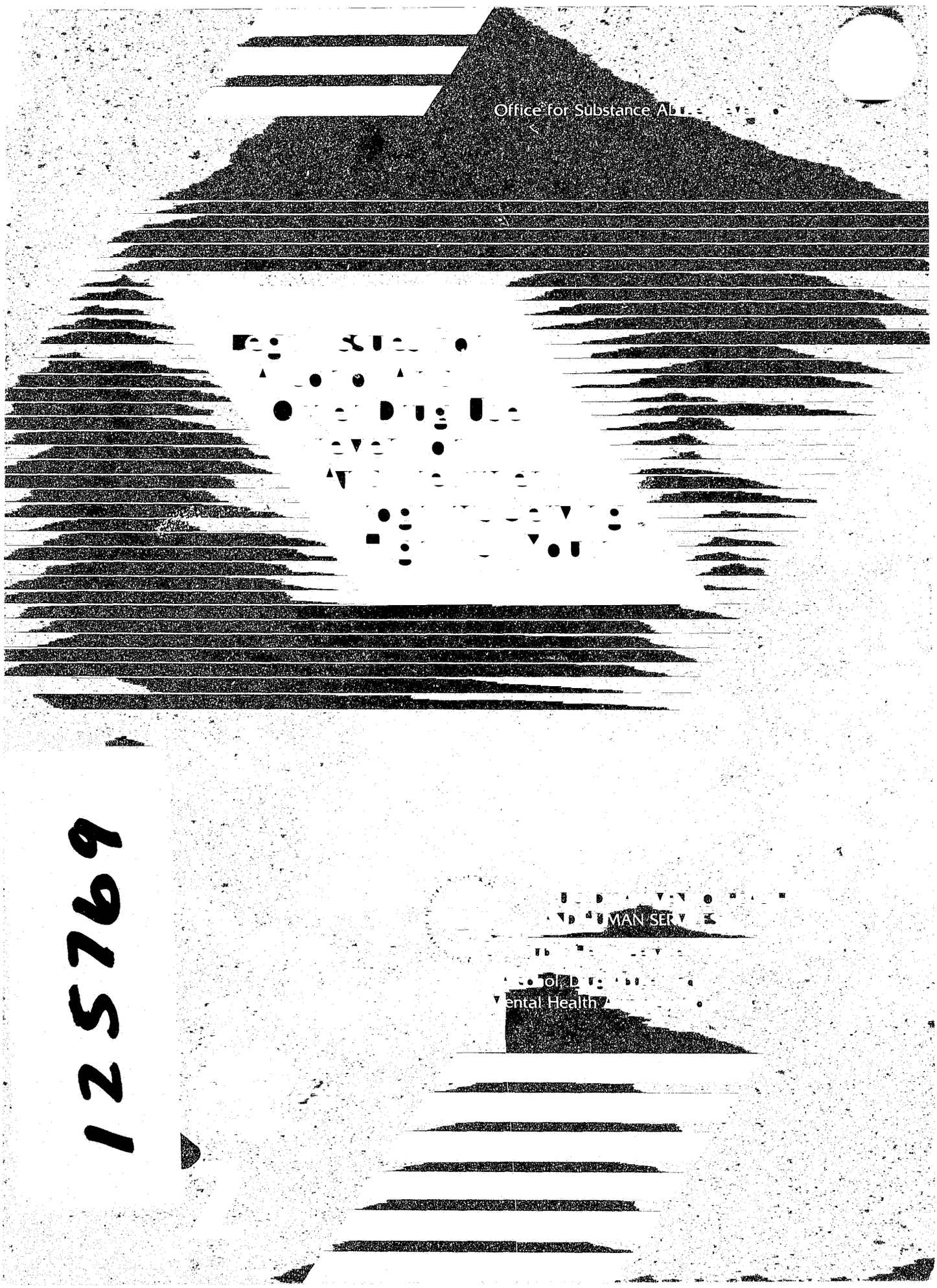

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OSAP Technical Report–2

Legal Issues For Alcohol And Other Drug Use Prevention And Treatment Programs Serving High-Risk Youth

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Introduction

Agencies offering alcohol and other drug prevention and treatment services to youth often have questions about a variety of legal and policy issues. Questions agencies most often ask include:

1. whether they must comply with the Federal laws and regulations governing confidentiality of patient records and, if they must comply, how they may do so;
2. when they may offer services to minors without parental consent;
3. when and how they must report child abuse and neglect;
4. how they can best screen employees and volunteers to ensure that no one on staff abuses or injures a client; and
5. whether they are in compliance with applicable quality of care standards.

