COMMONWEALTH of VIRGINIA

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FROM: David E. Brown, D.C.
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DATE: December 30, 2021

RE: Report pursuant to SB431 (2020)

Attached is the report of the Department of Health Professions pursuant to Senate Bill 431 (2020), relating to issues of mental health services to a minor and access to records. The subject matters contained in the legislation were referred by the Senate Committee on Education and Health for study. A workgroup established to conduct the study found the issue far more complex than could be addressed in one year and extended the study period to 2021.

Should you have questions about this report, please feel free to contact me at (804) 367-4456 or at Jaime Hoyle, Executive Director of the Boards of Counseling, Psychology and Social Work at Jaime.hoyle@dhp.virginia.gov .

Virginia Department of Health Professions

REPORT ON ISSUES RELATING TO MENTAL HEALTH SERVICES TO A MINOR AND ACCESS TO RECORDS: SB431 (2020)

NOVEMBER 22, 2021

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I. EXECUTIVE SUMMARY

Pursuant to Rule 20(o) of the Rules of the Senate of Virginia, the Senate Committee on Education and Health referred the subject matters contained in Senate Bill 431 (see-attached bill) to the Department of Health Professions (DHP) for study. The legislation seeks to prohibit "a health care provider from refusing to provide mental health services to a minor on the basis that the parents of such minor refuse to agree to limit their access to such a minor's health care records, or request that such health care provider testify in a court proceeding regarding the treatment of the minor."

In response to this request, DHP established a workgroup consisting of physicians, psychologists, professional counselors, marriage and family therapists, social workers and family law attorneys. All of the representatives have experience working with children and families, as well as navigating the family court system.

Work Group Members

Roger C. Burket, MD, DFAPA, DFAACAP
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The workgroup found the issue far more complex than could be addressed in one year, extended the study period, undertook a jurisdictional analysis of the issue, and reviewed case law. The group defines these issues as integral to the discussion:

1. maintaining a trusting and confidential relationship with a child-client in a therapeutic relationship;
2. providing immunity for clinicians who act in good faith;
3. preventing further damage to parent-child relationships;
4. preventing children from feeling betrayed by the therapy professions; and
5. providing courts with access to necessary information to determine the best interests of the child in child custody determinations.

At the conclusion of the study period, the following themes emerge.

Policies addressing this issue should:

1. grant immunity from a complaint to the professional board or from civil prosecution for a health professional who acts in good faith.

2. require that a child's mental health records remain as confidential as possible, consistent with the need for counsel and the court to review those records for the purposes of the action before it.
3. suggest/require the court employ a closed inspection of the child's records, alternatively.
4. suggest/require the court use on-camera, private testimony from the mental health provider with review of the minor's records to which only the judge has access. The judge would not be permitted to release this information to the parents.
5. strengthen the "best interest of the child" statute to protect the therapeutic relationship of a mental health provider with the minor.

In addition, a review of the laws in other states reveals that if SB431 were enacted, Virginia would be the first state to ban a mental health provider from contractually binding parents to forgo access to the minors' records or agree not to subpoena the clinician. It is unlikely that such a contract could be enforceable if the court ruled that access to the records was in the best interest of a child.

II. REPORT OF THE WORKGROUP

Members of the workgroup had extensive experience working with families and navigating the family court system. The group recognized the tension between the confidentiality of a patient's relationship with a therapeutic provider and the need for decision makers, including the family court system, to have access to the information needed to support a sound custody decision. They also noted that contracts that require a parent sign that neither the provider nor the mental health records of a minor be subpoenaed are becoming more prevalent. Mental health providers stress the need for such contracts in order to protect the therapeutic relationship with the minor. They also note that the theoretical risk of a breach of trust trumps the need of the court to have access to the child's records. Attorneys and the courts charged with identifying the custody arrangement for the best interest of the child report they need access to the child's mental health records to determine the best custody arrangement in the best interest of the child. Without access to those records, they claim that the court does not have a full picture in order to make such an important assessment.

