HOUSE BILL REPORT
E2SHB 1874

As Amended by the Senate

Title: An act relating to implementing policies related to expanding adolescent behavioral health care access as reviewed and recommended by the children's mental health work group.

Brief Description: Implementing policies related to expanding adolescent behavioral health care access as reviewed and recommended by the children's mental health work group.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Frame, Eslick, Davis, Bergquist and Doglio).

Brief History:
Committee Activity:
Human Services & Early Learning: 2/6/19, 2/19/19 [DPS];
Appropriations: 2/27/19, 2/28/19 [DP2S(w/o sub HSEL)].
Floor Activity:
Passed House: 3/11/19, 89-8.
Senate Amended.
Passed Senate: 4/15/19, 48-0.

Brief Summary of Engrossed Second Substitute Bill

- Authorizes mental health professionals to provide certain mental health treatment information to a parent who is involved in the treatment of the adolescent when the mental health professional believes that sharing this information would not be detrimental to the adolescent.
- Authorizes the Department of Children, Youth, and Families to share certain mental health treatment records with a care provider.
- Authorizes a parent of an adolescent to request and receive medically necessary outpatient mental health or substance use disorder treatment for the adolescent for up to 12 sessions within a three-month period and treatment in other less restrictive settings.
- Expands the definition of "parent" for purposes of family accessed treatment to include individuals whom the minor's parent has given a signed authorization to make health care decisions and adults representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of

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perjury stating that the adult person is a relative responsible for the health care of the minor patient.

- Requires the Health Care Authority (HCA) to provide online training for behavioral health providers related to parent-initiated treatment and other treatment options.
- Requires the HCA to conduct an annual survey of parents, youth, and behavioral health providers to measure the impacts of policy changes in parent-initiated treatment.

HOUSE COMMITTEE ON HUMAN SERVICES & EARLY LEARNING

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 10 members: Representatives Senn, Chair; Callan, Vice Chair; Frame, Vice Chair; Dent, Ranking Minority Member; Eslick, Assistant Ranking Minority Member; Goodman, Griffey, Kilduff, Lovick and Ortiz-Self.

Minority Report: Do not pass. Signed by 3 members: Representatives McCaslin, Assistant Ranking Minority Member; Corry and Klippert.

Staff: Luke Wickham (786-7146).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Human Services & Early Learning. Signed by 29 members: Representatives Ormsby, Chair; Bergquist, 2nd Vice Chair; Robinson, 1st Vice Chair; Stokesbary, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Cody, Dolan, Dye, Fitzgibbon, Hansen, Hoff, Hudgins, Jinkins, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Senn, Springer, Stanford, Steele, Sullivan, Sutherland, Tarleton, Tharinger and Ybarra.

Minority Report: Do not pass. Signed by 2 members: Representatives Chandler and Kraft.

Staff: Andy Toulon (786-7178).

Background:

Age of Consent for Behavioral Health Treatment.
A minor age 13 or older may admit himself or herself to an evaluation and treatment facility for inpatient mental health treatment or an approved substance use disorder treatment program for inpatient substance use disorder treatment without parental consent. The admission shall occur only if the professional person in charge of the facility concurs with the need for inpatient treatment. Parental authorization, or authorization from a person who may consent on behalf of the minor, is required for inpatient treatment of a minor under age 13.

When, in the judgment of the professional person in charge of an evaluation and treatment facility or approved substance use disorder treatment program, there is reason to believe that a minor is in need of inpatient treatment because of a mental disorder or substance use disorder, and the facility provides the type of evaluation and treatment needed by the minor, and it is not feasible to treat the minor in any less restrictive setting or the minor's home, the minor may be admitted to the facility.

Written renewal of voluntary consent must be obtained from the applicant no less than once every 12 months. The minor's need for continued inpatient treatments shall be reviewed and documented no less than every 180 days.

Any minor age 13 or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor, is required for outpatient treatment of a minor under age 13.