This technical report examines these issues.

Confidentiality

Two Federal laws and a set of Federal regulations guarantee the strict confidentiality of persons (including youths) receiving alcohol and other drug services. (The legal citations for these laws and regulations are 42 U.S.C. § 290 dd-3 and ee-3; 42 CFR Part 2.) The laws and regulations are designed to protect clients' privacy rights and thereby to attract people into treatment.

The Federal confidentiality laws and regulations protect any information about a youth if the youth has applied for or received any alcohol or other drug-related services—including diagnosis, treatment, or referral for treatment—from a covered program. The restrictions on disclosure apply to any information, whether or not recorded, that would identify the youth as an alcohol or other drug user, either directly or by implication.

Which Programs Are Covered?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for youth with alcohol or other drug problems must comply with the Federal confidentiality regulations. (42 CFR § 2.12(e).)[1] The Federal regulations explicitly provide that specialized school-based substance abuse programs are subject to the reg ulations' confidentiality requirements. However, alcohol and other drug education programs that are not designed to provide individual treatment or diagnosis and referral are not covered.

The Federal regulations apply only to programs that are federally assisted, but this includes indirect forms of Federal aid such as tax-exempt status, or State or local government funding that originated with the Federal Government. Virtually all programs in public schools, and many private school programs, meet this requirement.

Coverage under the Federal regulations does not depend on the administrative structure of the program. A program that is run by a school district and staffed by school employees must comply with the Federal law, as must a freestanding program or a program operated in a school on a contract basis by a community treatment program.

Coverage under the Federal regulations does not depend on how a program characterizes its services. Calling itself a "prevention program" does not insulate a program. It is the kind of services—not the label the program applies to its services—that determines whether it must comply with the Federal law and regulations. Throughout this technical report, the terms "patient" and "client" are used interchangeably to underscore the fact that no legal distinction exists between "patients" and "clients" or "students" in prevention interventions.

Some examples may help to illustrate the kinds of programs to which Federal confidentiality requirements apply.

Example 1: The Uptown School provides classroom education on alcohol and other drugs. The teachers conducting these classes are not responsible for counseling individual students or making formal assessments and referrals. However, students sometimes confide in the teacher after class. The teacher listens to their problems and provides support and advice, including advice to seek treatment.

Is the information that the teacher learns about a student's drug or alcohol use in this setting protected by the Federal law? No, because the Federal regulations apply only to programs that specialize in providing diagnosis, treatment, or referral for treatment. A classroom education program is not covered, even if the teacher does serve as a confidant for students and discusses their problems on an informal basis.

Example 2: The Downtown School has a counseling program that deals with a wide range of student problems, including psychological, emotional, and family problems as well as alcohol and other drug use. Program staff run "rap groups," provide counseling to individual students, and make referrals to treatment programs in the community.

This program is covered by the Federal regulations, since the regulations apply to programs that specialize, in whole *or in part*, in alcohol or other drug counseling, assessment, or referral. However, the only information that is protected is information identifying a particular youth as an alcohol or drug user. The Federal regulations do not restrict disclosure of the fact that a youth has been seen by the program, because participation in the program does not imply alcohol or other drug use; it could just as well mean that the

[1] All citations refer to sections of Title 42 of the Code of Federal Regulations (42 CFR) unless otherwise specified.

youth is receiving counseling for other problems.

Example 3: Hilltop is a counseling program much like Downtown, except that it deals exclusively with alcohol or other drug problems. Clearly, this program is also covered by the regulations. And in this case, the confidentiality regulations restrict all disclosures that reveal or acknowledge that a particular youth is being or has been counseled, evaluated, or referred by the program, since disclosing that information necessarily implies that the youth is or was an alcohol or other drug user.

Example 4: The Midtown school-based program, which has determined that it is governed by the Federal regulations, wants to meet with parents, teachers, or others to discuss whether Jerry Jones, a student who is suspected of having an alcohol or other drug problem, needs intervention and treatment. Is the information that Jerry Jones is believed to be in need of services protected by the Federal regulations?

