MINOR'S CONSENT TO CONFIDENTIAL MENTAL HEALTH SERVICES

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This is dedicated to my family
and friends for all of their support
throughout my academic career.

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ABSTRACT

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by Cody Bartow

When making decisions in their professional roles, school psychologists must be aware of the legal aspects of situations that arise in the delivery of services (i.e., federal, state, and case law), as well as potential ethical issues. The National Association of School Psychologists [NASP] (2010) explicitly permits school psychologists to provide counseling services to mature minors who self-refer without parent notice or consent *where allowed by law and district policy*. The code also allows the school psychologist to refer a student to alternative sources of assistance that do not require parent notice or consent without notifying the parent of the referral (NASP-PPE Standard I.1.2). Law (both case and statutory) has much to say on confidentiality, privilege, and minors; when a minor can consent to mental health services on their own; when the information can (or must) be shared with or withheld from parents; parent access to records of their minor child; and other related issues.

It is important for school psychologists to know ethical and legal restrictions concerning confidentiality and access of minors to mental health care, not only for their own practice in the school setting, but in helping adolescents to find community resources that can assist them. The purpose of this thesis project was to provide an overview of the laws in each state in regard to access to mental health services for minors without the consent of their parents and limitations to such access. To do this the exact language of state statutory or case law regarding what mental health professionals are required, permitted, or prohibited from doing was explored, as well as what is simply not addressed. This thesis project provides state-by-state information as to whether or not it is permissible by law to provide un-emancipated minors mental health services

without parental consent and if an age requirement is specified, any limitations to confidentiality, any limitations on types of services or service providers, any duration limitations, and who is responsible for payment of the services if the parent is not required to consent.

A state-by-state search of Statutory Code on the state's website (www.ZZ.gov), or related state resource, was conducted to find information pertaining to the age of majority and laws for consenting to health and mental health care. Additionally, a state-by-state search on LexisNexis of State Codes (with selected sources Statutory Code, Administrative Code, and Constitution) was conducted using key words: mental health, minors, and consent. A second researcher conducted similar searches for comparison to ensure accuracy of the collected information. When disagreements between the researchers occurred regarding the content or meaning of a state's law, the researchers reviewed and discussed the relevant law until consensus was reached.

Some states were silent in all areas examined by the research project or mandated that individuals be at least 18 years of age to consent to their own outpatient mental health services. However, 8 of these states allowed for emergency mental health services, such as suicide assessment and harm prevention. Twenty-two states and the District of Columbia grant minors the right to consent to outpatient mental health services on their own behalf. Many factors vary across these states, such as the age at which consent is allowed, the types of services that can be provided, who can provide the services, and the degree to which information is kept confidential.

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CHAPTER I

INTRODUCTION

Adolescents, as a group, tend to engage in a wide variety of risk-taking behaviors. A Centers for Disease Control and Prevention (CDC, 2010) report on risky youth behavior for students in grades 9 through 12 reported that 72.5% of students had tried alcohol at least once in their lifetime, 41.8% drank within the 30 days prior to the survey, and 24.2% had five or more drinks (i.e., binge drinking) in the 30 days prior to the study. In addition, 20.8% reported having used marijuana at least once in the previous 30 days. Other risky behaviors included unprotected sex (about 39% of the students who were sexually active reported they did not wear a condom during their last sexual intercourse), riding in a car in which the driver had been drinking (over 28% of students had done so in the previous 30 days), and drunk driving (9.7% had driven after drinking in the 30 days prior to the survey). These survey findings suggest a substantial percentage of high school students engage in risky behaviors. Ford, Bearman, and Moody (1999) found that adolescents who regularly smoked, consumed alcohol, and/or had sexual intercourse were less likely to seek health care than those who did not.

While not all adolescents experience difficulties with peer relationships and/or mental health problems, a significant number do. For example, the CDC (2010) report on youth risk behaviors found that nationwide about 20% of students had been bullied within the 12 months prior to the survey and 5% of students had not gone to school because of safety concerns at least once during the previous 30 days. In addition, the report also found that over 26% of students felt so sad or hopeless for a period of 2 weeks or more that they stopped doing some of the activities they normally did, and that 13.8% of students had seriously considered attempting suicide in the

year before the survey. Almost 11% of all students had a suicide plan and over 6% had attempted suicide at least once in the 12 months before the survey. Access to mental health services for these individuals is important to help them cope with problems, situations, and/or difficulties that are leading them to have such ideations and to allow them to become healthy young adults.

As mentioned above, many youth who engage in risky behaviors do not seek health care. This could be caused by fear of a lack of confidentiality. This has been demonstrated in research by Reddy, Fleming, and Swain (2002) who found that adolescent girls are less likely to use sexual health care services if confidentiality is perceived to be at risk. Furthermore, Walcott and Music (2012) stated adolescence is a time when many disorders such as depression, eating disorders, and psychosis peak but the number of adolescents who seek mental health services is low. This could be the result of cultural factors that make solving their own problems seem desirable, fear of parent reaction if told about their behaviors, or a perception that mental health professionals are either not trustworthy or not helpful. In addition, Joiner (2010) suggested that a risk factor for suicide is an individual's perception that he or she has become a burden to others. Some adolescents may fear that disclosing their problems to a parent (e.g., "I'm being bullied at school") will create stress and a burden for the parent. Therefore, it seems that adolescents who engage in risky behaviors and fear that health services will not be confidential are not likely to seek the services they may need. As a result, it is important that adolescents have access to confidential mental health services from caring individuals with sound professional judgment.

Outpatient mental health services are any mental health services performed outside of a residential (i.e., inpatient) treatment program. The issue of providing outpatient mental health services to an un-emancipated minor without parent permission is ethically and legally complex, because it involves balancing the obligation to ensure the wellbeing of a child while at the same

time respecting parental rights (see Jacob, Decker, & Hartshorne, 2011, and Koocher & Daniel, 2012).

