).

⁶⁸ *How Drugs Alter Brain Development and Affect Teens*, GET SMART ABOUT DRUGS (Feb. 7, 2020), <https://www.getsmartaboutdrugs.gov/consequences/how-drugs-alter-brain-development-and-affect-teens>.

⁶⁹ Erika Packard, *That Teenage Feeling*, 38 AM. PSYCHOL. ASS’N 20, 21 (Apr. 2007), <https://www.apa.org/monitor/apr07/teenage.aspx>.

⁷⁰ *Id.*

reasoning increases, including the ability to make inferences about others' thoughts and feelings, so does social anxiety, which may make adolescents feel more vulnerable and self-conscious.⁷¹ SUD may affect this brain development and psychological growth.

During brain maturation, the frontal lobe, associated with "planning, inhibition, emotional regulation, and integration of novel stimuli," increases in efficiency.⁷² The brain's plasticity permits large learning capacity, which may be affected by alcohol and substance use.⁷³ Exposure to harmful substances during a period of key brain development "interrupt[s] the natural course of brain maturation."⁷⁴ Substance use in pre-teenagers has extraordinary risks because it increases the likelihood that this use will progress to more dangerous substances, in turn affecting the adolescent's "physical, physiologic, neurologic, and emotional development."⁷⁵

Heavy drinking in teen years disturbs the working memory, including "attention, information retrieval, . . . visuospatial functioning," information processing speed, and executive functioning.⁷⁶ In a study by Brown et al., adolescent drinkers recalled 10% less verbal and nonverbal information compared to non-drinkers.⁷⁷ Even after the minor stops drinking, it may be weeks or months until the brain is back to its optimal capacity.⁷⁸

Marijuana use causes similar neurological damage among adolescents. Many believe that marijuana is less harmful than alcohol; however, many recent studies confirm that it may be more harmful.⁷⁹ Adolescents who use marijuana have "a less efficient pattern of activation compared to non-users on working memory, verbal learning, and cognitive control tasks."⁸⁰ Further, Cass et al. found that early

⁷¹ *Id.* Isabelle Rosso, PhD, works in Harvard University's McLean Hospital Cognitive Neuroimaging and Neuropsychology Laboratory. *Id.*

⁷² L.M. Squeglia, J. Jacobus & S.F. Tapert, *The Influence of Substance Use on Adolescent Brain Development*, 40 *CLINICAL EEG & NEUROSCIENCE* 31, 32 (2010) ("In a study comparing prefrontal cortex volumes of adolescent heavy drinkers to non-drinkers and marijuana and alcohol users, prefrontal volumes were smaller in heavy drinkers relative to controls.").

⁷³ Richard C. Bodlt, Symposium, *Adolescent Decision Making: Legal Issues with Respect to Treatment for Substance Misuse and Mental Illness*, 15 *J. HEALTH CARE L. & POL'Y* 75, 87 (2012).

⁷⁴ Squeglia et al., *supra* note 72, at 2.

⁷⁵ John W. Kulig & The Comm. on Substance Abuse, *Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse*, 115 *J. AM. ACAD. PEDIATRICS* 816, 820 (2005).

⁷⁶ Sunita Bava & Susan F. Tapert, *Adolescent Brain Development and the Risk for Alcohol and Other Drug Problems*, 20 *NEUROPSYCHOLOGY REV.* 398, 405 (2010).

⁷⁷ Squeglia et al., *supra* note 72, at 32 (continuing verbal and nonverbal problems even three weeks after abstinence).

⁷⁸ *How Drugs Alter Brain Development and Affect Teens*, *supra* note 67.

⁷⁹ Charles, *supra* note 64 (according to a study published in the American Journal of Psychiatry, marijuana has a more damaging long-term effect on the cognitive abilities of teenagers than alcohol).

⁸⁰ Bava & Tapert, *supra* note 76.

adolescent brain receptors repeatedly exposed to cannabinoids ultimately experienced a slowed prefrontal cortex.⁸¹ These deficiencies linger, and after four weeks of abstinence, adolescents who regularly smoked continued to poorly perform on tests of working memory, learning, and cognitive flexibility, along with other performance tests.⁸² These same adolescents with SUD have shown their capacity to make good decisions by seeking treatment, but other decisions might be challenging in different ways because of the adolescent's immaturity compounded by the cognitive deficits of substance use.⁸³ The new decision-making hurdles that adolescents might face also surround social and relational fears, showing the need to destigmatize SUD.⁸⁴ Providers must fully evaluate both the nature and extent of the substance use in order to offer counseling that is appropriate, or know when to make referrals.⁸⁵