Only individuals who have applied for or received services from a program are protected by the Federal law. Thus, if a youth has not yet been evaluated or counseled by a program, and has not sought the program's help, the program is free to discuss the youth's alcohol or other drug problems with others. However, from the time the program first conducts an evaluation or begins to counsel the youth, or the youth applies for these services, the program must comply with the Federal regulations when disclosing any information that would identify him or her as an alcohol or other drug user.

When May Confidential Information Be Shared With Others?

To reiterate, the Federal confidentiality laws and regulations prohibit all disclosures of information about a youth that would identify the youth as an alcohol or other drug user (either explicitly or implicitly). This general rule applies from the time the youth makes an appointment. The rule applies whether or not the information is recorded and whether or not the person making an inquiry already has the information, has other ways of getting it, enjoys official status, is authorized by State law, or comes armed with a subpoena.

The Exceptions

Information that is protected by the Federal confidentiality regulations may always be disclosed after the youth has signed a proper consent form. (As discussed below, parental consent must also be obtained in some States.) The regulations also permit disclosure without the client's consent in several situations, including medical emergencies, child abuse reports, and communications made within a program.

Consent

Most disclosures are permissible if a patient has signed a valid consent form which has not expired or been revoked by the patient. (§ 2.33.) [2]

Proper format for consent to release information

A proper consent form must be in writing and contain *each* of the items specified in § 2.31:

1. the name (or general description) of the program(s) making the disclosure;
2. the name or title of the individual or organization that will receive the disclosed information;
3. the name of the patient;
4. the purpose or need for the disclosure;
5. how much and what kind of information will be disclosed;
6. a statement that the patient may revoke the consent at any time, except to the extent that the program has already acted in reliance on it;
7. the date, event, or condition upon which the consent expires if not already revoked;
8. the signature of the patient (and, in some States his or her parent); and
9. the date that the consent is signed.

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable and does not allow a program to make a disclosure.

Several items on this list require further explanation (see exhibit 1):

(a) **The purpose of the disclosure, and how much and what kind of information will be disclosed.**

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure. (§ 2.13(a)) It would be

[2] However, no information obtained from a program may be used in a criminal investigation or prosecution of a patient unless a court order has been issued under the special circumstances set forth in § 2.65. (§ 2.12(a), (d))

Exhibit 1

Consent for the Release of Confidential Information

I, _____, authorize

_____

(Name or general designation of program making disclosure)

to disclose to

_____

(Name of person or organization to which disclosure is to be made)

the following information:

_____

(a) *(Nature of the information, as limited as possible)*

The purpose of the disclosure authorized herein is to:

_____

(a) *(Purpose of disclosure, as specific as possible)*

(b) I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

_____

(c) *(Specification of the date, event, or condition upon which this consent expires)*

(d) Dated: _____ _____

Signature of participant

_____

(d) Signature of parent, guardian, or authorized representative when required

NOTE: See text for explanation.

improper to disclose everything in a patient's file if the person making the request only needs one specific piece of information.

In completing a consent form, therefore, it is important to determine the purpose or need for the requested information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the identified purpose.

Illustration: If a student needs to have the fact that she is in treatment verified in order to leave school an hour early, the purpose of the disclosure would be to permit early release for treatment, and the amount and kind of information to be disclosed would be "verification of current treatment status." The disclosure would then be limited to a statement that "Joan Smith (the patient) attends the XYZ Program as of April 17, 1989."

(b) Revocation statement

The youth may revoke consent to disclose at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed.

The regulations state that "acting in reliance" includes providing services in reliance on a consent form permitting disclosures to a third-party payer. (§ 2.31(a)(8)) Thus, a program can bill the third-party payer for past services to the patient even after consent has been revoked. However, a program that continues to provide services after a patient has revoked a consent authorizing disclosure to a third-party payer does so at its own financial peril.

(c) Expiration

The consent form must also contain the date, event, or condition upon which the consent will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given." (§ 2.31(a)(9)) If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, therefore, it is better to fill in that amount of time rather than a longer period or to have all consents uniformly expire in 60 or 90 days.

The consent form does not need to contain a specific expiration date, but may instead specify an event or condition. For example, if a youth has been placed on probation at school on the condition that the treatment program provide monthly progress reports, a consent form should be used that does not expire until the completion of the period of probation. Alternatively, if a patient is being referred to a specialist for a single appointment, the consent form should provide that it will expire after he has seen "Dr. X."