> A potential benefit of allowing minors access to psychological assistance without parent notice or consent is that it may encourage them to seek and receive the help they need to manage emotional or developmental challenges (Lehrer, Pantell, Tebb, & Schafer, 2007). A potential negative outcome is that the parents may ultimately learn that their child is receiving psychological assistance without their permission, possibly resulting in increased tensions within the family and the belief that the service provider interfered with their parental rights. (Jacob, in press)

The National Association of School Psychologists' *Principles for Professional Ethics* (NASP-PPE, 2010) explicitly permits school psychologists to provide counseling services to mature minors who self-refer without parent notice or consent *where allowed by law and district policy*. The code also allows the school psychologist to refer a student to alternative sources of assistance that do not require parent notice or consent without notifying the parent of the referral (NASP-PPE Standard I.1.2). English, Bass, Boyle, and Eshragh (2010) indicated that about 34 states have laws pertinent to minor consent to outpatient mental health services and 49 allow minors access to treatment for substance abuse without parent involvement. There are, however, differences in how states define terms (e.g., *minor*, *mental health* treatment), the types of mental health treatment available, the types of professionals permitted to provide services to minors without parental involvement, the number of sessions permitted without parental consent, the terms of confidentiality of a minor's mental health records, and the party who is responsible for payment. The purpose of this research project was to investigate state laws on the rights of un-emancipated minors to "consent" to mental health treatment without parent involvement.

CHAPTER II

REVIEW OF LITERATURE

When making decisions in their professional roles, school psychologists must be aware of the legal aspects of situations that arise in the delivery of services (i.e., federal, state, and case law), as well as potential ethical issues.[1] The National Association of School Psychologists (NASP) developed and adopted a code of ethics titled *Principles for Professional Ethics* (NASP-PPE), most recently revised in 2010. The American Psychological Association (APA) has a separate ethics code that was written for psychologists in diverse areas of practice. Law (both case and statutory) has much to say on confidentiality, privilege, and minors; when a minor can consent to mental health services on their own; when the information disclosed by a minor can (or must) be shared with or withheld from parents; parent access to records of their minor child; and related issues. It is important for school psychologists to know ethical and legal restrictions concerning confidentiality and access of minors to mental health care, not only for their own practice in the school setting, but in helping adolescents to find community resources that can assist them.

There are many legal issues to consider when addressing the mental health concerns of a minor, and law regarding the topic frequently changes (English et al., 2010). The purpose of this literature review is to examine evidence supporting and opposed to allowing minors access to mental health care without parent notice or consent, the age at which a minor should be considered cognitively able to provide informed consent, circumstances under which mental

[1] The author is not an attorney. Information provided should not be used as legal advice. For legal questions a lawyer should be consulted.

health care can generally be provided without parent consent, and some of the reasons why confidential mental health services for minors is of importance.

For the purpose of this thesis, *minor* will refer to un-emancipated minors; in other words a minor is defined as an individual who is not of the age of majority as defined by state law and is still the charge of a parent or guardian. Under many emancipation statutes, as well as under common law, marriage is considered a criterion for emancipation before reaching the age of majority, so this paper also excludes married individuals, regardless of age (English et al., 2010). Different states consider minors emancipated under other special circumstances (for example see Vukadinovich, 2004). Consistent with the 2010 NASP code definition, *parent* will refer to biological (i.e., birth) parents, adoptive parents (including grandparents or other relatives, stepparents, or domestic partners), as well as individuals who are legally responsible for the welfare of the child.

Cognitive Capacity and Emotional Maturity of Minors to Provide Consent

When discussing mental health services for minors, the first thing that must be considered is their ability to provide informed consent, a complex topic that is part of the reason why allowing minors access to mental health services without parent involvement is controversial. As Grisso and Vierling (1978) noted:

> We need to examine systematically which minors are capable of assuming what decision-making roles in which treatment situations with what consequences for the minor, the family unit, the professional, and society. Our own attempts to respond in an ethical and therapeutic way to minors in treatment require such information, lest in our zeal we burden some minors with decisions that they cannot make intelligently (sometimes to

> their detriment) or inadvertently deny to some the opportunity to make decisions of which they are fully capable. (p. 412)

A number of developmental factors should be considered when determining whether a minor is capable of providing informed consent. Legally, consent is the permission of an individual that is given knowingly, voluntarily, and intelligently (Grisso & Vierling, 1978, p. 415). This leads to the question of whether minors are cognitively and emotionally able to provide knowing, intelligent, and voluntary consent.

Grisso and Vierling (1978) provided a comprehensive discussion of the developmental considerations for each of these areas. They defined *knowing* as the individual being able to understand the information being given, and pointed out that this partly depends on the manner in which the information is communicated. At the time of publication there were not enough data to determine at what age adolescents can make a knowing decision, a point that Melton (1981) subsequently reiterated and that remains unclear at present.

As for *intelligent*, Grisso and Vierling (1978) defined it as the individual being able to competently arrive at the consent decision in a rational manner, meaning the person is able to use a process to make a decision based on the information presented. The authors noted that, to make an intelligent decision, the individual must be able to attend to the information provided and abstractly reason through risks and alternatives that may not be immediately present. They suggested that reflective children are more likely to have the reasoning skills necessary to make intelligent consent decisions when compared to more impulsive children. In addition, Grisso and Vierling observed that often children under the age of 12 or 13 perceive events to be under the control of external forces. If this is the case, youth below this age could be less likely to think

through decisions before providing consent, a developmental limit on the ability to provide knowing consent.

Determining specific ages at which minors are able to make such adult-like choices is difficult because of the variability across individuals; however, by age 16, there do not seem to be appreciable differences between logical reasoning abilities of adolescents and adults in structured situations, though adolescents show high levels of impulsivity in other situations (Steinberg, Cauffman, Woolard, Graham, & Banich, 2009a). The fact that adolescents can make rational, adult-like decisions in some situations is the basis for exceptions that allow minors to consent in some circumstances in a legal system that generally views minors as incapable of making such decisions (Steinberg, Cauffman, Woolard, Graham, & Banich, 2009b). Grisso and Vierling (1978) pointed out that the ability to provide intelligent consent appears to come after Piaget's concrete operational stage when the individual has entered the formal operational stage. They contend, however, that there are disagreements about the exact age at which the transition occurs and suggest that the ages 11-13 are a period of transition during which some children may have the reasoning skills to make intelligent informed consent decisions.