The group identified and enumerated these issues:

1. the maintenance of a trusting, confidential relationship with a child-client in a therapeutic relationship;
2. immunity from prosecution or professional board compliant for clinicians who act in good faith;
3. the prevention of further damage to parent-child relationships;
4. the assurance that children do not feel betrayed by the therapy professions; and,

5. the allowance for the court to access necessary information to determine the best interests of the child in child custody determinations.

III. SUMMARY OF PERTINENT LAWS AND CASE LAW IN OTHER JURISDICTIONS

The group sought additional information before making recommendations. The issue regarding access and denial to a minor's health records does not exist in Virginia alone, but across the country and in other nations. As such, the workgroup undertook an analysis of laws in other jurisdictions and a literature review to determine how other jurisdictions address this complex issue. As an initial step, DHP staff corresponded with stakeholder associations, such as the Association of State and Provincial Psychology Boards (ASPPB), Association of Social Work Boards (ASWB), Association of Marriage and Family Therapy Regulatory Boards (AMFTRB), the American Association of State Counseling Boards (AASCB), and the Association of State Medical Boards (ASMB). This correspondence yielded little to no results, so the workgroup and staff completed both a jurisdictional analysis of pertinent laws addressing minors' mental health records and a review of case law.

Information garnered in the jurisdictional analysis is included as Appendix 1. In general, the following are found across jurisdictions:

- Minors' records are confidential.
- Parents have a right to a minor's records.
- At a certain age, a minor can object to use of their mental health records in court proceedings.
- Courts may subpoena records of parents and minors to determine custody, even if those records are confidential.
- The best interest of the child is the standard in cases involving children.

Although parents generally have a right to access the mental health records of children, the New Hampshire Supreme Court ruled this right is significantly limited when asserted in connection with divorce proceedings and custody disputes. The court noted in these situations there is a "distinct possibility" that a parent will not make a decision regarding access to the child's mental health records based on the child's best interests. The court further added that the parents may be the source of the child's distress and unfettered access to the therapy records and forced disclosure may result in substantial emotional harm to the child. At a minimum, the child should have the right to object to the involuntary disclosure. This court cited rulings from California, Florida, Kentucky, Maryland, Massachusetts, and Missouri that have afforded protection to the mental health records of children who are at the center of a custody dispute or whose interests may be in conflict with those of their parents. As a result, parents do not have an absolute right to access to these records. The judge determines access based on whether access is in the best interests of a child to have confidential and privileged therapy records

revealed to their parents. The judge also gives particular emphasis to the preservation of the child's ability to engage in open and productive therapeutic treatment.

It appears that if SB431 were enacted, Virginia would be the first state to prohibit a health care provider from requiring a minor's parents to sign a contract, prior to the health professional providing services to the child, that the parents will not subpoena the health care provider or the child's mental health records for court proceedings. However, even with such a contract, it seems unlikely that it would be enforceable if the court ruled that access to the records was in the best interest of a child.

IV. SUMMARY OF VIRGINIA STATUTES AND CASE LAW

In Virginia, a therapist or other health practitioner may deny the parents of a minor-patient access to such minor-patient's health records if:

1. A court ordered denial based upon "good cause shown" (§ 20-124.6)
2. The therapist (or treating physician or social worker) alleges that in their professional opinion, there is a "reasonable likelihood of substantial harm" (§ 20-124.6)
3. The minor is "deemed an adult" for purposes of consenting to treatment (§ 54.1-2969)
4. The records are held by the Department of Juvenile Justice and the Department determines that disclosure would be detrimental to the child or a third party and the Juvenile Domestic Relations court concurs (§ 16.1-300)

In Virginia, a therapist or other health practitioner shall disclose access to such minor-patient's health records if:

1. The physical or mental condition of the minor-patient is at issue (§§ 8.01-399, 8.01-400.2)
2. The court deems in necessary to the proper administration of justice (§ 8.01-399)
3. It is necessary in connection with the care of the patient (§ 8.01-399)
4. During testimonial matters relating to child abuse and neglect (§ 8.01-400.2)
5. Reporting is mandated pursuant to § 63.2-1509 (suspicion of abuse/neglect)
6. The records are limited to those made pursuant to a court-ordered independent mental health or psychological evaluation to assist the court in its determination of the Best Interest of the Child (§ 20-124.2)

In determining custody, Virginia courts must primarily consider the parent-child relationship (as against third parties) and the best interest of the child. See Va. Code § 20-124.2 (B). Sometimes it becomes necessary for courts to obtain otherwise confidential health records to carry out its function of determining the child's best interests.