(d) The signature of the youth (and the parent if required)

Youths must always sign the consent form for a program to release information, even to their parents. The program must get the parent's signature only if the program was required by State law to obtain parental permission before providing treatment to the minor. (§ 2.14) ("Parent" includes guardian or other person legally responsible for the minor.) The confidentiality regulations leave the issues of who is a minor, and whether a minor can obtain alcohol or other drug treatment without parental consent, entirely to State law.

In other words, if State law does not require the program to get parental consent to treat the minor, then parental consent is not required to make disclosures. If State law requires parental consent for treatment, then parental consent is required to make any disclosures. The program must *always* obtain the minor's consent for disclosures and cannot rely on the parent's signature alone.

The program may contact the parent without the minor's consent only if the program director (1) believes that the minor, because of extreme youth or medical condition, does not have the capacity to decide rationally whether to consent to the notification; and (2) the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else. (§ 2.14(d))

School-based programs must also pay attention to the requirements of the Federal Family Educational Rights and Privacy Act of 1974

(FERPA) (20 U.S.C. § 1232g). FERPA requires that the written consent of a parent be obtained before disclosing personally identifiable information from a student's records to anyone outside of the school or local district. (FERPA does not require parental consent if the student is over 18 or attending a postsecondary institution.)

Written prohibition on redisclosure

Once the consent form has been properly filled out, one last formal requirement remains. Any disclosure made with patient consent must be accompanied by a written statement (exhibit 2) that the information disclosed is protected by Federal law and that the recipient cannot make any further disclosure of it unless permitted by the regulations. (§ 2.32)

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from re-releasing the information except as permitted by the regulations. (Of course, a patient may sign a consent form specifically authorizing such a redisclosure.) The regulations prohibit redisclosure by third-party payers or entities having direct administrative control over a program even if they have not received the written notice described above. (§ 2.12(d)(2)) However, keep in mind that the program is required to attach the notice prohibiting redisclosure to *all* disclosures made with patient consent, regardless of who is receiving the information.

Exhibit 2. Prohibition of redisclosure of information concerning client in alcohol or drug use treatment

This notice accompanies a disclosure of information concerning a client in alcohol or other drug use treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug use patient.

The use of consent forms

The fact that a patient has signed a proper consent form authorizing the release of information does not *force* a program to make the proposed disclosure, unless the program has also received a subpoena or court order. (§§ 2.3(b); 2.61(a), (b))

In most cases, then, the decision to make a disclosure pursuant to a consent form is within the discretion of the program unless State law requires or prohibits disclosure once consent is given.

Criminal justice system referrals

The confidentiality regulations set forth some special rules when a patient's participation in a treatment program is an official condition of probation or parole, sentence, dismissal of charges, release from imprisonment, or other disposition of any criminal proceeding. While a consent form (or court order) is still required before any disclosure can be made about a youth who is the subject of a criminal justice system (CJS) referral, the rules concerning duration and revocability of the consent are different. (§ 2.35)

Specifically, the regulations require that the following factors be considered in determining how long the consent will remain in effect: the anticipated length of treatment, the type of criminal proceeding, the need for treatment information in disposing of that proceeding, when the final disposition will occur, and anything else the patient, program, or criminal justice agency deems pertinent.

In practice, instead of specifying a particular time, many programs use as an expiration condition "when a substantial change occurs in the patient's criminal justice system status." A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next.

Illustration: If a youth is on parole or probation, a change in criminal justice system status

would occur when the parole or probation ends, either by successful completion or revocation. Thus, the program could provide periodic reports to the parole or probation officer monitoring the youth, and could even testify at a parole or probation revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing.

The regulations permit the CJS consent form (exhibit 3) to be irrevocable so that individuals who agree to enter treatment in lieu of prosecution or punishment cannot then prevent the court or probation, parole, or other agency from monitoring their progress. CJS consent forms should contain a statement that consent cannot be revoked until a certain specified date or condition occurs. (Note that although a CJS consent may be made irrevocable for a specified period, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the patient may freely revoke consent.)