Grisso and Vierling (1978) defined *voluntary* consent as consent that is made free from coercion and is not deferent to authority. They point out that it is important that the individual is not simply conforming to what they believe is expected of them. They found that during the preadolescent years children exhibit a high level of deference to authority to avoid negative consequences and a high level of concern for meeting social expectations. As a result, they suggested that the risk for deferent responses may be high until ages 15-17. "Below 15-17 years, then, there is reason to question whether minors in general can satisfy the voluntary element of competent consent" (Grisso & Vierling, 1978, p. 423).

Over the past decades, since the seminal Grisso and Vierling 1978 article, much has remained the same with regard to what constitutes informed consent and whether minors are cognitively and emotionally able to make such decisions. The Supreme Court subsequently heard cases regarding the ability of minors to make adult-like choices. Steinberg et al. (2009a, 2009b) discussed how, at first glance, it appeared that the American Psychological Association (APA) argued two contradictory positions in two cases. In *Hodgson v. Minnesota* (1990), the APA argued that when it comes to making decisions about having an abortion, a minor is just as mature as an adult. In a second case, *Roper v. Simmons* (2005), the APA argued that juveniles are not as mature as adults and should not receive the death penalty. Steinberg et al. (2009b) investigated why this distinction was made, and determined that the ability to make decisions regarding abortion is reached at an earlier age than the capacity to inhibit impulsive acts and resist peer pressure to participate in criminal activity. The decisions, they point out, involve different types of decision making processes. Decisions such as having an abortion often (though not always) can be made with the support of a caring professional and may lack the immediacy and peer pressure often present when an adolescent makes law-breaking decisions. The lack of immediacy and peer pressure leads to a more rational and deliberate manner of decision making that demonstrates a more mature cognitive capacity (Steinberg et al., 2009a). Citing the majority opinion in *Roper v. Simmons,* Steinberg et al. (2009a) pointed out that the Justices drew attention to three specific reasons adolescents have diminished criminal culpability: "their underdeveloped sense of responsibility (and difficulty controlling their impulses), their heightened vulnerability to peer pressure, and the unformed nature of their characters" (p. 583).

It should be clear that determining whether a minor is developmentally capable of informed consent is a complex topic. Melton (1981) suggested that "adolescents usually are

competent to give consent at least after age 15" (p. 251). More recently, Steinberg et al. (2009a) suggested that after age 16 there does not appear to be much difference in the logical reasoning abilities of adults and adolescents. Grisso and Vierling (1978) suggested that until age 15-17, social influences may prevent adolescents from making a truly voluntary decision. The brain and cognitive abilities continue to grow and increase during adolescence. While some adolescents may be able to give informed consent at a younger age, generally speaking older adolescents are more likely to be capable of giving informed consent. This gives a framework around which codes and laws can be designed. Melton (1981) cautions that psychologists who provide extensive ongoing services to minors younger than 15 or 16 without parent consent should be careful, as they may be in violation of the law and the consent provided by the minor may not be truly informed consent.

Forgone Health Care

Despite possible concerns about a minor's ability to consent, English et al. (2010) reported that all states allow minors to consent to confidential care in relation to sexually transmitted diseases. It should be noted, however, that some states limit the scope of services to prevention and/or diagnosis and/or treatment. Just how variable this access is from state to state is unknown. For example English et al. (2010) found that only 46 states authorize consent by minors to HIV/AIDS care specifically and some of these states limit the consent to testing only. Furthermore, the Supreme Court has ruled that minors have the right to access contraceptives (e.g., *Carey v Population Services International,* 1977), and other (lower) courts have struck down statutes attempting to mandate that parental consent be obtained before contraceptives are given (English et al., 2010). This is important because studies have found that adolescent girls

are less likely to use sexual health care services if they believe confidentiality is at risk, even if it is for a service that would remain confidential (Reddy et al., 2002).

Reddy et al. (2002) conducted an extensive study of girls under age 18 who used any of the Planned Parenthood locations in Wisconsin. The study found that 47% of girls would discontinue use of sexual health care services that involved mandatory parental notification and some would stop visiting for any services regardless of whether a particular service was confidential. Of these girls, 99% reported that they would continue having sexual intercourse. This clearly shows the importance of confidentiality to help reduce adolescent pregnancy and encourage practices such as screenings for sexually transmitted disease or infection.

School psychologists may encounter an adolescent student who wants to know about sexual health. It is important to know what resources are available that can address such issues and to what extent the information will be confidential. The likelihood that the student will seek out these resources increases if the practitioner is able to recommend a resource that will keep information and services confidential. Of note is that any site that receives Title X Family Planning funds (passed as Public Law 91-572 in 1970 as part of the federal Public Health Service Act) is required to provide confidential screening for sexually transmitted diseases and contraceptives (Lehrer, Pantell, Tebb, & Shafer, 2007; United States Department of Health & Human Services, 2012).

Sexual health is not the only area in which adolescents may choose to forgo services if there is a lack of confidentiality. In a study of adolescents who did not get necessary health care in the past year, over 10% of boys and 14% of girls reported that the reason for not receiving the care was in part or in whole due to confidentiality concerns (Lehrer et al., 2007). This study

further found that youths who cited this as the reason for forgone health care had higher levels of unsatisfactory communication with parents, higher rates of past-year suicidal ideation and attempts, as well as higher past-week depressive symptoms. In addition, girls who cited confidentiality as a reason for forgoing health care were more likely to have had sexual intercourse, not used birth control, exhibited higher depressive symptoms, and to have used alcohol in the past year. "U.S adolescents who forgo care due in whole or in part to confidentiality concern [sic] are a particularly high-risk population in need of health care services" (Lehrer et. al, 2007, p. 222). Other studies have also indicated that adolescents who regularly partook in activities such as smoking, drinking, and sexual intercourse were less likely to seek health care (for example, see Ford, Bearman, & Moody, 1999).