The right to a minor's health records in Virginia turns most on who is requesting access. Parents, courts, a guardian ad litem (lawyers who represent the interests of a child or

person under disability), and minors (themselves) may request the health records of a minor. The statutory provision that courts must interpret depends on the relationship between the person requesting disclosure and the person whose records they seek.

Parents, generally, have the broadest right to receive the health records of their minor child. There are several reasons a court could deny a parent access to their minor child's records. The primary reasons are set forth in § 20-124.6 and include: (1) a court's decision to deny a parent the right to disclose their child's records for "good cause shown" and, (2) denial of disclosure of records held by a health practitioner based on that practitioner's reasonable belief that it would cause "substantial injury" to the child.

Courts also deny access based on the court deeming the child an "adult" for purposes of seeking treatment, or obtaining an age and maturity showing such minor's capacity to consent individually, without parental consent. § 20-124.6 is the governing section of the Code of Virginia that courts apply when a parent requests the disclosure of their child's academic or health records.

The seminal case interpreting the impact of this statute is *Sherfrey v. Cushing*, 103 Va. Cir. 285 (2019). In *Sherfrey*, a child's mother and father were each seeking sole legal and physical custody of the child whose mental health records were at issue. After eight years of legal battles related to the divorce, the therapist objected to the subpoena duces tecum to produce further records relating to discussions with the child. The therapist included a written statement that in his professional judgment, the release of health records "would be reasonably likely to cause substantial harm to the minor…based on destroying any feeling of privacy and safety that enables the minor child to freely seek counseling and therapy." The court held that the appropriate recourse for a parent denied access to such records pursuant to § 20-124.6 is to seek an independent reviewing physician's binding opinion on whether such a denial is properly based on "reasonable [likelihood of causing] substantial harm to the minor," in accordance with § 32.1-127.1:03. The court also held that it was not within its discretion to overrule such a determination.

In child custody proceedings, disclosure of records to the court is often upon request of one of the parties to the litigation. The most common scenario involves one parent requesting disclosure of the health or therapy records of the other parent as a means to show that it would be in the best interests of the child (or children) to agree to the requesting parent's custody preferences. The right of courts to order or deny disclosure of a minor or an adult's health records is delineated in § 32.1-127.1:03 (H) (9): "…The provisions of this subsection [subsection H] shall apply to subpoenas for health records of both minors and adults."

Further, the trial court should determine whether the child is of sufficient maturity to make sound judgment about access to these records based on the child's age, intelligence, maturity, the intensity with which the child advances his preference, and

whether the child bases their preference upon undesirable or improper influences. If the judge finds the child to be a mature minor, the court should give substantial weight to the child's preference in deciding whether a parent should be entitled to access the child's mental health records. "Developments in Mental Health Law", The Institute of Law, Psychiatry & Public Policy - The University of Virginia, Volume 25, Number 1 (January 2006) citing In re Berg, 886 A.2d 980 (N.H. 2005).

V. SUMMARY ANALYSIS

Again, if SB431 were enacted, Virginia would be the first state to prohibit a health care provider from requiring a minor's parents to sign a contract, prior to the health professional providing services to the child, that the parents will not subpoena the health care provider or the child's mental health records for court proceedings. It seems unlikely that a contract could be enforceable if the court ruled that access to the records was in the best interest of a child. Still such contracts are becoming more prevalent in Virginia. Mental health providers stress the need for such contracts in order to protect the therapeutic relationship with the minor. Mental health providers stress the theoretical risk of a breach of trust trumps the need of the court to have access to the child's records. Attorneys and the courts charged with identifying the custody arrangement for the best interest of the child report they need access to the child's mental health records to determine fully the best custody arrangement in the best interest of the child. Without access to those records, the court does not have a full picture in order to make such an important assessment.