Several other considerations relating to CJS referrals are important. First, any information received from a treatment program by one of the eligible criminal justice recipients can be used only in connection with its official duties with respect to that particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals. (§ 2.35(d))

Second, whenever possible, it is best to have the judge or referring agency require that a proper CJS consent form be signed before a youth is referred to the treatment program. If that is not possible, the program should obtain the youth's (and, where required, the parent's) consent to the release of information to the appropriate agency at the very first meeting with the youth. With a proper CJS consent, the treatment program can then communicate with the referring criminal justice agency even if the youth appears for treatment only once or twice. This avoids the unfortunate problems that can arise if a CJS referral leaves before successfully completing treatment without ever having signed a consent form.

If a CJS agency requests information and the program has failed to obtain a CJS consent, the program has few options if a youth leaves before successfully completing treatment. The program could attempt to locate the departed youth and have him (and, where required, his parent) sign a consent form, but that is unlikely to happen. Nor can a court order authorize the program to release information about a referral who has left the program in this type of case. The regulations allow a court to order disclosure of treatment records for the purpose of investigating or prosecuting a patient for a crime only where the crime was "extremely serious," and a parole or probation violation generally will not meet that criterion.

Therefore, unless a consent form is obtained at the very beginning of treatment, the program may be prevented from providing any information to the criminal justice agency that referred the patient for treatment.

A final note: If a person referred by the criminal justice system never applies for or receives services from the program, that fact may be disclosed to a criminal justice agency without patient consent. (§ 2.13(c)(2))

Internal Program Communications

A second important exception to the Federal law's general rule that no information about a patient may be disclosed to anyone permits some information to be disclosed to individuals within the same program. Section 2.12(c)(3) of the Federal regulations provides that:

> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program. (§ 2.12(c)(3))

A question that frequently arises is whether this exception allows a school-based program to share confidential information with others in the school system, such as teachers, guidance counselors, principals, or district administrators, without obtaining the student's consent. As is

Exhibit 3

Consent for the Release of Information:
Criminal Justice System Referral

I, _____, hereby consent to communication between _____ and _____
(treatment program)

_____
(Court, probation, parole, and/or other referring agency)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

☐ there has been a formal and effective termination or revocation of my probation, parole, conditional release, or other proceeding under which I was mandated into treatment, or

☐ _____
(other time when consent can be revoked)

☐ _____
(other expiration of consent)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

_____ _____
(Dated) *(Signature of defendant/patient)*

_____ _____
(Dated) *(Signature of parent, guardian, or authorized representative, if required)*

often the case in this area, the answer is, "It depends."

Disclosures to other school personnel are exempt from confidentiality restrictions only if the disclosure is made to someone who (1) is in direct administrative control of the program *and* (2) needs the information for the purpose of facilitating the provision of alcohol- or other drug-related services to the student.

Unconsented disclosures from a school-based program to other school or district personnel cannot be justified as internal communications if the program is not under the school system's direct control (for example, a treatment program providing services to a school or district on a contract basis).

If the program is under the direct administrative control of the school or district, unconsented disclosures to other school personnel are permissible, but only if the disclosure is needed to help provide effective alcohol or other drug use services. For example, disclosures may need to be made to an administrator who is responsible for issuing passes to a student who needs to leave class to attend the program. However, disclosures for nontreatment purposes—such as suspending or expelling a student for drug or alcohol use—are *not* permissible internal communications and may not be made unless the student consents.

When information is disclosed to other school personnel under the internal communications exemption, it remains protected by the Federal confidentiality laws. The program should advise the recipient of the information that redisclosure (except in the situations authorized by the confidentiality regulations) is prohibited, and that violation of the law can result in Federal criminal sanctions.

Other Exceptions to the General Rule

Qualified service organization agreements

If a program needs to share certain information with school officials to facilitate the provision of services (such as disclosures to allow the issuance of attendance passes) but is not under a school system's direct administrative control, the program can enter into what is known as a qualified service organization agreement (QSOA). A QSOA is a written agreement between a program and a person providing services to the program, in which that person

1. acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, it is fully bound by [the Federal confidentiality] regulations; and

2. if necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations. (§§ 2.11, 2.12(c)(4))

If a program needs to share confidential information about youths who are clients with certain school officials who are providing a service to the program, and those officials are willing to sign and abide by the terms of a QSOA, the program can disclose the information without obtaining the youths' consent. A QSOA should only be used when an outside agency or official is providing a service to the program. It is not a substitute for individual consent in other situations. Disclosures under a QSOA, like disclosures made under the internal communications exemption, must be limited to information that is needed by others so that the program can function effectively.