The fact that many adolescents are willing to forgo health care if they are concerned about confidentiality is especially troubling given that the development of the brain during adolescence leads to an increase in risk–taking behavior. There is a general trend for adolescents to have less confidence and lower self-esteem at puberty, the risk of clinical depression doubles, an increase in suicidal ideation exists, and there is a potential increase in law-breaking activities (Berger, 2012). Moffitt and Caspi (2001) made a distinction between *life-course persistent offenders* and *adolescence-limited offenders*. The former have contextual and brain-based factors, that increase the risk of breaking the law in early adolescence or prior and continuing through adulthood, whereas the latter break the law primarily because of psychosocial contexts (breaking the law with their friends) and to demonstrate their autonomy from their parents. According to Moffitt and Caspi (2001) adolescence-limited offenders have a short-term delinquency, and are more prevalent than life-course persistent offenders. Adolescence-limited offenders who are

protected from dropping out of school, becoming drug addicted, entering prison, and becoming an early parent may outgrow the criminal behavior. The best outcome occurs if the delinquent behavior is stopped before police involvement occurs. Interventions for those exhibiting stubbornness and defiance, shoplifting, and bullying can prevent more serious law breaking in the future (Berger, 2012). If health care is avoided by a large number of at-risk minors when confidentiality is not guaranteed, it would seem that professionals who can assure confidentiality may have the best chance of reaching out to these adolescents and providing them with the help they need.

As reported by Maza (2010), a particularly vulnerable group of adolescents are those identifying as lesbian, gay, bisexual, or transgender (LGBT), as well as those questioning of their gender identity and/or sexual orientation. These teenagers are frequently discriminated against, bullied and harassed at school, condemned in the media and by religious organizations, and may even face rejection at home. As a result, LGBT adolescents are more likely to report high rates of depression and anxiety, have suicidal thoughts, engage in self-harm, and attempt suicide. These individuals may be afraid of ramifications if their parents find out they are LGBT. This shows the need for confidential mental health services for these youth, which has been shown to be beneficial even when not accompanied by psychopharmacological treatment.

Substance Abuse Programs

As mentioned previously, Title X allows access by minors to confidential sexually transmitted disease screenings and contraceptives. In a similar fashion, federal regulations about confidentiality of drug and alcohol treatment programs apply when states have a law allowing minors to consent to these services (English et al., 2010). While some states have specific

confidentiality and disclosure provisions, these may be in disagreement with federal confidentiality rules and such provisions must be analyzed. Most states allow consent to drug and alcohol treatment programs by minors and have enacted rules in conformity with federal regulations safeguarding the confidentiality of such treatment. English et al. (2010) noted that "at least 49 states have enacted statutes that expressly allow minors to consent for care related to the use of drugs or alcohol or to receive care without parental consent" (p. 6). Because of the high prevalence of access to this type of treatment across states and the complex interplay between federal regulations and state laws, this research project excluded examination of state laws that specifically targeted consent to drug and alcohol treatment by minors.

Early Findings on Access to Mental Health Care by Minors

A study by Melton (1981) examined how a law passed in Virginia was being implemented one year after it went into effect. The law stated that minors, with no age guidelines provided, were to be considered adults for the purpose of consenting to medical or health services for outpatient care and treatment for mental illness or emotional disturbance. Melton conducted interviews with 41 community mental health clinics in Virginia that all reported having policies in place for providing services for children. He found that there had been no substantial increase in the number of cases in which minors sought treatment without parent consent, though noted that some of these facilities had seen minors without parent consent before the law was changed. He also noted that the youngest patient seen by any of the clinics was 12 and most were at least 14, with the most common reasons for seeking treatment being sex-related issues, drug abuse, and extreme family discord. He concluded:

> the present study suggests that fears that incompetent minors will seek treatment if they are allowed to do so may be ill founded. Despite the lack of an age standard in the statute,

> all of the minors who had sought treatment without parental consent were adolescents. (Melton, 1981, p. 653)

Importance to School Psychology

School psychologists are in a position in which they might be approached by minors for a variety of mental health or other concerns. As a result it is important to know what services can be provided without parental consent, as well as what local services are available that do not require parental consent. The NASP-PPE states that for school psychologists:

> It is ethically permissible to provide psychological assistance without parent notice or consent in emergency situations or if there is reason to believe a student may pose a danger to others; is at risk for self-harm; or is in danger of injury, exploitation, or maltreatment. (Standard I.1.2)

In addition the NASP-PPE states that when a minor student self-refers:

> It is ethically permissible to provide psychological assistance without parent notice or consent for one or several meetings to establish the nature and degree of the need for services and assure the child is safe and not in danger. (Standard I.1.2)

Furthermore Standard I.1.2 goes on to say that the school psychologist can provide services to mature minors without parent consent if it is permissible under state law and school district policy. Many differences exist from state to state in terms of statutory code and case law as to what services can and cannot be provided to minors. School psychologists and other community mental health professionals should be familiar with their state laws (case and statutory), as well as those at the federal level. Ethics codes and applicable laws should also be considered in determining what information is to be shared with the parent, whether confidentiality is an option or not.

Thus far this review has examined why the ability of the minor to consent is of importance, areas in which parents are not required to consent for services to be provided (e.g., sexually transmitted disease care and drug and alcohol treatment programs in most states), and some reasons why access to confidential mental health care for minors is important (e.g., less likely to get treatment if it is not confidential, LGBT support). The next area that is important to consider is limits to the confidentiality of information shared.

Confidentiality of Information Shared in Mental Health Provider-Minor Client Relationships

The Health Insurance Portability and Accountability Act (HIPPA, Pub. L. No. 104-191) is a 1996 federal law designed to protect the privacy and security of patient mental and physical health information while ensuring a smooth flow of necessary health information that is needed for treatment and health care claims (Office for Civil Rights, 2003). Mental health providers who work in private practice or in health care settings are usually required to comply with HIPPA. HIPPA guidelines state that in most cases parents are personal representatives for minor children and can access the medical records on behalf of the children, but also note that in some cases the parent is not considered the minor's personal representative. In these cases:

> the Privacy Rule defers to State and other law to determine the rights of the parents to access and control the protected health information of their minor children. If State and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's protected health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment. (Office for Civil Rights, 2003, p. 16)

Furthermore, HIPPA allows minors to act on their own behalf in regards to protected health information when the minor has consented to the services and no other consent was needed

under state law or the minor's parent, guardian, or other authorized person has consented to the services and assented to a confidentiality agreement between the minor and the healthcare provider (Vukadinovich, 2004). This indicates that in some situations, depending on state and local law, licensed mental health care providers have the authority to decide whether to share information disclosed to them by a minor with the child's parents.