Parent-Initiated Inpatient Treatment.
A parent may bring, or authorize the bringing of, his or her minor child to:

- an evaluation and treatment facility or a licensed inpatient facility and request that the professional person examine the minor to determine whether the minor has a mental disorder and is in need of inpatient treatment; or
- a secure detoxification facility or approved substance use disorder treatment program and request that a substance use disorder assessment be conducted by a professional person to determine whether the minor has a substance use disorder and is in need of inpatient treatment.

The consent of the minor is not required for admission, evaluation, and treatment if the parent brings the minor to the facility.

The Health Care Authority (HCA) must assure that, for any minor admitted to inpatient treatment under parent-initiated treatment, a review is conducted by a physician or other mental health professional who is employed by the HCA, or an agency under contract with the HCA, and who neither has a financial interest in continued inpatient treatment of the minor nor is affiliated with the facility providing the treatment. The physician or other mental health professional shall conduct the review not less than seven, but no more than 14, days following the date the minor was brought to the facility to determine whether it is a medical necessity to continue the minor's treatment on an inpatient basis. In conducting this review, the HCA must consider the opinion of the treatment provider, the safety of the minor, and the likelihood the minor's mental health will deteriorate if released from inpatient treatment. The HCA must also consult with the parent in advance of making its determination.

If the HCA determines it is no longer a medical necessity for a minor to receive inpatient treatment, the HCA must immediately notify the parents and the facility. The facility must release the minor to the parents within 24 hours of receiving notice. If the professional person in charge and the parent believe that it is a medical necessity for the minor to remain in inpatient treatment, the minor shall be released to the parent on the second day following the HCA's determination in order to allow the parent time to file an at-risk youth petition. If

the HCA determines it is a medical necessity for the minor to receive outpatient treatment and the minor declines to obtain such treatment, such refusal shall be grounds for the parent to file an at-risk youth petition.

Following the HCA review, a minor child may petition the superior court for his or her release from a facility. This petition may be filed five days following the review. The court must release the minor unless it finds, upon a preponderance of the evidence, that it is a medical necessity for the minor to remain at the facility.

Parent-Initiated Outpatient Treatment.
A parent may bring, or authorize the bringing of, his or her minor child to:

- a provider of outpatient mental health treatment and request that an appropriately trained professional person examine the minor to determine whether the minor has a mental disorder and is in need of outpatient treatment; or
- a provider of outpatient substance use disorder treatment and request that an appropriately trained professional person examine the minor to determine whether the minor has a substance use disorder and is in need of outpatient treatment.

The consent of the minor is not required for evaluation if the parent brings the minor to the provider. The professional person may evaluate whether the minor has a mental disorder or substance use disorder and is in need of outpatient treatment.

Summary of Engrossed Second Substitute Bill:

The definition of "chemical dependency professional" is expanded to include a chemical dependency trainee working under the direct supervision of a certified chemical dependency professional.

The definition of "parent" is modified for purposes of family accessed treatment to include the following persons in order of priority:

- a guardian or legal custodian;
- a person authorized by the court to consent to medical care for a child in out-of-home placement;
- a biological or adoptive parent who has legal custody of the child;
- an individual whom the minor's parent has given a signed authorization to make health care decisions for the minor patient; or
- a competent adult representing himself or herself to be a relative responsible for the health care of such minor patient or a competent adult who has signed and dated a declaration under penalty of perjury stating that the adult person is a relative responsible for the health care of the minor patient.

An "adolescent" is defined as a minor age 13 or older.

The notice that an evaluation and treatment facility is required to provide to parents upon voluntary entry into or exit from inpatient treatment is limited to mental health inpatient treatment.

A mental health treatment facility must notify the parent of a child voluntarily accessing inpatient treatment as soon as reasonably practicable or notify the Department of Children, Youth, and Families if there are compelling reasons not to notify a parent or if contact cannot be made.