VI. DISCUSSION AND RECOMMENDATIONS

The Code establishes that parents are to have access to their children's medical records, including mental health treatment records, unless certain conditions exist that providing access would create a danger to the health and wellbeing of the child. The Courts have established that mental health treatment records may be necessary to establish the best interest of the child in custody, foster care, and other cases. There is a statutory/ethical obligation that exists for treatment providers to testify/provide records where there are issues involving child abuse, neglect, etc. Also, arguably, where there may be potential harm to the child due to custodial issues.

The issue at hand is not about prohibiting private contracts, but about establishing which situations justify a potential insertion into or breach of the therapist/child relationship. Those situations should be determined by the courts, as outlined by the Code, and would override any attempt to eliminate access or testimony via private contracts.

However, the ruling in *Sherfrey v. Cushing* that addresses the access to parental mental health records in custody cases might inform Virginia's policies regarding access to a minor's mental health records. Specifically, according to the court, mental health records

should remain as confidential as possible, consistent with the need for counsel and the court to review those records for the purposes of the action before it.

To this end, the court might use a closed inspection of the minor's records. This would eliminate the issue of breaching confidentiality while satisfying the interests of the child, the parent, and the court. This approach would maintain the therapist-patient privilege and allow courts access to important information in deciding custody cases in the best interest of the child. This approach would also prevent the disclosure of irrelevant, but potentially damaging, information.

The court might also employ on-camera, private mental health provider testimony and review of the minor's records to which only the judge has access. This approach keeps the minor's confidentiality with their therapist intact because the judge never releases any information, only uses it to inform the custody decision.

Likewise, strengthening the "best interest of the child" statute may protects the therapeutic relationship with the minor. The child would not know the deciding factor in the custody decision, and ideally, only the judge and attorneys would be privy to that information.

While policy issues are codified by the General Assembly, the professional Boards must determine when a mental health provider who refuses to participate in providing information where subpoenaed or where that information is necessary to protect a child may be subject to discipline by the Board. The Boards do not have a regulation that prohibits providers from entering into contracts such as those at the heart of this legislation. The Boards assess the need for discipline on a case-by-case basis. Providers have an obligation to "do no harm" and they also have a mandatory obligation to report suspected abuse or neglect. The Boards must balance the requirement to report and the request to supply records with the assertion of harm. This is done on a case-by-case basis. However, to encourage providers to testify and provide records that may be in the best interest of the child, the workgroup maintains its primary recommendation to include an immunity clause for providers acting in good faith in any policy decision.

Appendix 1

A review of statutes indicates that Virginia would be the first jurisdiction to ban a mental health provider from contractually forcing parents to forgo access to the minors' records or agree not to subpoena the clinician. Anecdotally the practice is widespread and not unique to the Commonwealth.

Samples of Relevant Statutes from other Jurisdictions

California

(a) The representative of a minor shall not be entitled to inspect or obtain copies of the minor's patient records in either of the following circumstances:

(1) With respect to which the minor has a right of inspection under Section 123110 .

(2) Where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection or copying under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

(b) When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient, subject to the following conditions:

(1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.

(2)(A) The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor, designated by request of the patient.

(B) Any person registered as a marriage and family therapist intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, may not inspect the patient' s mental health records or obtain copies thereof, except pursuant to the direction or supervision of a licensed professional specified in subdivision (g) of Section 4980.03 of the Business and Professions Code . Prior to providing copies of mental health records to a registered marriage and family therapist intern, a receipt for those records shall be signed by the supervising licensed professional.

(C) Any person registered as a clinical counselor intern, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, may not inspect the patient's mental health records or obtain copies thereof, except pursuant to the direction or supervision of a licensed professional specified in subdivision (h) of Section 4999.12 of the Business and Professions Code . Prior to providing copies of mental health records to a person registered as a clinical counselor intern, a receipt for those records shall be signed by the supervising licensed professional.