HIPPA has other caveats as to when it is and is not appropriate to share information with parents of minors. Sales, DeKraai, Hall, and Duvall (2008) noted that:

> under HIPPA the health care provider may not give information to a parent if it is contrary to state privilege laws or if the health care provider "in the exercise of professional judgment decides it is not in the best interest of the [child] to treat the [parent] as the child's personal representative" (HIPPA (sic) Privacy Rules § 164.502 (g)(3)(i)(2003). (p. 529).

This appears to offer some discretion for mental health care providers who believe that sharing information with parents would be detrimental to the well-being of the minor. Sales et al. (2008) discussed *Abrams v. Jones* (2000) in which a divorced father, in a custody battle, tried to gain access to notes from a psychologist, Dr. Abrams, from whom his daughter had been receiving services. According to Dr. Abrams the girl had been very concerned about sharing information with him if her parents would be able to find out what she said, so he said he would only share broad concepts of what was discussed and not specifics. The father asked the court to order Dr. Abrams to hand over his therapy notes. The court ruled that since it was a custody battle and there may be motives that were not in the best interest of the child, the records did not have to be released to the father. Sales et al. (2008) concluded that:

> In sum, when parents request access to their child's therapeutic records, the therapist should assess whether disclosure is in the best interests of the child. If the child has the capacity to consent and desires confidentiality, or if the child does not have the capacity to consent and disclosure would not be in the best interests of the child, the therapist should deny parental access. There are a number of legal theories on which parents may seek access in a court of law (e.g., Madden, 1982). The court will then determine whether access should be granted. (p. 529-530)

While the last thing many psychologists want is to end up in court, the client's wishes and what is in the best interest of the client must be taken into consideration based on professional ethics. In such a case the court is the best source of mediation in deciding if the parent should be allowed access to the records or not. This may be especially true in states that have professional-client privilege laws that prevent disclosure of confidential information shared in a psychologist-client relationship. When such laws are in place, impermissible breach of client confidentiality can lead to civil lawsuits against the mental health professional and/or the loss of credentials to practice (Jacob & Powers, 2009).

Even if the mental health care provider makes the decision not to disclose that a minor is seeking treatment to the parent, or why, that information may be obtained by the parents in another way. If a minor pays for services by billing an insurance company and he or she is a dependent on a parents insurance plan, the policyholder may obtain information the minor expected would remain confidential. According to English, Gold, Nash, and Levine (2012) this sometimes happens as the result of a widely used billing and claims-processing procedure that involves sending the policyholder an explanation of benefits form (EOBs) anytime care is provided to anyone on the policy. Different states have different laws that affect the contents of

EOBs and what insurance companies can report to policyholders (for a state by state review see English et al., 2012). "EOBs typically identify the individual who received the care, the health care provider and the type of care obtained" (English et al., 2012, p. 5). HIPPA allows the use of protected health information to secure payment, so insurance companies often issue EOBs to policy holders to ensure they are aware of charges and actions occurring under their policy. Parents who are policyholders may therefore discover their child has sought treatment.

For public school mental health providers compliance with the Family Educational Rights and Privacy Act of 1974 (FERPA) is mandated instead of compliance with HIPPA (U.S. Department of Health and Human Services & U.S. Department of Education, 2008). Parents have the right to inspect and review the education records of their K-12 student, including records created by a school-employed mental health provider. This right transfers to the student at the age of 18. However parents can inspect education records of high school students who are dependents as defined by federal tax law (34 C.F. R. §§ 99.5, 99.31[a][8]). This does not, however, pertain to *sole possession records*, which are "Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record" (34 C.F.R. § 99.3). These records are separate from education records and therefore not part of what the parent is legally entitled to review under FERPA.

Research Questions

The intent of this research project was to examine access by minors to general outpatient mental health services, excluding those seeking substance abuse or family planning services since these services are often available to minors based on federal laws. To do this the exact language of state statutory or case law regarding what mental health professionals are required,

permitted, or prohibited from doing was explored, as well as what is simply not addressed. Specifically, the current study examined the following:

1. Does the state's law specify that minors are allowed emergency mental health services when no parent is available?
2. Does the state's law specify the age when un-emancipated minors are allowed to consent to general outpatient mental health services? If yes, at what age?
3. Does the state's law identify limitations on types of mental health services that may be provided without parent consent (e.g., no medication, electroconvulsive shock)?
4. Does the state's law limit the number of visits for mental health care that can be provided to an un-emancipated minor without parent notice or consent?
5. Does the state's law limit/specify the types of mental health providers who may work with un-emancipated minors?
6. Does the state's law give mental health providers discretion about whether to inform parents about a minor's treatment?
7. Does the state's law allow mental health providers to release information to parents without minor consent if the minor is perceived to be in a serious risky situation (e.g., danger to self or others, victim of physical or sexual abuse)?
8. Under state law, are the mental health records of a minor patient under the control of the minor who sought treatment and not accessible to the parent without the minor's permission?
9. Does the state's law relieve the parent of financial responsibility for care provided to a minor patient who received treatment in the absence of parent consent? If yes, is the minor responsible for payment?

CHAPTER III

METHOD

A state-by-state search of Statutory Code on the state's website (www.ZZ.gov) or related state resource, for information pertaining to the age of majority and laws for consenting to health and mental health care was conducted. For some states this information was not available, or the information was limited. Therefore, another search state by state on LexisNexis of State Codes (with selected sources Statutory Code, Administrative Code, and Constitution) was conducted using keywords: mental health, minors, and consent. For states in which these keywords did not produce results, additional searches were conducted using the keyword child in place of minor followed by an additional search with the keyword outpatient in place of consent. In addition a search using the keyword age of majority was conducted if this information was not available on the state's website.

A table was developed to allow this researcher and an undergraduate researcher to independently fill in information for each state indicating the answer to the research questions and to make citations of the relevant code. An undergraduate researcher also conducted a state by state review of laws and codes pertaining to minors' access to mental health care. To increase validity of the collected information, a comparison was made between information that was located by this researcher and the undergraduate researcher. When disagreements occurred the relevant state codes were reviewed again to ensure the most recent was being used and that there was agreement. A plan was in place to ask a third party, the faculty advisor, if there was continued lack of agreement or understanding of a law or code. This occurred once with the Pennsylvania code related to the information that could be shared with parents.