D. Treatment Alternatives for SUD

There are numerous types of treatments that may be used for adolescents with SUD, and not all treatment options will benefit each adolescent in the same way.⁸⁶ There are behavioral approaches that work to “modify [adolescents'] attitudes and behaviors related to drug abuse” and assist with other communication issues or environmental reasons an adolescent would use substances.⁸⁷ Group therapy also allows adolescents to connect with and receive support from their peers.⁸⁸ Family-based treatments may be more effective than individual and group treatment approaches, allowing parents and family into the process of the SUD recovery to both communicate and work on conflict resolution.⁸⁹

SAMHSA notes the importance of social support and building meaningful relationships within the community in SUD recovery.⁹⁰ Social support may vary among adolescents who may have different primary relationships in their lives; some may confide in peers, while others may involve parents or a trusted adult.⁹¹ Upon entering SUD treatment, providers must know the adolescent's relational

⁸¹ *Study: Regularly Using Marijuana as a Teen Slows Brain Development*, GET SMART ABOUT DRUGS (Oct. 13, 2017), <https://www.getsmartaboutsubstances.gov/news-statistics/2017/04/14/study-regularly-using-marijuana-teen-slows-brain-development>.

⁸² Squeglia et al., *supra* note 72, at 3.

⁸³ *See supra* Part II.C.

⁸⁴ *See* Packard, *supra* note 69.

⁸⁵ *Id.*

⁸⁶ NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF ADOLESCENT SUBSTANCE USE DISORDER TREATMENT 23 (2014).

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *See id.* at 17.

⁹⁰ *Recovery and Recovery Support*, SUBSTANCE ABUSE AND MENTAL HEALTH ADMIN. (Oct. 2018), <https://www.samhsa.gov/recovery>.

⁹¹ *See id.*

network and their strengths and weaknesses.⁹² Providers must understand the culture of the community that they serve, including the community's values and traditions, in order to create and advise effective treatment plans.⁹³

Adolescents undergoing SUD treatment must be fully informed of the various types of treatment. Further, adolescents should be informed of the treatment options that may no longer be available to them if they chose to make their SUD treatment confidential.

III. STANDARDS FOR CAPACITY AND UNDERSTANDING WITHIN MEDICAL DECISIONS

Adolescents dealing with SUD have the capacity to seek treatment.⁹⁴ There is not an issue with allowing minors to access treatment; however, the problem with current treatment regulations stems from the fact that most of these adolescents may have trouble making decisions about treatment options because they may overestimate how SUD stigma can harm their relationships and underestimate the importance of support networks.⁹⁵ Immaturity and increased vulnerability make these issues more complex.⁹⁶ Adolescents have an appraisal system tasked with weighing the positives and negatives of decisions.⁹⁷ The appraisal system “over-emphasizes the positive aspects of a choice, and de-emphasizes the negative aspects of a choice.”⁹⁸ Adolescents who are more likely to have an SUD have a hyper-rational brain,⁹⁹ meaning the adolescents place more weight on the benefit than the risk.¹⁰⁰ Therefore, adolescents who have a heightened hyper-rational brain may not be able to appropriately weigh the “risk” of telling their parent against the benefit.¹⁰¹ Moreover, the substance use, depending on nature and type, may have further damaged the adolescent's ability to fully consider the decision of confidentiality.

Adolescents have made the good decision to seek treatment; however, based on the nature of SUD, further assistance may be necessary to achieve broader understanding of the role of support and the need to disclose their SUD. These adolescents must be provided adequate information, based on their maturity, in order for them to receive the best treatment possible.

⁹² *See id.*

⁹³ *Id.*

⁹⁴ *See* 42 C.F.R. § 2.14(a) (2018).

⁹⁵ *See supra* notes 86, 90.

⁹⁶ *Supra* Part II.C.

⁹⁷ Michael Dahr, *Is the Teen Brain More Vulnerable to Addiction?*, HUFFPOST (Jan. 21, 2014), https://www.huffpost.com/entry/teen-brain-addiction-vulnerable_n_4638723.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ Todd Finley, *Your Face Scares Me: Understanding the Hyperrational Adolescent Brain*, EDUTOPIA (June 10, 2014), <https://www.edutopia.org/blog/understanding-the-hyperrational-adolescent-brain-todd-finley>.