(D) A licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, registered marriage and family therapist intern, or person registered as a clinical counselor intern to whom the records are provided for inspection or copying shall not permit inspection or copying by the patient.

(3) The health care provider shall inform the patient of the provider's refusal to permit him or her to inspect or obtain copies of the requested records, and inform the patient of the right to require the provider to permit inspection by, or provide copies to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor designated by written authorization of the patient.

(4) The health care provider shall indicate in the mental health records of the patient whether the request was made under paragraph (2).

Michigan

Sec. 748a. (1) If there is a compelling need for mental health records or information to determine whether child abuse or child neglect has occurred or to take action to protect a minor where there may be a substantial risk of harm, a family independence agency caseworker or administrator directly involved in the child abuse or neglect investigation shall notify a mental health professional that a child abuse or neglect investigation has been initiated involving a person who has received services from the mental health professional and shall request in writing mental health records and information that are pertinent to that investigation. Upon receipt of this notification and request, the mental health professional shall review all mental health records and information in the mental health professional's possession to determine if there are mental health records or information that is pertinent to that investigation. Within 14 days after receipt of a request made under this subsection, the mental health professional shall release those pertinent mental health records and information to the caseworker or administrator directly involved in the child abuse or neglect investigation.

(2) the following privileges do not apply to mental health records or information to which access is given under this section:

(a) the physician-patient privilege created in section 2157 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2157 .

(b) the dentist-patient privilege created in section 16648 of the public health code, 1978 PA 368, MCL 333.16648 .

(c) The licensed professional counselor-client and limited licensed counselor-client privilege created in section 18117 of the public health code, 1978 PA 368, MCL 333.18117 .

(D) the psychologist-patient privilege created in section 18237 of the public health code, 1978 PA 368, MCL 333.18237 .

(e) Any other health professional-patient privilege created or recognized by law.

(3) To the extent not protected by the immunity conferred by 1964 PA 170, MCL 691.1401 to 691.1415 , an individual who in good faith gives access to mental health records or information under this section is immune from civil or administrative liability arising from that conduct, unless the conduct was gross negligence or willful and wanton misconduct.

(4) A duty under this act relating to child abuse and neglect does not alter a duty imposed under another statute, including the child protection law, 1975 PA 238, MCL 722.621 to 722.638 , regarding the reporting or investigation of child abuse or neglect.

Minnesota

Minnesota Statute 518.17 lays out how a court determines the best interests of the child in a custody and support situation, but does not directly address the confidentiality of records:

(a) In evaluating the best interests of the child for purposes of determining issues of custody and parenting time, the court must consider and evaluate all relevant factors, including:

(1) a child's physical, emotional, cultural, spiritual, and other needs, and the effect of the proposed arrangements on the child's needs and development;

(2) any special medical, mental health, or educational needs that the child may have that may require special parenting arrangements or access to recommended services;

(3) the reasonable preference of the child, if the court deems the child to be of sufficient ability, age, and maturity to express an independent, reliable preference;

(4) whether domestic abuse, as defined in section 518B.01, has occurred in the parents' or either parent's household or relationship; the nature and context of the domestic abuse; and the implications of the domestic abuse for parenting and for the child's safety, well-being, and developmental needs;

(5) any physical, mental, or chemical health issue of a parent that affects the child's safety or developmental needs;

(6) the history and nature of each parent's participation in providing care for the child;

(7) the willingness and ability of each parent to provide ongoing care for the child; to meet the child's ongoing developmental, emotional, spiritual, and cultural needs; and to maintain consistency and follow through with parenting time;

(8) the effect on the child's well-being and development of changes to home, school, and community;

(9) the effect of the proposed arrangements on the ongoing relationships between the child and each parent, siblings, and other significant persons in the child's life;

(10) the benefit to the child in maximizing parenting time with both parents and the detriment to the child in limiting parenting time with either parent;

(11) except in cases in which domestic abuse as described in clause (4) has occurred, the disposition of each parent to support the child's relationship with the other parent and to encourage and permit frequent and continuing contact between the child and the other parent; and

(12) the willingness and ability of parents to cooperate in the rearing of their child; to maximize sharing information and minimize exposure of the child to parental conflict; and to utilize methods for resolving disputes regarding any major decision concerning the life of the child.