Of course, the same information about each client may be disclosed to school officials if each client (and, where applicable, parent) consents in writing on a proper form.

Communications that do not disclose patient-identifying information

A fourth important exception to the general rule prohibiting disclosure of any information about a patient permits disclosure if no patient-identifying information is disclosed. Thus, a program may disclose information about a youth if that information does not identify the youth as an alcohol or other drug client or verify someone else's identification of the youth as such.

Programs can make nonpatient-identifying disclosures in two primary ways: (1) by reporting aggregate data about client population, or some

about a youth in a way that does not disclose the youth's status as an alcohol or other drug client. For example, a program that provides services to a youth with other problems or illness as well as to alcohol and other drug users may disclose information about a client as long as the fact that the youth has an alcohol or other drug problem is not revealed. Thus, the Downtown School program described above, which deals with a wide range of student problems, may disclose that "Ellen Smith is attending the program" because that statement does not disclose that Ellen Smith has an alcohol or other drug problem.

Programs that provide only alcohol and other drug services—like the Hilltop program described above—cannot make a similar statement, because that statement would necessarily imply that Ellen Smith has an alcohol or other drug problem. However, such programs can sometimes make anonymous disclosures, i.e., disclosures that do not mention the name of the program or otherwise reveal the youth's status as an alcohol or other drug use client.

Child abuse and neglect reporting

The Federal law permits programs to comply with State laws that require the reporting of child abuse and neglect. However, this exception to the general rule prohibiting disclosure of any information about a client applies only to *initial* reports of child abuse or neglect. Programs may not respond to followup requests for information or even subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, *unless* the youth consents or the appropriate court issues an order under subpart E of the regulations.

Court-ordered disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about a client that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is *not* sufficient, standing alone, to require or even to permit a program to disclose information. (§ 2.61)

Before a court can issue an authorizing court order, the program and any patient whose records are sought must be notified of the application for the order and given some opportunity to make an oral or written statement to the court. [3]

Generally, the application and any court order must use fictitious names for any known patient, and all court proceedings in connection with the application must remain confidential unless the patient requests otherwise. (§§ 2.64(a), (b), 2.65, 2.66)

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find good cause only if it determines that the public interest and the need for disclosure outweigh any adverse effect that the disclosure will have on the patient, the doctor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective. (§ 2.64(d)) The judge may examine the records before making a decision. (§ 2.64(c))

The scope of disclosure that a court may authorize is limited, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the patient's confidentiality, including sealing court records from public scrutiny.

The court may order disclosure of "confidential communications" by a youth to the program only if the disclosure (a) is necessary to protect against a threat to life or serious bodily injury, or

---

[3] However, if the information is being sought to investigate or prosecute a patient, only the program need be notified. (§ 2.65) And if the information is sought to investigate or prosecute the program, no prior notice at all is required. (§ 2.66)

(b) is necessary to investigate or prosecute an extremely serious crime (including child abuse), or (c) is in connection with a proceeding at which the youth has already presented evidence concerning confidential communications. (§ 2.63)

Medical emergencies

A program may make disclosures to public or private medical personnel to meet a bona fide medical emergency of the youth or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention. (§ 2.51)

The medical emergency exception only permits disclosure to medical personnel. This exception cannot be used as the basis for a disclosure to the police or other nonmedical personnel. Whenever a disclosure is made to cope with a medical emergency, the program must document in the youth's records the name and affiliation of the recipient of disclosure, the date and time of the disclosure, and the nature of the emergency.

Patient crimes on program premises or against program personnel

When a patient has committed or threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, the program can disclose, without any special authorization, the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program. (§ 2.12(c)(5))

Research, audit, or evaluation

The confidentiality regulations also permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met. (§§ 2.52, 2.53) The rules and requirements the researcher must meet depend upon the identity of the research organization. [4]

Patient Notice and Access to Records

The Federal confidentiality regulations require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to patients at admission or soon thereafter. (§ 2.22(a)) (See exhibit 4.) The regulations also contain a sample notice.

Exhibit 4. Sample Client Notice

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *unless:*

(1) The patient consents in writing; OR

(2) The disclosure is allowed by a court order; OR

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR

(4) The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

(See 42 U.S.C. §§290ee-3, 290ff-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

[4] For a more complete explanation of the requirements of §§ 2.52 and 2.53, see *Confidentiality: A Guide to the New Federal Regulations*, New York: Legal Action Center, 1988.