Parental Authorization for Outpatient Treatment.
If a provider determines that an adolescent is in need of outpatient treatment, parents of adolescents may request and receive medically necessary outpatient mental health or substance use disorder treatment for the adolescent without the consent of the adolescent for up to 12 outpatient sessions in a three-month period of outpatient treatment. Following that treatment period, the adolescent must consent to further treatment with that specific provider.

Parental Authorization for Less Restrictive Treatment.
If a provider determines that an adolescent is in need of treatment in a less restrictive setting, a parent of an adolescent may request and receive treatment for his or her adolescent in a less restrictive setting, including partial hospitalization or intensive outpatient treatment without the consent of the adolescent.

Entities providing solely mental health less restrictive treatment authorized by a parent of an adolescent must convene a treatment review at least every 30 days after the treatment begins and provide notification of the adolescent's treatment to an independent reviewer at the HCA within 24 hours of the adolescent's receipt of treatment to determine whether the treatment is medically necessary. At least 45 days after the adolescent's first receipt of treatment the HCA must complete a review to determine whether the treatment is medically necessary.

Entities providing less restrictive substance use disorder treatment must convene a treatment review and provide notification of the treatment to an independent reviewer at the HCA only if the adolescent provides consent or as permitted by federal law.

Sharing of Adolescent Mental Health Information.
Mental health professionals are prohibited from proactively providing treatment information with a parent unless the adolescent consents or in cases involving the imminent health and safety of the youth.

In the event a mental health professional discloses mental health information and records of an adolescent to a parent under current law, the mental health professional must provide notice of this disclosure to the adolescent, and the adolescent must have an ample opportunity to express any concerns about disclosure well in advance of action to disclose that mental health treatment information.

Substance use disorder treatment information or evaluation information may only be disclosed to parents without consent of an adolescent if permitted by federal law.

Outpatient or inpatient mental health providers are not civilly liable for the decision to disclose or not to disclose mental health information and records to a parent so long as that decision is made in good faith and without gross negligence. The liability of chemical dependency professionals providing inpatient or outpatient substance use disorder treatment information to a parent without an adolescent's consent is limited so long as that decision is

made in good faith and without gross negligence, in the event that this disclosure is permitted by federal law.

The Department of Children, Youth, and Families (DCYF) is allowed to share mental health treatment records with a care provider to include:

- diagnosis;
- treatment plan and progress in treatment;
- recommended medication;
- psychoeducation about the child's mental health condition;
- referrals to community resources;
- coaching on parenting or behavioral management strategies; and
- crisis prevention planning and safety planning.

The bill may be known and cited as the Adolescent Behavioral Health Care Access Act.

EFFECT OF SENATE AMENDMENT(S):

The Senate amendment modifies the definition of parent for purposes of family-initiated treatment to include persons who the parent has given a signed authorization to make health care decisions for the adolescent, stepparents involved in caring for the adolescent, kinship caregivers involved in caring for the adolescent, or another relative responsible for the health care of the adolescent who may be required to provide a declaration stating, under penalty of perjury, that he or she is a relative responsible for the health care of the adolescent. If a dispute arises between individuals authorized to act as a parent for the purposes of family-initiated treatment, the disagreement must be resolved according to the priority established in the surrogate decision-maker statute.

The Senate amendment allows inpatient treatment providers to withhold notice to a parent when a child voluntarily admits herself if there is a compelling reason that such disclosure would be detrimental or if contact cannot be made. The Senate amendment requires such facilities that withhold notice or cannot make contact with a parent to consult the state patrol missing persons database once every 8 hours for the first 72 hours and once every 24 hours thereafter and notify DCYF if the child is listed there.

The Senate amendment allows the HCA to randomly review adolescent substance abuse inpatient treatment on application of the parent.

The Senate amendment encourages mental health professionals to proactively share certain treatment information and records with parents.