(b) Clauses (1) to (9) govern the application of the best interests of the child factors by the court:

(1) The court must make detailed findings on each of the factors in paragraph (a) based on the evidence presented and explain how each factor led to its conclusions and to the determination of custody and parenting time. The court may not use one factor to the exclusion of all others, and the court shall consider that the factors may be interrelated.

(2) The court shall consider that it is in the best interests of the child to promote the child's healthy growth and development through safe, stable, nurturing relationships between a child and both parents.

(3) The court shall consider both parents as having the capacity to develop and sustain nurturing relationships with their children unless there are substantial reasons to believe otherwise. In assessing whether parents are capable of sustaining nurturing relationships with their children, the court shall recognize that there are many ways that parents can respond to a child's needs with sensitivity and provide the child love and guidance, and these may differ between parents and among cultures.

(4) The court shall not consider conduct of a party that does not affect the party's relationship with the child.

(5) Disability alone, as defined in section 363A.03, of a proposed custodian or the child shall not be determinative of the custody of the child.

(6) The court shall consider evidence of a violation of section 609.507 in determining the best interests of the child.

(7) There is no presumption for or against joint physical custody, except as provided in clause (9).

(8) Joint physical custody does not require an absolutely equal division of time.

(9) The court shall use a rebuttable presumption that upon request of either or both parties, joint legal custody is in the best interests of the child. However, the court shall use a rebuttable presumption that joint legal custody or joint physical custody is not in the best interests of the child if domestic abuse, as defined in section 518B.01, has occurred between the parents. In determining whether the presumption is rebutted, the court shall consider the nature and context of the domestic abuse and the implications of the domestic abuse for parenting and for the child's safety, well-being, and developmental needs. Disagreement alone over whether to grant sole or joint custody does not constitute an inability of parents to cooperate in the rearing of their children as referenced in paragraph (a), clause (12).

(c) In a proceeding involving the custodial responsibility of a service member's child, a court may not consider only a parent's past deployment or possible future deployment in determining the best interests of the child. For purposes of this paragraph, "custodial responsibility" has the meaning given in section 518E.102, paragraph (f).

https://www.jdsupra.com/legalnews/a-custody-case-is-not-a-place-to-get-8303262/

Montana

Montana does not allow a licensee to disclose any information the licensee acquires from clients consulting the licensee in a professional capacity except:

(1) with the written consent of the client or, in the case of the client's death or mental incapacity, with the written consent of the client's personal representative or guardian;

(2) that the licensee need not treat as confidential a communication otherwise confidential that reveals the contemplation of a crime by the client or any other person or that in the licensee's professional opinion reveals a threat of imminent harm to the client or others;

(3) that if the client is a minor and information acquired by the licensee indicates that the client was the victim of a crime, the licensee may be required to testify fully in relation to the information in any investigation, trial, or other legal proceeding in which the commission of that crime is the subject of inquiry;

(4) that if the client or the client's personal representative or guardian brings an action against a licensee for a claim arising out of the social worker-client relationship, the client is considered to have waived any privilege;

(5) to the extent that the privilege is otherwise waived by the client; and

(6) as may otherwise be required by law. (MCA 37-22-401)

Texas

In Texas, patients, as well as their parents or guardians, have an almost absolute right to access their mental health records, and it is doubtful a provider can require a parent or guardian to give up this right in exchange for services. They can certainly ask parents/ guardians not to breach the confidence, but any such requirement is likely unenforceable under Texas law and may be viewed as void ab initio. 45C.F.R. § 164.524(a)(3)(i), HIPAA superseded Section 611.0045 of the Health and Safety Code, because it sets forth a higher standard that must be met before records may be withheld. As a result the Texas Psychology Board rule, 465.22(c)(9)(C) differs from the standard in 611.0045(b).