CHAPTER IV

RESULTS

The age of majority is 18 in all but four states. Alabama and Nebraska both established 19 as the age of majority, while in Mississippi and Pennsylvania 21 is the age of majority. Two of these states (Mississippi and Nebraska) are silent in terms of the age at which minors can consent to mental health services, while the other two (Alabama and Pennsylvania) allow minors 14 years of age and older to consent to mental health services on their own behalf.

Nineteen states were silent across all research questions or mandated that a person be at least 18 years of age to consent to outpatient mental health services on their own behalf: Alaska, Arkansas, Georgia, Hawaii, Idaho, Indiana, Louisiana, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia, and Wyoming. Wisconsin mandates a person be at least 18 years of age to consent to outpatient mental health services, but allows those over 14 years of age to petition the court if their parent will not provide consent for treatment. (State codes are cited in Appendix A).

Eight states (Arizona, Delaware, Iowa, Minnesota, Missouri, Montana, North Dakota, and Oklahoma) have laws that allow for emergency mental health services if a parent cannot be contacted, but do not have laws explicitly allowing minors to consent to outpatient treatments. Arizona and North Dakota define mental health emergency services as those necessary to prevent serious injury or life-threatening behavior. Missouri limits services to suicide assessment only. Arizona and Oklahoma mandate that parents are informed when emergency mental health services are provided to minors without parental consent. Arizona, like Wisconsin, allows minors to petition the court if a parent will not consent for treatment.

Table 1. Access to Emergency and General Outpatient Mental Health Services by Minors

State	Emergency Mental Health Services when No Parent Available	Age Minor can consent to General Outpatient Mental Health Services
Alabama	Yes	14
California	Yes	12[1]
Colorado	Yes	15
Connecticut	Yes	Discretion of provider
District of Columbia	Silent	Discretion of provider
Florida	Yes	13
Illinois	Yes[2]	12
Kansas	Silent	14
Kentucky	Yes	16
Maine	Silent	Minor[3]
Maryland	Silent	16
Massachusetts	Silent	16
Michigan	Silent	14
New Mexico	Silent	14[4]
New York	Yes	Knowing[3]
North Carolina	Yes	Minor[3]
Ohio	Yes	14
Oregon	Silent	14
Pennsylvania	Yes	14
Tennessee	Silent	14/16[1]
Texas	Yes	Children[1]
Virginia	Yes	Minor[3]
Washington	Silent	13

[1] Certain limitations apply
[2] If the child is 12 and provides consent
[3] Specific age not given
[4] 14 and older may consent in general; 14 and under may have an initial evaluation

Table 1 presents the state's law in terms of emergency services, if one was available, and the age at which minors in these states can consent to outpatient mental health services on their own behalf. Twenty-two states and the District of Columbia have explicit laws that grant minors the right to consent to outpatient mental health services on their own behalf.

Of these, 7 have laws that limit the number of visits or specify a limit to the period of time over which the minor patient can be seen without parental notification and/or consent. This information is presented in Table 2.

In some states, the mental health professional is obligated to share information from sessions with parents upon parental request. In others, they are prohibited from doing so without the consent of the minor. In some cases sharing information with parents when the child is in a risky situation is at the discretion of the mental health provider, whereas in other cases it is mandated that they must share such information with the parents. Table 3 on the next page presents the relevant standards for each of the states where a specific law about disclosure to parents could be found—16 states and the District of Columbia.

Table 2. State Restrictions on Number of Sessions or Treatment Duration

State	Limitations on Number of Visits or Duration
Connecticut	6 sessions[1]
District of Columbia	90 days[1]
Florida	No more than 2 visits during a given week
Illinois	No more than 5 45-minute sessions
Michigan	12 sessions or 4 months per request
New Mexico	2 weeks of verbal therapy if under 14
Ohio	6 sessions or 30 days, whichever is sooner

[1] Can continue services if it would be harmful to notify parents

Table 3. Disclosure of Information to Parents

State	Mental Health Provider Given Discretion About Informing Parent About Treatment	Mental Health Provider May Disclose Information Without Minor Consent if Minor is Perceived to be in a Risky Situation
California	Yes- Parent notified unless doing so poses a threat	Yes- Parent notified, unless the clinician judges it would pose a threat
Colorado	Yes	Yes
Connecticut	No- minor must consent	Silent
District of Columbia	No- minor must consent or be of an age that consent is implied	Yes
Florida	Yes	Yes
Illinois	No- minor must consent or be informed of a facility director's decision of necessary disclosure	Yes, but must inform the minor disclosure will be made
Kansas	No- Parents must be informed	Silent
Kentucky	Yes	Yes
Maine	Yes- if they believe that not doing so would jeopardize the minor's health	Yes- if not doing so would jeopardize the minor's health
Maryland	Yes	Yes
Michigan	No- minor must consent	Yes, if minor told that this will happen
New Mexico	Varies- 14 and over no, must consent; 14 and under yes	Yes, if the minor is 14 or under
Ohio	No- Minor must consent	Yes
Oregon	Yes	Yes
Pennsylvania	Mixed- if a parent consents to new or additional treatment a provider may disclose all records to a new provider, even if the minor provided initial consent, otherwise the minor has control of release of records	Silent
Tennessee	Yes	Yes
Texas	Yes	Yes

Table 4. State Restrictions on Types of Service Providers

State	Limit on Type of Mental Health Provider
California	Family Code § 6924 defines a list of providers who can work with minors, including marriage and family therapists, licensed school psychologists, clinical psychologists, and a variety of other professionals. Interested readers are referred to California Family Code § 6924 for specifics
Connecticut	Licensed psychologist, psychiatrist, family therapist, or social worker
Florida	State licensed mental health provider or services from a mental health facility licensed by the state
Kentucky	Physician
Maryland	Physician, psychologist, or services from a clinic
New Mexico	Clinician for 14 and under
North Carolina	Physician licensed for treating emotional disturbances.
Ohio	Mental health professional
Oregon	Licensed physician, psychologist, nurse practioner, or social worker or an approved community mental health program
Texas	Physician, psychologist, counselor, or social worker

While some states (e.g., Arizona, Wisconsin) allow minors to petition the court to be deemed capable of consenting on their own behalf if a parent refuses to do so, no state currently requires a court deem a minor mature enough to consent to their own mental health treatment.

Some states have specific limitations on the types of mental health providers who may provide treatment to minors. Table 4 presents this information.