¹⁰¹ *See id.*

A. Medical Informed Consent

Along with capacity, informed consent is important within the medical decision-making process. There are four elements that must be met for informed consent: (1) the person must have the capacity to make the decision; (2) the provider must disclose all information, including the likelihood of benefits and risks; (3) the information must be understood; and (4) the patient must voluntarily consent.¹⁰² Providers must tell patients the material information a reasonable person would need to make an intelligent decision.¹⁰³ Disclosure includes the likelihood of the risks and the benefits, side effects, and alternatives to whatever procedure or treatment option is discussed.¹⁰⁴ Informed consent is vital to patient autonomy, allowing patients to make their own medical decisions.¹⁰⁵ Further, informed consent must be obtained before patients' medical information can be released.

B. Medical Capacity and Providers' Ethical Duties

When caring for patients, physicians rely on four elements to assess capacity.¹⁰⁶ Patients must have: (1) understanding of relevant information about proposed diagnostic treatment; (2) appreciation for their situation; (3) reasoning used to make decisions; and (4) the ability to communicate their choice.¹⁰⁷ Medical scholars have noted that, where patients' capacity is in question, other experts like psychiatrists should be used.¹⁰⁸

The American Medical Association (AMA) Code of Medical Ethics provides further guidance on challenging ethical questions that many providers face when dealing with their patients, the law, and their morals.¹⁰⁹ The Opinion, "Confidential Care for Minors,"¹¹⁰ states that minors should be involved in the medical decision process to the extent that their abilities allow.¹¹¹ Providers are encouraged to give minors as much autonomy as possible so minors feel in control of their treatment;

¹⁰² Richard A. Wagner, *Informed Consent*, EMEDICINE HEALTH (Oct. 17, 2018), https://www.emedicinehealth.com/informed_consent/article_em.htm#what_is_informed_consent.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Assessing Medical Decision-Making Capacity*, PHYSICIANS WEEKLY (May 8, 2012), <https://www.physiciansweekly.com/medical-decision-making-capacity/>.

¹⁰⁷ *Id.*

¹⁰⁸ Joyeeta G. Dastidar & Andy Odden, *How Do I Determine if My Patient Has Decision-Making Capacity?*, THE HOSPITALIST (Aug. 2011), <https://www.the-hospitalist.org/hospitalist/article/124731/how-do-i-determine-if-my-patient-has-decision-making-capacity>.

¹⁰⁹ See AMA CODE OF MEDICAL ETHICS, <https://www.ama-assn.org/delivering-care/ama-code-medical-ethics> (last updated 2018).

¹¹⁰ *Opinion 5.055-Confidential Care for Minors*, AM. MED. ASS'N J. ETHICS (Nov. 2014), <https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinion-adolescent-care/2014-11>.

¹¹¹ *Id.*

however, physicians should also encourage parental involvement.¹¹² The Opinion notes that, especially regarding substance and alcohol use, “when the physician believes that, without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified.”¹¹³ Before disclosure, the breach of confidentiality must be discussed with the minor patient, and at times, the AMA supports following the child’s disclosure wishes.¹¹⁴

C. Legal Capacity

Legal capacity comes into question in many decision-making circumstances. To determine capacity, courts look at one’s ability to reason, deliberate, hold both values and goals, appreciate circumstances, understand information, and communicate a choice.¹¹⁵ Capacity may change over time; therefore, repeated assessments of capacity may be necessary.¹¹⁶ One perspective courts use is that capacity is a balancing act examining how much autonomy a person possesses and how much value lies in respecting the autonomy.¹¹⁷ Generally, the higher a person’s level of capacity, the more that person’s autonomy will be respected.¹¹⁸ Adolescents’ ability to deliberate or reason may be diminished by immaturity, poor understanding of actions and consequences, and SUD’s effect on the brain.¹¹⁹ For example, adolescents may overestimate the threat of telling parents about their SUD.

D. Traditional Legal Treatment of Minors in Health Decisions

The legal system has traditionally viewed children and teens as a vulnerable group, subject to extra protections.¹²⁰ The Supreme Court has articulated that “[o]ur history is replete with laws and judicial recognition that minors . . . generally are less mature and responsible than adults. Particularly ‘during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment’ expected of adults.”¹²¹ The legal system assumes that adults are

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ Alec Buchanan, *Mental Capacity, Legal Competence and Consent to Treatment*, 97 J. ROYAL SOC’Y MED. 415, 415 (2004).

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 416.

¹¹⁸ *Id.*

¹¹⁹ *See supra* Part II.C.

¹²⁰ *See What are the Legal Rights of Children?*, FINDLAW.COM, <https://family.findlaw.com/emancipation-of-minors/what-are-the-legal-rights-of-children.html> (last visited Oct. 17, 2018) (showing the amount of laws put in place to protect children).