Yet, no law in Texas exists that requires a licensee to deliver services to a patient, minor or otherwise. While it is a question as to whether a Texas provider may condition his/her services upon a person giving up their right of access to patient records, a provider does not have to provide services to a minor if the parents/guardian refuse to allow the provider to treat a minor patient with confidentiality. A provider may also discontinue providing services if parents or guardians request access to minor patient information, but in this scenario, the parent or guardian would have access to the existing records and information.

As a best practice, licensees should explain the importance and benefits of confidentiality and the trust needed to develop rapport with a minor patient and ask the parents not to breach that trust by requesting records, etc. Nevertheless, Texas law is clear that if the parent/guardian elects to breach that trust, the provider must comply with their requests, unless some very narrow exceptions for withholding records apply.

Canada

Canada developed guidelines around this issue, and they provide more latitude to psychologists; informed judgment about whether minors were competent to consent.

Practice Guideline on Consent for Children and Youth
Effective 1 June 2019
1. The *Canadian Code of Ethics for Psychologists* (4th Ed.) addresses matters of consent in psychological practice, especially in the Values Statement for Principle 1, Respect for the Dignity of Persons and Peoples, and in standards I.16 through I.36 (Informed consent, Freedom of consent, Protections for vulnerable individuals and groups).

2. Psychologists' ethical principles, consistent with legislation and common law, require informed consent by recipients of psychological services such as assessment and treatment when those recipients are capable of giving consent, and informed consent from the person or persons mandated to make decisions on behalf of persons who are not capable of giving consent.

3. Psychologists give careful consideration to whether a person is capable of providing consent to assessment and treatment. Even though the *Consent to Treatment and Health Care Directives Act* may not apply to all psychological services, its description of how consent may be assessed (Section 7) is pertinent, and indicates that a person has capacity to consent if the person is, in the health practitioner's opinion, able (a) to understand the information that is relevant to making a decision concerning the treatment; (b) to understand that the information applies to his or her particular situation; (c) to understand that the person has the right to make a decision; and (d) to
appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

4. Unless there is evidence of significant disorder or disability that would impair the capacities identified in (3) above, adults age 18 years or over are assumed capable with respect to consent for assessment and treatment. Psychologists normally should also apply this assumption to persons age 16 and 17 years, age 16 being referenced in some pieces of legislation (e.g., *Consent to Treatment Act*, *Mental Health Act*, *Child Protection Act*) in a manner suggesting its acceptance as a benchmark for most people to have the maturity to make important decisions. In any particular case, individual circumstances might mean that the assumption should not be relied on, in which case care should be taken to consider the criteria noted in paragraph 3.

5. The question of whether a person has sufficient maturity to be capable of giving consent is not answered by age alone. Common law in Canada recognizes the possibility of some minors under the age of 16 years being capable of making, and thus having the right to make, their own decisions regarding consent to some interventions. As such, psychologists need to make a professional judgment about the capacity of a child under the age of 16 to provide informed consent, consistent with the criteria identified in (3) above. In cases where the psychologist determines that a child under age 16 is capable of giving consent, the psychologist will document her or his decision making process, including consultation with colleagues, and consideration of the benefits and costs of proceeding or not proceeding with the services requested. Generally, the younger the child, the heavier the burden on the psychologist to justify proceeding without consent of the adult who normally carries decision-making responsibility for the child.

6. If a child capable of giving consent does give consent, it is desirable, even though not legally required, for the parents or others with custodial responsibility to collaborate in decision making regarding assessment and treatment.

7. If a child is capable of providing consent and does not provide consent, the psychologist should refrain from providing services.