Common restrictions on treatments that can be performed include no medication, at least before a specific age, and no electroconvulsive therapy (in general, or without specific consent from parents and/or the courts). Some states have additional restrictions or limitations on the types of treatments that can be provided to minors without parent consent. This information is presented in Table 5.

Table 5. State Restrictions on Types of Services Provided

State	Limitations on Types of Mental Health Services Provided Without Parental Consent
California	No drugs or convulsive therapy
Connecticut	No medications
District of Columbia	No medication if under 16; limitations if over 16
Florida	No medications, no somatic methods, no aversive stimuli, no substantial deprivation
Illinois	No electroconvulsive therapy without a court order and consent of parent/guardian
Kansas	No medications
Maine	Restricted to treatment of drug abuse or emotional or psychological problems
Michigan	No psychotropic drugs; no pregnancy termination referral services
New Mexico	Verbal therapy only if under age 14; psychotropics may be prescribed if over 14, but parents must be notified
New York	No psychotropic drugs before age 16
North Carolina	Restricted to emotional disturbances
Ohio	No medication
Tennessee	No psychosurgery; no medication if under age 16; no electroconvulsive therapy
Texas	Restricted to suicide prevention, chemical addiction/dependency, sexual, physical, or emotional abuse

Some states that allow minors to receive emergency mental health services and/or allow minors to consent to outpatient mental health services have laws explicitly relieving parents of the responsibility for paying for treatment to which they did not consent. These states are: Alabama, California, Connecticut, Florida, Illinois, Kentucky, Maine, Maryland, Michigan, Minnesota, Montana, Ohio, Oregon, and Texas. Of these, Alabama, Maine, and Minnesota make

the minor responsible for the costs. Montana allows for the parent's insurance to be billed, but relieves parents of the responsibility for paying for the services directly.

CHAPTER V

DISCUSSION

The intent of this research project was to examine each state's laws regarding the rights of minors to consent to their own mental health care, including if the state allows such access and if the state has any restrictions on such access. Because services are generally available to minors relating to substance abuse treatment and family planning services based on federal laws, these were excluded from consideration to the degree possible. Some laws specifically mentioned them within the same statutes that allowed for mental health services for other reasons, hence it was not possible to fully ignore such statutes. This research project examined the exact language of state statutory or case law regarding what mental health professionals are required, permitted, or prohibited from doing. States varied in their specificity towards each of the questions this study sought to answer, ranging from being silent (i.e., no relevant law or code was found) to having a specific or detailed law. Specific findings from each state were presented in the results section. This section serves to briefly discuss the overall findings and patterns, offers thoughts on how school psychologists can best use this information, and examines the limitations of this research project.

State Laws Regarding Access to Mental Health Services by Minors

A large proportion of states (19) did not have any laws pertaining to any of the research questions that were examined or mandated that a person be at least 18 years of age to consent to outpatient mental health. In addition, Wisconsin mandates a person be at least 18 years of age to consent to outpatient mental health services on their own behalf, but allows those over 14 years of age to petition the court if their parent will not provide consent for treatment.

An additional 8 states that do not allow minors to consent to general outpatient services have laws that allow minors to consent to emergency mental health services if a parent cannot be reached for consent, but do not allow for (or are silent about) minors to consent to outpatient mental health services on their own behalf. Some states (i.e., Arizona and North Dakota) specifically define mental health emergency services as preventing serious injury or life-threatening behavior; Missouri is more specific limiting services to suicide assessment only. Two states (i.e., Arizona and Oklahoma) mandate parental notification of any emergency mental health services provided to minors.

Arizona, like Wisconsin, allows minors to petition the court if a parent will not provide consent for treatment. Of the remaining states that have laws allowing minors to consent to services, no state mandates that a court deem the minor competent to consent.

Twenty-two states and the District of Columbia have laws explicitly allowing minors the right to consent to outpatient mental health services on their own behalf. Of these, 7 have laws that limit the number of visits or specify a limit to the period of time over which the minor patient can be seen without parental notification and/or consent.

In 16 states and the District of Columbia there are specific laws pertaining to disclosure of information to parents. In some of these states the mental health professional is obligated to share information from sessions with parents upon parental request. Other states prohibit sharing information with parents without the minor's consent to do so. Some of the states explicitly allow the mental health professional to decide whether or not to share information with parents if there is a risky situation, while others mandate the information must be shared with the parent.

Fourteen states that allow minors to receive emergency mental health services and/or allow minors to consent to outpatient mental health services have laws explicitly relieving parents of the responsibility for paying for treatment to which they do not consent. Three of these states (i.e., Alabama, Maine, and Minnesota) make the minor responsible for the costs. Another, Montana, allows for the parent's insurance to be billed, but relieves parents of the responsibility for paying for the services directly.

Ten states have specific limitations on the types of service providers who may treat minors with the minors consent and without that of the parent. These states typically require the services be provided by someone with a professional degree and/or license or from an accredited clinic.

In states that had restrictions on the types of services that could be provided or limitations on types of treatments, it was common for medication to be prohibited without parental consent and a prohibition on the use of electroconvulsive therapy. Some states have additional restrictions or limitations on the types of treatments that can be provided to minors based solely on their own consent. Restrictions or limitations on types of services were found for 13 states and the District of Columbia.

Applying Findings in the Field

School psychologists work within the context of numerous different federal and state laws, as well as district policies and regulations. Each school psychologist has a responsibility to understand the regulations of their job and what services they are allowed to provide. School policies and the laws governing psychologists working within the school system may be different from the state laws presented above, which govern outpatient mental health services. This does not make these results unimportant. These results are important because a school psychologist

may encounter a situation in which they do not feel they are the best trained or best prepared to handle a given situation, or their district may restrict them from providing counseling services. In these cases it is important to know if the state law allows minors to be seen by other professionals and any relevant restrictions on the types of service providers, types of services, duration of service, and whether or not information the minor shares will be shared with their parent or not. While a goal in counseling should be to encourage open communication with the family, this may be dangerous in some situations or prevent the minor from seeking services. Because of this, the school psychologist will want to be able to openly answer the student's questions if making a referral to a professional outside of the school system.