Programs have the discretion to decide when to permit youths to view or obtain copies of their records, unless State law grants patients the right of access to records. Programs need not obtain written consent from youths before permitting them to see their own records.

Confidentiality Versus a Parent's Right to Information

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g) and regulations issued under it by the U.S. Department of Education (34 CFR, Part 99) require educational institutions to give parents the right to inspect and review the education records of their children. [5]

"Education records" are defined as records relating to a particular student that are maintained by an educational agency or institution, or by a party acting for that agency or institution. The definition of "records" is limited to information recorded in some form, such as print or handwriting, tape or microfilm.

The written records of most school-based alcohol or other drug programs are subject to FERPA, since such programs usually are part of an educational agency or are acting for an educational agency under contract. The school must comply with a request to review records within 45 days.

FERPA's requirement of disclosure to parents will sometimes conflict with the obligations of a school-based program under the Federal confidentiality laws and regulations. The confidentiality regulations generally forbid a program from disclosing any information to a parent concerning a student/client's alcohol or other drug problem unless the student has signed a consent form authorizing the disclosure. Under FERPA, however, a school-based program must comply with a parent's request to inspect records, whether or not the student consents. [6]

The conflict between these two Federal laws has not yet been resolved by the courts or Federal agencies. This puts programs in the unfortunate position of having to choose between violating one law or the other. Under the confidentiality laws, any program or individual making an impermissible disclosure may face a criminal penality (a fine of up to $5,000 for each disclosure) and civil liability for damages. Violations of FERPA can also result in lawsuits for damages, as well as a cutoff of Federal funding.

A strong argument can be made that the Federal confidentiality statutes, which are somewhat more specific, should take precedence when the two laws conflict. The U.S. Department of Education is now considering a request from the Legal Action Center for an opinion on this issue.

Whenever possible, school-based alcohol and other drug programs should seek to comply with both FERPA and the confidentiality laws. If a parent requests program records, the program should ask the youth to sign a consent form authorizing the disclosure. If a consent form is obtained, the program can release the records as required by FERPA without violating the confidentiality laws. Only when the youth refuses consent must the program face the conflict discussed above.

One way to avoid this problem is for the program to obtain the youths' consent when they enter the program. (The difficulty here is that youths can revoke their consent at any time, including when their parents request information.) Another way to avoid the conflict between FERPA and the Federal confidentiality laws is to ask the parents to waive their right of access. However, the program must get the youth's consent to contact the parent to request the waiver.

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[5] Parents of students under the age of 18 have the right to inspect and review records. Students 18 or older and those attending postsecondary institutions have the right (but not their parents).

[6] However, two limited exceptions in FERPA may sometimes apply. One exception is for records that are in the sole possession of the maker of the record and are not accessible or disclosed to any other individual except a substitute. (This means that a counselor's personal notes are exempt, but they become subject to FERPA if they are shown to anyone else—even other program staff.) The second exception is for treatment or counseling records concerning a student who is 18 or older or is attending a postsecondary institution, if the records are not disclosed to anyone outside the program.

Applying the Regulations: Some Questions and Answers

Responding to Inquiries from Parents

Q: Sam Roe, a 14-year-old, has been attending counseling sessions at the Hillview program for 10 weeks. His father has called Sam's counselor to discuss Sam's progress. Can the counselor talk to Mr. Roe?

A: The Federal regulations require that before a program discloses information about a client, the client must consent in writing. Therefore, the first step the program should take is to get Sam's consent to confer with his father.

In getting Sam's consent, the program should consult with Sam about whether he (and it) want to be able to confer with Mr. Roe just once or periodically. This decision will affect how the program fills out the consent form. If the program and Sam decide they want Sam's counselor to be free to talk to his father, the purpose of the disclosure (which must be stated on the consent form) would be "to provide periodic reports to Mr. Roe" and the kind of information to be disclosed (which must also be stated on the consent form) would be "Sam's progress in treatment." The expiration on this kind of open-ended consent form might be set at the date the program and Sam foresee his counseling ending or even "when Sam's participation in the program ends" (although Sam can revoke the consent any time he chooses).