8. When a minor is not capable of providing consent, then the psychologist must turn to the person(s) with such authority. In considering how to proceed, the psychologist will take into consideration the *Custody Jurisdiction and Enforcement Act*. In situations where there is disagreement among those responsible for giving consent, the psychologist should endeavor to develop agreement, if possible, among all parties consistent with the best interests of the child. The following are guidelines regarding situations with which the psychologist might be presented:

a. Where the child lives with both parents together, then either parent may provide consent on behalf of the child. This arises from a legal presumption that parents living together are working together to raise the child. In a case where both parents live together, and one consents but the other disagrees, the decision to consent to intervention trumps the disapproval, and enables the psychologist to provide assessment or treatment; a possible remedy for the parent who disapproves is to seek a court order.

b. Where the parents are separated and the child primarily lives with one of the parents with the "consent, implied consent or acquiescence" of the other, then only the parent with whom the child primarily lives may provide consent, unless there is a separation agreement or court order that provides otherwise.

c. Where the parents are separated and the child lives primarily with one parent but that living arrangement is not with the "consent, implied consent or acquiescence" of the other, then consent from both parents is required, unless there is a separation agreement or court order that provides otherwise. In this case, if the parents disagree on the matter of consent, it would be the parent who wants intervention to proceed who might need to seek a court order to make that happen.

d. Where the parents are separated and the child lives with both parents, splitting time with them on a relatively equal basis, then consent from both parents is required, unless there is a separation agreement or court order that provides otherwise. In this case, if the parents disagree on the matter of consent, it would be the parent who wants intervention to proceed who would need to seek a court order to make that happen.

e. Where the parents are separated and a separation agreement or court order is in place, that agreement or court order should be reviewed in determining who may make consent decisions.

f. If a court order is in place assigning custodial responsibility to some person other than a parent (such as the Director of Child Protection, another relative, or any other person), that court order should be reviewed in determining who may make consent decisions.

g. In any situation where the child does not live with the parents together, i.e., any of (b) through (f) above, the psychologist will seek clarity regarding which living circumstance, or agreement or court order, is in place, taking into account the report of the person presenting with the child and whether that appears to be presented in good faith, in some cases contact with the parent who is not presenting with the child, and review of such agreements or court orders as may be available. In a situation where any person is acting in the place of a parent, it is that person's responsibility to establish the right to give consent on behalf of the child. In all cases, the psychologist will document the basis on which authority to provide consent be recognized.

Appendix 2

SB 431 (2020)

SENATE BILL NO. 431

Offered January 8, 2020

Prefiled January 7, 2020

*A BILL to amend and reenact §§ **20-124.6** and **54.1-2915** of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 35 of Title 54.1 a section numbered **54.1-3506.2** and by adding in Chapter 36 of Title 54.1 a section numbered **54.1-3617**, relating to provision of mental health services to a minor; access to health records.*

--SB 43 1--

Patron-- Surovell

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ **20-124.6** and **54.1-2915** of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 35 of Title 54.1 a section numbered **54.1-3506.2** and by adding in Chapter 36 of Title 54.1 a section numbered **54.1-3617** as follows:

§ **20-124.6**. Access to minor's records.

A. Notwithstanding any other provision of law, neither parent, regardless of whether such parent has custody, shall be denied access to the academic or health records of that parent's minor child unless otherwise ordered by the court for good cause shown or pursuant to subsection B.

B. In the case of health records, access may also be denied if the minor's treating physician or the minor's treating clinical psychologist has made a part of the minor's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the requesting parent of such health records would be reasonably likely to cause substantial harm to the minor or another person. If a health care entity denies a parental request for access to, or copies of, a minor's health record, the health care entity denying the request shall comply with the provisions of subsection F of § **32.1-127.1:03**. The minor or his parent, either or both, shall have the right to have the denial reviewed as specified in subsection F of § **32.1-127.1:03** to determine whether to make the minor's health record available to the requesting parent.

C. *No health care provider shall refuse to provide mental health services to a minor solely on the basis that a parent of such minor does not consent to having his access to the health records of such minor limited or denied for any reason other than those provided in subsections A and B.*

D. For the purposes of this section, ~~the meaning of the term "health record" or the plural thereof and the term "health care entity" shall be as~~ *"health care entity," "health care provider," and "health record" mean the same as those terms are* defined in subsection B of § **32.1-127.1:03**.