¹²¹ *Thompson v. Oklahoma*, 487 U.S. 815, 834 (1988) (quoting *Bellotti v. Baird*, 443 U.S. 622, 635 (1979)).

competent, but children often must prove that they are competent.¹²² While research shows that some children demonstrate adult competence around the age of fourteen, this depends on the situation and the complexity of the issues that the minor faces.¹²³ Thus, minors who make decisions often deserve protection according to the law.

Courts have historically distinguished children and adults¹²⁴ because children are psychologically more vulnerable to external influences.¹²⁵ In *Bellotti v. Baird*, the Supreme Court ultimately decided that, although minors did not need parental approval for abortions, their autonomy and ability to seek treatment cannot be the same as adults because of vulnerability, their inability to make mature, informed decisions, and the importance of parents' role in raising their children.¹²⁶ The Supreme Court found that, while the child did not need parental approval before obtaining an abortion, children still represent a protected class due in part to their vulnerability.¹²⁷ *Bellotti v. Baird* gives children extra protections even if parents are not involved in the initial medical decision-making process.¹²⁸ Based on precedent, extra protections should be afforded to adolescents seeking SUD treatment. The protections should manifest in the way that adolescents are being informed of their treatment options because not only do adolescents generally lack maturity, but, in these cases, they also suffer from the deficit of the SUD.

The Supreme Court again noted the seriousness of children's medical decisions prompting stigma. In *Parham v. J.R.*, concerning a child's involuntary institutionalization because of mental illness, the Court noted the importance of determining whether institutionalization was necessary because it was stigmatizing;¹²⁹ therefore, it was decided that other professionals should confirm treatment needs besides simply relying on the decision of the parents.¹³⁰ Courts will insert themselves into familial relationships to protect children's interests only in the most serious cases,¹³¹ because "parents can and usually do play a significant role in the treatment . . . [and] there is a serious risk that an adversary confrontation will adversely affect the ability of the parents to assist the child."¹³²

¹²² Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 743–44 (1993) (introducing framework that would still presume incompetence to protect the rights and interests of the child).

¹²³ *Id.* at 725, 727.

¹²⁴ *Thompson v. Oklahoma*, 487 U.S. at 823 (prohibiting the execution of a person who was sixteen years old at the time of the committed murder).

¹²⁵ *Id.* at 834 (quoting *Eddings v. Oklahoma*, 455 U.S. 104, 115–16 (1982)).

¹²⁶ 443 U.S. 622, 633–34 (1979) (finding mature minors can go to the court to receive court consent for the minor to receive an abortion).

¹²⁷ *Id.*

¹²⁸ *Id.* at 643–44.

¹²⁹ *Parham v. J.R.*, 442 U.S. 584, 600–01 (1979).

¹³⁰ *Id.* at 606–07.

¹³¹ *See id.* at 610.

¹³² *Id.*

While courts will interfere with children's medical decisions made by parents, courts interference will clearly be in very limited and stigmatizing circumstances.

Not all advocates agree with the precedent of protecting minors and questioning their decision-making abilities, but instead see children's legal and societal lack of decision-making ability as an affront to their dignity.¹³³ Some believe that children are "the most oppressed of all the minorities" because they are unable to make their own life decisions.¹³⁴ Children's rights advocates note that in order for children to not be mistreated, they should always receive a say in the decisions affecting their lives.¹³⁵ Many feel that as children possess a voice regarding their life decisions they are then provided with a higher level of autonomy.¹³⁶

However, similar to the Supreme Court noting that parents may "play a significant role in treatment," parental involvement should be encouraged in most forms of SUD treatment.¹³⁷ The confidentiality in Section 2.14 for minors may place a chilling effect on both providers encouraging parental involvement in treatment, and adolescents fully understanding the benefits which they are closing themselves off from with confidentiality.

IV. ISSUES OF CONFIDENTIALITY AND MINOR PATIENTS WITHIN SECTION 2.14(C)

There are times when providers may breach confidentiality because significant harm may arise from not reporting SUD treatment.¹³⁸ It is important to note that adolescents have the capacity to enter into the initial SUD treatment, therefore initial capacity should not be considered.¹³⁹ Based on Section 2.14(c), there are a few situations where treatment providers can break confidentiality.¹⁴⁰ Section (c) of "Minor patients" articulates that confidentiality for the minor can be broken if the minor:

lacks capacity for *rational choice*. Facts relevant to reducing a *substantial threat to the life or physical well-being of the minor applicant* . . . may be disclosed to the parent . . . or other individual authorized under state law to act in the minor's behalf if the part 2 program director judges that: (1) A minor applicant for services lacks capacity because of *extreme youth*[](sic.) or *mental or physical condition to make a rational decision* on whether to consent to a disclosure . . . to their parent . . . or other individual authorized under

¹³³ See Redding, *supra* note 122, at 704.

