Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Behavioral and Primary Health Regulatory Alignment Task Force: Parental Notice of a Minor's Substance Use Disorder Treatment

Engrossed Third Substitute House Bill 1713, Section 533(4)
Chapter 29, Laws of 2016, 1st Special Session
Codified as RCW 71.24.860(4)

September 22, 2016

Behavioral Health Administration
Division of Behavioral Health and Recovery
PO Box 45330
Olympia, WA 98504-5330
(360) 725-3789
https://www.dshs.wa.gov/bha/

Washington State Department of Social & Health Services
Transforming lives

TABLE OF CONTENTS

Background

The 2016 Legislature enacted Engrossed Third Substitute House Bill 1713, Section 533(1) (Chapter 29, Laws of 2016, 1st Special Session), which required the Department of Social and Health Services (DSHS) and the Washington State Health Care Authority (HCA) to convene a Task Force, "including participation by a representative cross-section of behavioral health organizations and behavioral health providers to align regulations between behavioral health and primary health care settings and simplify regulations for behavioral health providers."

The Task Force held public meetings on July 16, July 28, and August 16, 2016, and included representation from the Behavioral Health Organizations, the Washington Council on Behavioral Health, Washington Tribes, and other interested parties. A list of task force members is found in Appendix A.

Section 533(4) of that act required the Task Force and DSHS to do the following:

> The task force described in subsection (1) of this section must consider means to provide notice to parents when a minor requests chemical dependency treatment, which are consistent with federal privacy laws and consistent with the best interests of the minor and the minor's family. The department must provide a report to the relevant committees of the legislature by December 1, 2016.

The federal privacy laws referenced in this section are found in Title 42, Code of Federal Regulations (CFR), Part 2, Subpart B (General Provisions),[1] which addresses consent for treatment and disclosure of information regarding a minor's substance use disorder treatment to the minor's parents :

> **§2.14 Minor patients.**
>
> (a) *Definition of minor.* As used in these regulations the term "minor" means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.
>
> (b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.
>
> (c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

[1] Electronic Code of Federal Regulations (e-CFR) at: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2 e-CFR data is current as of September 20, 2016.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

Report

Pursuant to Section 533(4) of E3SHB 1713, the Task Force and DSHS considered the issue of notice to parents when a minor requests chemical dependency treatment in terms of: (1) consistency with federal privacy laws; and (2) consistent with the best interests of the minor and the minor's family.

(1) Consistency with federal privacy laws.

As noted in Subsection (a) of 42 CFR §2.14, the definition of a "minor" appears to be at the discretion of the State:

> As used in these regulations the term "minor" means a person who has not attained the age of majority *specified in the applicable State law*, or if no age of majority is specified in the applicable State law, the age of eighteen years. (Emphasis added.)

Washington State law allows persons thirteen years of age or older to consent to treatment without parental authorization. Specifically, RCW 70.96A.095 (Age of consent—Outpatient treatment of minors for chemical dependency)[2] states:

> Any person thirteen years of age or older may give consent for himself or herself to the furnishing of outpatient treatment by a chemical dependency treatment program certified by the department. Parental authorization is required for any treatment of a minor under the age of thirteen.

Title 42 CFR Part 2, Subpart D (Disclosures Without Patient Consent) outlines circumstances by which information can be disclosed without a patient's consent:

- §2.51 Medical emergencies;
- §2.52 Research activities; and
- §2.53 Audit and evaluation activities.

However, none of these circumstances would allow notification to parents without the minor patient's consent. The federal requirements are clear that notice to parents when a minor requests chemical dependency treatment can only be given with the minor's consent. In particular, Subsection (b) of 42 CFR §2.14 states:

> If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations [Disclosures With Patient's Consent] may be given *only* by the minor patient. (Emphasis added.)

The Legislature could provide a means to provide notice to parents when a minor requests chemical dependency treatment which is consistent with federal privacy laws by changing the age of consent as defined in RCW 70.96A.095.

[2] This section is repealed by Section 301(3) of Engrossed Third Substitute House Bill 1713, effective April 1, 2018.

(2) Consistency with the best interests of the minor and the minor's family.

The Task Force finds it difficult to determine if such an action would be in the best interests of the minor and the minor's family. The task force identified the following reasons why:

- "Best interests" will naturally vary between individuals and between families. There is no one standard which would apply to everyone.

- The best interests of the minor and the best interests of the minor's family are often different, sometimes to the point of being in conflict. This is especially the case when a minor is emancipated, or the minor is or has been abused or is at risk of abuse.

- "Best interests" is a measure that is determined clinically and should not be legally mandated.

The task force is in general agreement that in those cases where a minor is requesting substance use disorder services, encouraging the minor to allow the family to receive notification and participate in the minor's treatment, when clinically appropriate, would be consistent with best practice. However, the goal of increased collaboration between the minor, the minor's family, and the treatment provider likely would not be met through a legal mandate to share information without the minor's consent and could act as a deterrent to the minor seeking treatment.

In summary, there is no provision in 42 CFR Part 2 as currently written that would grant an exception to disclose information regarding a minor's substance use disorder treatment information to the minor's parents without the minor's consent, unless the state statute is changed. Even if such a disclosure was considered to be in the best interests of the minor and the minor's family, this would not qualify as an exception to the federal law and would not be allowed.

Appendix A

Behavioral and Physical Health Alignment Task Force
Meetings held on June 16, July 28, and August 16
List of Invitees

Richard Stride, Cascade Mental Health
Robin Cronin, Catholic Family and Child Services
Rick Weaver, Comprehensive Healthcare
Gregory Robinson, The WA Council
Libby Hein, Community Health Services
Will Rice, Catholic Community Services
Marc Bollinger, Great Rivers BHO
Nancy Tyson, DOH
Jeron Ravin, WA Association of Community and Migrant Health Centers
Brian Sandoval, YVFWC / WA Association of Community and Migrant Health Centers
Joe Avalos, Thurston-Mason BHO
Kevin Black, Senate
Gary Romjue, Catholic Community Services
Betsy Kruse, North Sound BHO
Timothy Farrell, DOH
Todd Broderius, Great Rivers BHO
Scott Sims, Columbia Treatment Services
Julie Tomaro, DOH
Brad Burnham, DOH
Dan Floyd, King County Disease Control and Health Statistic
Pam Brown, West End Outreach Services
Joan Miller, WA Council for Behavioral Health
Richard Stride, Cascade Mental Health Care
Max Whipple, Belair Clinic
Adam Marquis, Jefferson Mental Health Services
Craig Pridemore, Columbia River Mental Health Services
Brigitte Folz, Harborview Behavioral Health
Timothy Hoekstra, Columbia Valley Community Health
Mary Stone Smith, Catholic Community Services
Darla Boothman, Grant County Integrated Services
Heather Fennell, Compassion Health
Jennifer Kreidler-Moss, Peninsula Community Health
Tre Normoyle, Valley View Health Center

Peggy Papsdorf, P-H-S
Linda Grant, Evergreen Manor
Scott Munson, Sundown M Ranch
Carl Kester, Lakeside Milam Recovery
Jason Bean-Mortinson, Thurston County
Sylvia Gil, Community Health Network of WA
Terri Card, Greater Lakes Mental Healthcare
Connie Mom-Chhing, CHPW
Sandy Ellingboe, Multicare BH
Annette Schuffenhauer, HCA
Tony O'Leary, DSHS
Melinda Froud, HCA
Charissa Fotinos, MD, HCA
Alice Lind, HCA
Debbie Morrill, HCA