The Senate amendment specifically authorizes mental health agencies, psychiatric hospitals, and evaluation and treatment facilities to release mental health information about an adolescent to a parent without the consent of the adolescent subject to the limitations of the bill.

The Senate amendment includes in the online training conducted by the HCA for behavioral health providers standards for sharing of information about behavioral health services received by an adolescent.

The Senate amendment changes the term "adolescent accessed treatment" to "adolescent initiated treatment" and the term "family accessed treatment" is changed to "family initiated treatment."

The Senate amendment also makes technical changes.

Appropriation: None.

Fiscal Note: Available.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 15 and 17, relating to minor involuntary treatment, which take effect July 1, 2026. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Human Services & Early Learning):

(In support) The provisions of this bill originated from the parent-initiated treatment subcommittee that met 23 times during the interim. There is an intent in the children's mental health law that parents are involved in the behavioral health treatment decisions of their children; however, that is often not the case. Denial and resistance are hallmark examples of mental disorders. Children age 13 often do not have the capacity to make behavioral health decisions. This bill strikes a balance between protecting the rights of youth and involving parents to ensure the behavioral health of their children. Key test results, diagnoses, and other behavioral health information of adolescents are not shared with parents. This lack of parental involvement leads to a great fear about what may happen to a child. Imagine if a parent was not made aware of key details of their child's life-threatening disease. Limiting the information that can be shared to certain information at a treatment professional's discretion is a good balance between protecting the rights of children and involving parents. Sharing this information with parents will save many families from suffering and pain. An adolescent child can be moved from one treatment facility to another without a parent's knowledge due to the age of consent law. It is important for children to seek and obtain behavioral health treatment without the consent of a parent. There needs to be balance to protect that right and involve parents in behavioral health treatment. This bill empowers children to access treatment but expands the ability for parents to be involved with the treatment of youth.

(Opposed) None.

(Other) While there is support for improved behavioral health access, the current bill conflicts with federal law regarding confidentiality of substance use disorder treatment information. There are efforts underway to address these conflicts.

Staff Summary of Public Testimony (Appropriations):

(In support) The Parent-Initiated Treatment Stakeholder Advisory Group that was under the purview of the Children's Mental Health Workgroup spent a lot of time working on this issue and trying to find ways to make the process work better for youth and parents. Many

concerns have been voiced over the years from parents of adolescents who feel helpless when their kids refuse treatment. There is a law that allows parents to do something, but it is not well known or well used, and the process is challenging. This bill provides a good balance between what parents and clinicians need, and hopefully what will work much better for the youth involved.

About 50 percent of individuals who suffer from serious mental illness start showing symptoms by the age of 14. The state needs to figure out a way to get more of those individuals into treatment earlier. The parent-initiated treatment system will not respond until a young person needs to be hospitalized. This bill provides more tools for a parent to consent on behalf of youth and get them into treatment before they are so sick that they need to be hospitalized. There may be an additional cost of providing the 12 outpatient visits within three months, but the offset of having so many fewer youth needing hospitalization will more than pay for itself. Providing treatment to youth while they are young will keep them out of the criminal justice system and prevent them from damaging their lives.

(Opposed) None.

Persons Testifying (Human Services & Early Learning): (In support) Representative Frame, prime sponsor; Peggy Dolane; Erin Goodman; Michelle Landwher; Alex; Miriah Sachs; Jim Theofelis, A Way Home Washington; and Melanie Smith, Washington State Society for Clinical Social Workers.

(Other) Diana Cockrell, Health Care Authority; Alicia Ferris, Community Youth Services; Chris Bandoli, Washington State Hospital Association; and Sean Graham, Washington State Medical Association.

Persons Testifying (Appropriations): Laurie Lippold, Partners for Our Children; and Melanie Smith, National Alliance on Mental Illness and Washington State Society for Clinical Social Work.

Persons Signed In To Testify But Not Testifying (Human Services & Early Learning): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.