¹³⁴ *Id.* (quoting THE CHILDREN'S RIGHTS MOVEMENT: OVERCOMING THE OPPRESSION OF YOUNG PEOPLE 1 (Beatrice Gross & Ronald Gross eds., 1977)).

¹³⁵ *Id.*

¹³⁶ See *id.*

¹³⁷ Parham v. J.R., 442 U.S. 584, 610 (1979).

¹³⁸ 42 C.F.R. § 2.14(c) (2018).

¹³⁹ See *id.*

¹⁴⁰ *Id.*

state law to act in the minor's behalf; and (2) The minor applicant's situation poses a *substantial threat to the life or physical well-being of the minor applicant . . .* which may be reduced by communicating relevant facts to the minor's parent . . . or other individual authorized under state law to act in the minor's behalf.¹⁴¹

Similar to the public's comments about the vagueness of the regulation,¹⁴² more guidance should be given to treatment providers on how to assess the adolescent's maturity or ability to make a "rational choice." Treatment providers should also be given better guidelines to understand the "substantial threat[s]" that can be caused by SUD. Analysis of section (c) is necessary to understand where additions and clarifications are needed within the regulation.

A. Minors Lacking Maturity Based on Psychological Studies and Supreme Court Precedent within Section 2.14(c)(1)

Most adolescents have the initial level of capacity to receive SUD treatment; however, the mental state of adolescents should be taken into consideration and continually reassessed, especially for confidentiality within substance use treatments.¹⁴³ Considering subsection (1) of Section 2.14(c), regarding mental conditions affecting an adolescent's ability to make a "rational decision," treatment providers should be considering what type of substance the youth has been using and how long use has occurred.¹⁴⁴ This would include issues like heavy drinking, which is known to cause problems with the working memory,¹⁴⁵ and regular marijuana use, which causes problems with decision-making ability.¹⁴⁶

When examining the substantially precarious mental state of children with SUD, it is important to consider that they have a decision-making deficit that stems from the implications of substance use on the growing brain, along with immaturity.¹⁴⁷ While the core issue is not a "mental . . . condition,"¹⁴⁸ there is instead a lack of understanding and appreciation that continued confidentiality may be problematic for their treatment. While inclusion of adolescents in decision-making proves important for development and trust,¹⁴⁹ there may be times, based on psychological states, that they lack the maturity to fully make decisions. Further, involving adolescents in the decision-making process does not negate the

¹⁴¹ *Id.* (emphasis added).

¹⁴² *Supra* notes 44–45 and accompanying text.

¹⁴³ *See* Buchanan, *supra* note 115, at 415.

¹⁴⁴ 42 C.F.R. § 2.14(c)(1) (2018).

¹⁴⁵ Bava & Tapert, *supra* note 76, at 405.

¹⁴⁶ Squeglia et al., *supra* note 72, at 3.

¹⁴⁷ *See supra* Part II.C.

¹⁴⁸ 42 C.F.R. § 2.14(c)(1) (2018).

¹⁴⁹ *See* COMM'R FOR CHILDREN, INVOLVING CHILDREN IN DECISION MAKING (2015) (including children in the decision-making process has many developmental benefits).

fact that most parents should, at most times, be aware of what happens in their children's lives, especially with SUD treatment decisions.¹⁵⁰

B. Substantial Threat to the Well-being of Minors Under Section 2.14(c)(2)

Confidentiality of minors within a substance use treatment program may also be broken if “[t]he minor applicant's situation poses a substantial threat to the life or physical well-being of the minor applicant . . . which may be reduced by communicating relevant facts to the minor's parent.”¹⁵¹ The substantial threat would most likely come from the type and amount of the substances the adolescent uses.¹⁵² Adolescents using opioids should most likely be reported to parents or guardians due to the serious and substantive information that has been gathered surrounding the opioid epidemic and its serious effects on adolescents; for example, 55% of child opioid deaths in a poison control study were teenagers.¹⁵³ Parents should also be notified when certain lethal combinations of substances are used.