The inconsistencies between states in terms of outpatient mental health law can be problematic for students and families that may have certain expectations about access and confidentiality limits of records when they move to a different state. It also makes it difficult for professionals who may work in more than one state, or who move to a different state. It is important for the professional to understand the laws and policies for each area in which they are employed, and to explain to individuals who are seeking services the limitations of services and confidentiality.

Some concern may arise as to whether students with mental health concerns can truly provide informed consent. For example, students who are emotionally impaired may not have the capacity to provide truly informed consent for services. It is the professional's responsibility to make sure that consent being provided is informed. Findings by Melton (1981) suggest that this may not be a highly prevalent issue. In his study he found that after a law was enacted in Virginia allowing minors access to mental health services there was not a significant increase in the number of youth being treated without parental consent, and that most of the minors who did

seek treatment on their own were at least 14 years of age. Youth who seek treatment without parental consent have the maturity and self-awareness to realize that they need assistance, which would suggest the ability to make adult-like informed consent decisions.

In states where the law is vague as to a specific age at which a minor may consent or is silent on the issue, the burden is placed more strongly on the professional to know their district policy, as well as best practices and professional ethics. As recommended as a footnote in the NASP code of ethics (NASP-PPE, 2010), some districts have added broad statements to their policy handbooks stating that students may be seen by mental health professionals for one or several meetings without parent notice or consent to ensure that the student is safe and not a danger to others. Professionals are urged to consider their professional ethical obligations and best practices.

For those in states that do not currently allow minors access to mental health care, or for those seeking to change the structure of the accessibility by advocating for policy changes, this paper could serve as a guide to what other states do.

Limitations of the Present Research Project

While care was taken to find the most accurate and up to date state laws and codes, no attorneys were consulted in preparing this document. This paper is not intended to be used as legal advice; rather it is a compilation and interpretation of state laws to provide an overview of law regarding the access of minors to outpatient mental health services without parent consent.

Another limitation of this research project is that state laws change over time. It is important to keep in mind this is a snapshot of what the laws were as of 2013. As time progresses states that are silent in some areas may add laws pertaining to those areas; states that have laws

pertaining to an area may change or nullify those laws. In researching for this project it was clear that some states had repealed and replaced various parts of their laws pertaining to mental health care over time, a trend that will likely continue in the future.

Conclusions

This research project examined state laws regarding access to outpatient mental health care without parental consent. School psychologists must be aware of the legal aspects of situations they may encounter. School psychologists may not be able to undertake individual counseling or a specific case within their school for a variety of reasons and may wish to refer a student to an outside service provider.

While some states do not address the topic of minors consenting to outpatient mental health services and a few mandate the individual is at least 18 years of age to consent to services on their own behalf if they are not emancipated, 22 states and the District of Columbia allow minors to consent to general outpatient services and an additional 8 states that do not allow minors to consent to general outpatient services allow emergency mental health services (e.g., suicide assessment, prevention of self-harm or harm to others). These states have varying degrees of specificity (ranging from unspecified to detailed) about whom may treat a self-referring youth and the types of treatments and services that can be provided without parental consent. These states also vary in confidentiality requirements. Some states require parents be told about emergency services and/or perceived risky situations. Some states allow the mental health professional to decide if they share information with the parents, others require the minor whom consented to treatment must consent to any release of information.

Laws change over time. It is the professional obligation of school psychologists, like other professionals, to stay current with relevant federal, state, and local laws and policies over the course of their career.

APPENDIX A

REFERENCE OF RELEVANT STATE LAWS/CODES/DOCUMENTS

State	Relevant State Laws/Codes
Alabama	Code of Ala. § 22-8-3 to § 22-8-7; court case (*William vs. Baptist Health Sys*. 857)
Arizona	A.R.S. § 36-2272 and § 36-512
California	Cal Fam Code § 6924
Colorado	C.R.S. 27-65-103 and 25-1-802
Connecticut	Sec. 19a-14c; Sec. 17a-81
Delaware	13 Del. C. § 707
District of Columbia	D.C. Code § 7-1231.14; CDCR-22-B602
Florida	394.4784
Illinois	405 ILCS 5/3-500; 405 ILCS 5/3-501; 410 ILCS 210/4 and 210/5; 740 ILCS 110/4; 59 Ill. Adm. Code 112.90
Iowa	225C.19
Kansas	AG 2004-22; 59-2976
Kentucky	KRS § 214.185
Maine	Title 22 MRS § 1501 to § 1506
Maryland	COMAR 10.21.29.04-1 and Md. HEALTH-GENERAL Code Ann. § 20-104
Massachusetts	ALM GL ch. 123, § 10
Michigan	Section 330.1707 Act 258 of 1974
Minnesota	Minn. Stat § 144.344 to § 144.347
Mississippi	Miss. Code § 41-41-3 and § 1-3-27
Missouri	§ 630.133 R.S.Mo; § 537.037; § 632.070
Montana	Mont. Code Anno., § 41-1-401 to § 407
Nebraska	Nebraska Revised Statute 43-2101
Nevada	Nev. Rev. Stat. Ann. § 433.484
New Jersey	N.J. Stat. § 45:14B-36

Reference of Relevant State Laws/Codes/Documents (continued)

State	Relevant State Laws/Codes
New Mexico	N.M. Stat. Ann. § 24-7A-6.2; N. M. Stat. Ann. § 32A-6A-14 and 15; N.M. Stat. Ann. § 32A-6A-24
New York	NY CLS Men Hyg § 33.21
North Dakota	N.D. Cent. Code, § 14-10-17.1
Ohio	ORC Ann. 5122.04
Oklahoma	63 Okl. St. 2602
Oregon	ORS 109.675; 109.680; 109.690
Pennsylvania	35 P.S. § 10101.1; 35 P.S. § 10101.2; 35 P.S. § 10104
Tennessee	Tenn. Comp. R. & Regs. R. 0940-5-16-.23; Tenn. Code Ann. § 33-3-104; Tenn. Code Ann. § 33-3-105; § 33-8-202; Tenn. Code Ann. § 33-8-303; State of Tennessee Department of Children's Services (2011)
Texas	Tex. Fam. Code § 32.004
Vermont	Cramer (n.d.)
Virginia	Va. Code Ann. § 54.1-2969
Washington	Rev. Code Wash. (ARCW) § 71.34.530
Wisconsin	Wis. Stat. § 51.14

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