Not only should treatment providers look at the type and frequency of substance use, but the providers must also balance the seriousness of the adolescent's issues with the risks or benefits of parental involvement. Family-based treatments can be more effective than individual and group treatment approaches.¹⁵⁴ Including parents and family in SUD treatment allows children to improve communication skills and work on conflict resolution within the family,¹⁵⁵ helping to identify and manage any underlying problems related to the substance use and may also allow parents to be supportive.¹⁵⁶ Parents can schedule appointments and “provid[e] needed structure and supervision through household rules and monitoring.”¹⁵⁷ Family involvement should be part of the SUD treatment package. Treatment providers have a duty to inform minors of the benefits of family inclusion under the “best interests of the patient” because this is an established treatment option.¹⁵⁸

¹⁵⁰ See NAT'L INST. ON DRUG ABUSE, *supra* note 86, at 17.

¹⁵¹ 42 C.F.R. § 2.14(c)(2) (2018).

¹⁵² SALLY C. CURTIN, BETZAIDA TEJADA-VERA & MARGARET WARNER, NAT'L CTR. FOR HEALTH STATS., DATA BRIEF NO. 282, DRUG OVERDOSE DEATHS AMONG ADOLESCENTS AGED 15–19 IN THE UNITED STATES: 1999–2015, at 1 (2017), <https://www.cdc.gov/nchs/products/databriefs/db282.htm> (“The death rate due to drug overdose among adolescents aged 15–19 more than doubled from 1999 (1.6 per 100,000) to 2007 (4.2), declined by 26% from 2007 to 2014 (3.1), and then increased in 2015 (3.7).”).

¹⁵³ Norton, *supra* note 66 (studying calls to U.S. poison control centers for help with children or teens who had ingested prescription opioids).

¹⁵⁴ NAT'L INST. ON DRUG ABUSE, *supra* note 86, at 25–26.

¹⁵⁵ Boldt, *supra* note 73, at 109–10.

¹⁵⁶ *Id.* at 110.

¹⁵⁷ NAT'L INST. ON DRUG ABUSE, *supra* note 86, at 117.

¹⁵⁸ *Opinion 5.055-Confidential Care for Minors*, *supra* note 110 (“[W]hen the physician believes that, without parental involvement and guidance, the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified.”).

While family-based treatments have been found to be beneficial to adolescents, in some cases, involving parents in SUD treatment could jeopardize success. Adolescents could be further harmed if their SUD comes from a dysfunctional family relationship or from inappropriate or harmful relationships with parents.¹⁵⁹ However, the National Institute on Drug Abuse noted that some therapy combinations of family-based treatment and individual treatment can be very beneficial for adolescents because they allow children to confront parents and identify issues in a healthy setting.¹⁶⁰ These treatments work to improve “communication, problem-solving, conflict resolution, and parenting skills.”¹⁶¹ Further, studies have found that simply having social support aids in the treatment process.¹⁶² The information on the substantial benefits of the family-based treatment, depending on the nature of the problem of the adolescent’s substance use, may outweigh the benefits of confidentiality.

V. PROPOSED SOLUTION TO THE VAGUENESS OF 42 CFR 2.14(C)

Section 2.14 of the regulation should be further updated to include more specific guidelines for minors and confidentiality.¹⁶³ Adolescents have the capacity to seek treatment, but once they do, they then need the social support to make good decisions in the future.¹⁶⁴ Removal of confidentiality may benefit future decision making. Updates should focus on adolescents making a “rational decision” by receiving full information from providers about the benefits of family-based treatment. Within Section 2.14 there should be full disclosure by providers about the benefits and risks of social support and family-based treatment. Also, there should be a clearer exception with Section 2.14(c), allowing confidentiality to be broken if assessments determine that the adolescent would benefit. The updates should also focus on providing guidelines so providers can accurately assess, within Section 2.14(c), if there is “substantial threat or harm” to the adolescent.

Under this updated system, initial confidentiality should apply until assessment is complete because there are risks that minors will not seek the treatment both that they need and are willing to receive if confidentiality cannot be guaranteed.¹⁶⁵ While some minors will not seek SUD treatment based on the possibility that it will be disclosed to their parents or guardians, the initial confidentiality between the treatment providers and adolescents will build trust

¹⁵⁹ Boldt, *supra* note 73, at 110.

¹⁶⁰ See NAT’L INST. ON DRUG ABUSE, *supra* note 86, at 26 (looking at not only the adolescent’s problems, but also at problems like parental substance use).

¹⁶¹ *Id.*

¹⁶² Sharon M. Kelly, Kevin E. O’Grady, Robert P. Schwartz, James A. Peterson, Monique E. Wilson & Barry S. Brown, *The Relationship of Social Support to Treatment Entry and Engagement: The Community Assessment Inventory*, PUBMED CENT. 1, 6–7 (2011).

¹⁶³ 42 C.F.R. § 2.14 (2018).

¹⁶⁴ *Recovery and Recovery Support*, *supra* note 90.

¹⁶⁵ See *supra* Part II.A.

with those adolescents who do seek help.¹⁶⁶ The trust will allow minors to have more open and honest conversations with their treatment providers, and hopefully encourage them to accept treatment providers' advice.¹⁶⁷ Similar to the AMA Code of Medical Ethics guidance for minors' confidentiality, patients' opinions must be considered to promote autonomy; however, if a provider feels that the minor's parents should be informed, the provider must discuss this with the minor prior to disclosure, even if Section 2.14 exceptions are met.¹⁶⁸ Conversations built from a trusting relationship can open channels of communication between the provider and minor, which ultimately will promote the minor's wellbeing.¹⁶⁹

The updated regulation will allow for more structure as to when providers can disclose SUD treatment. This proposed plan accords with the purposes underlying Section 2.14: not interfering with the parent-child relationship and giving providers freedom to protect minors from possibly harmful situations.¹⁷⁰

A. Providing Adolescents Information Necessary for Informed Consent: The Possible Benefits and Risks of Family-Based Treatment

In order to truly give informed consent, minors must be provided information about all of the risks and benefits of family-based treatment, and they must fully understand how confidentiality ties into the obstruction of these possible benefits. While there is not an extensive body of research, studies have found that family-based treatment is more effective than other treatments that do not use family-based approaches.¹⁷¹ The information about the benefits of family-based treatment should be explained to adolescents, and providers should make sure to confirm that the adolescents fully understand this information. Providers should also give information about the importance of social support benefits, encouraging adolescents to allow information to be shared with a trusted adult if their parents are unavailable or would not be helpful. If providers are able, they should also try to

¹⁶⁶ See Maria Allinson & Betty Chaar, *How to Build and Maintain Trust with Patients*, PHARMACEUTICAL J. (Nov. 16, 2016), https://www.pharmaceutical-journal.com/pharmacy-learning-centre/how-to-build-and-maintain-trust-with-patients/20201862.article?firstPass=false#fn_4.

¹⁶⁷ *Id.* (“High levels of trust have been associated with many benefits, including . . . greater acceptance to recommended treatment and adherence to that treatment.”).

¹⁶⁸ See *Opinion 5.055-Confidential Care for Minors*, *supra* note 110.

¹⁶⁹ See Allinson & Chaar, *supra* note 166.

¹⁷⁰ Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27802, 27808 (July 1, 1975) (to be codified at 42 C.F.R. pt. 2) (“Any other rule could subject clinicians to an intolerable choice between violating the provisions of this part on the one hand, or failing to take action to avoid a preventable tragedy involving a minor, on the other. The statutes authorizing this part should not be read as requiring such a choice.”).

¹⁷¹ Edward Kaufman & Marianne R.M. Yoshioka, SUBSTANCE ABUSE TREATMENT AND FAMILY THERAPY 12 (2004).

have a conversation with parents to better determine the parents' involvement in the adolescent's life and their understanding of the child's substance use.¹⁷²

The updated regulation would then continue with the inclusion of a mental health professional. If a minor still refused family-based treatment, a psychologist¹⁷³ would need to see the minor to determine if the minor would benefit from family-based treatment. The psychologist would then be required to document that family-based treatment would not be helpful in order to completely solidify the confidentiality. The family-based treatment may not be beneficial if the minor struggles from a precarious home-life and informing the parents would only exacerbate the situation.¹⁷⁴ However, psychologists will note times when family-based treatment can help adolescents with problems at home, because the treatment will address those underlying problems.¹⁷⁵

Further, the approach would comport with the AMA Code of Medical Ethics, where if a provider believes that "parents will be helpful and understanding," the information about the substance use treatment should be disclosed.¹⁷⁶ This guidance will ensure that minors are being given more information about the benefits of parental involvement in their SUD treatment. The approach will emphasize that for true informed consent to exist, minors must understand the possible benefits that they are giving up in choosing confidentiality.

B. Accessing the Risk for Substantial Harm: The Psychological Effects of the Amount and the Type of Substance Use

In entering SUD treatment, minors recognize that the substance use is a problem in their lives, but treatment providers still must identify the problem's extent. In the updated framework of the regulation, treatment providers should identify the length and frequency of the minor's substance use. Based on studies illustrating the detriments to an adolescent's brain due to substance use, the treatment provider would have to assess whether the SUD limits the minor's decision-making ability or affects the adolescent's brain after the minor's initial decision to receive treatment.¹⁷⁷ The assessment would occur not only through tests, SUD treatment providers also would be presented with a detailed guideline that defines what drugs should be flagged for possibly categorizing a child as *high risk*. The determination of a *high risk* child would be defined from the regulation as a child whose SUD combination or use possesses a "substantial threat to the life or physical well-being of the minor applicant."¹⁷⁸ These guidelines would give SUD

¹⁷² See *supra* Part II.C. (explaining that providers should attempt to interview parent-like figures in the adolescents' lives if they do not have substantial biological parent contact).

¹⁷³ If no psychologist is available, the assessment can be done by the provider.

¹⁷⁴ See Boldt, *supra* note 72, at 111.

¹⁷⁵ See NAT'L INST. ON DRUG ABUSE, *supra* note 86, at 25.

¹⁷⁶ *Opinion 5.055-Confidential Care for Minors*, *supra* note 110, at 901.

¹⁷⁷ See *supra* notes 75–83 and accompanying text.

¹⁷⁸ 42 C.F.R. § 2.14(c)(2) (2018).

providers more clarity on what *high risk* looks like or those substances that can substantially affect the brain, leading to swift and serious outcomes.

Providers would next identify whether the minor has the level of maturity to properly understand confidentiality. This would also be based on the information that was previously disclosed about the importance of social support systems and family-based treatment. The minor would need to show the ability to understand and appreciate the situation.¹⁷⁹ In these cases, the minor would need to be informed of the risks and benefits of the treatment without including the parents.¹⁸⁰ Minors would demonstrate their maturity not only through the meeting with the provider but also through several different types of assessments. The assessments would be administered through counseling to make sure that they understand the benefits of social support and family-treatment. The assessment would further test their level of maturity and understanding of the idea of confidentiality and the positives, along with negatives, of not including parents in treatment. The meetings with the provider, paired with the examinations, would ensure that minors fully understand the constraints of confidentiality in relation to their treatment.

These additions to the regulation would protect adolescents who are at *high risk* from falling through the cracks of the system or the regulation. Furthermore, it would ensure that adolescents are fully informed that the benefits of social support and parental involvement generally outweigh the “risks” of informing parents.

CONCLUSION

Adolescents have been treated as a vulnerable population, subject to extra protections, within society and the law. Adolescents with SUD may be in a heightened state of vulnerability because of their lack of maturity, compounded with the neurological deficits caused by SUD. Research has found that environmental factors play a large role in the treatment and recovery of adolescents suffering from SUD.¹⁸¹ These treatment options can range from group therapies to family-based treatments.¹⁸² The benefits of treatment may then come into conflict with Section 2.14, which has the main purpose of allowing minors to consent to confidentiality within SUD treatment.

When enacted in 1975, Part 2 served the goal of allowing people, including minors, to confidentially receive treatment for SUD without the stigma.¹⁸³ Based on the current knowledge of the effects of SUD on adolescents’ brains and the importance of social support, including family-based treatment, Section 2.14 should be updated to provide clear treatment reasons as to when disclosure of SUD treatment is necessary. The updates should include full disclosure to adolescents of

¹⁷⁹ *Assessing Medical Decision-Making Capacity*, *supra* note 105.

¹⁸⁰ See NAT’L INST. ON DRUG ABUSE, *supra* note 85, at 30 (showing the benefits of including parents in treatment options).

¹⁸¹ See *supra* notes 85–88 and accompanying text.

¹⁸² See NAT’L INST. ON DRUG ABUSE, *supra* note 85, at 23.

¹⁸³ Part 2—Confidentiality of Alcohol and Drug Abuse Patient Records, 40 Fed. Reg. 27,802; 42 C.F.R. § 2.14 (2018).

the benefits of family-based treatment, ensuring that adolescents fully understand and consider these benefits, and distinct guidelines for treatment providers to report SUD treatment to parents based on possible harm.

Ultimately, while the implications of the social stigma should be considered when treating adolescents with SUD, the social support may not only benefit adolescents, but may be necessary throughout minors' treatments. The purpose of Section 2.14 is to allow minors to seek the treatment that they need; therefore, it is vital that the regulation does not produce a chilling effect on the treatment, making providers hesitant to advocate against confidentiality and for family-based treatment. While the confidentiality and autonomy provided by Section 2.14 prove important, adolescents still maturing and dealing with the effects of SUD must be fully informed about how the benefits of family-based treatment may outweigh any risks that may concern them. In conclusion, the full disclosure of the benefits of SUD family-based treatments will allow adolescents to give informed consent, promoting autonomy, while still working to protect and treat these vulnerable adolescents.