If the counselor and/or Sam decide they want the counselor to confer with his father only once, the program would fill out the consent form differently. The purpose of the disclosure would be "to confer with Mr. Roe about Sam's progress as of [date]" and the kind of information to be disclosed would be "Sam's progress as of [date of the conference]." The expiration date should also be keyed to the date the counselor sees Mr. Roe.

What if Sam refuses to consent? Since the Federal confidentiality regulations prohibit disclosures without Sam's consent, the program cannot confer with Mr. Roe. Indeed, it cannot even tell him whether Sam is continuing to attend the program.

What if the program counseling Sam is a school-based program subject to FERPA; is there a problem? FERPA gives parents the right to inspect written records. Since Mr. Roe asked to speak to the counselor and not to review Sam's records, FERPA does not apply and the counselor must refuse to divulge any information. Of course, if Mr. Roe should ask to see Sam's treatment file, then the program is faced with the conflict between the Federal confidentiality laws and FERPA discussed above.

Reporting Criminal Activity

Q: Sam Roe has told his counselor at Hillview that before he entered treatment, he routinely stole things from stores and neighbors' houses. Does Sam's counselor have an obligation to report Sam's criminal activity? Can Sam's counselor get into trouble for not reporting it?

A: In most States, it is not a crime for an individual who knows that someone else committed a crime in the past to fail to report that information to law enforcement authorities. Even those few States that have laws that make it a crime to fail to report such information rarely prosecute violators.

Moreover, alcohol and other drug counselors,

by virtue of their special relationship with their clients (which, in many States, is protected by statutes designed to keep confidences private), may be exempt from any duty to report a crime.[7]

Q. Sam Roe has told his counselor that he committed a homicide 2 years ago. The crime was widely publicized at the time since the body of the victim, a young child, was never found. Sam told his counselor where he hid the body. Sam's counselor is very upset. He wants to be able to report this information to the police. Can he do so without violating the Federal regulations?

A. Sam's counselor can disclose this information to the police without violating the Federal confidentiality regulations if he takes one of the following steps:

1. He can get Sam's consent to make a report. (In some States, parental consent would also be required.)
2. He can report the crime in a way that does not reveal that Sam is in alcohol or other drug treatment. If the program serves youth with other problems, Sam's counselor could make his report and disclose that he is a counselor at the program. If Hillview provides only alcohol or other drug abuse services, Sam's counselor would have to make an anonymous report.[8]
3. He can apply for a court order under § 2.65 of the Federal confidentiality regulations. This section permits programs to request a court order to report patient crimes, but *only* when "the crime involved is extremely serious...including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect." (§ 2.65(d)(1)) Section 2.65 requires the program seeking the order to use a fictitious name to refer to any patient and requires the court to make specific findings before it issues the order. Note that, although Sam's counselor could use § 2.65 to request a court order to report the homicide, he probably could not use it to request a court order to report the petty larcenies Sam committed.[9]

Q: Sam Roe has told his counselor at Hillview that his father, Jack Roe, is selling crack. Sam's counselor knows Sam well enough to trust his account. Does Sam's counselor have an obligation to report Jack Roe's criminal activity?

A. In most cases, Sam's counselor would not have an obligation to report Sam's father's activity, unless he believes it is having an effect on Sam that amounts to reportable child abuse or neglect. If, for example, Sam told his counselor that his father was forcing him to deliver drugs to customers, Sam's counselor might well have an obligation to report to the State child abuse authorities.

If Mr. Roe's conduct is criminal but does not amount to child abuse or neglect, but Sam's counselor wants to report it to the police anyway, he can do so by using methods 1 or 2 outlined above. He can also obtain a court order under § 2.64 of the Federal regulations (see court-ordered disclosures above).

Duty to Warn

Q. Sam is distraught because his girlfriend has just jilted him for Rob. Sam has told his counselor that he is going to kill her if he sees the two of them together. Does Sam's counselor have a duty to warn someone of Sam's intention? Whom

7 For a more detailed answer to this question, see the May/June 1987 issue of *Of Substance*.

8 A note of caution: Before making any report about a past crime that a patient has mentioned to a counselor, the program should consult a lawyer about State law privileges. State laws vary widely on the protections they accord the relationship between a client or patient and the counselor. In some States, admissions of past criminal activity are not considered privileged, while in others they may be. Whether a communication is privileged under State law may depend upon the counselor's profession and whether he or she is licensed by the State. Checking with a lawyer familiar with State law is essential if a program is considering reporting a patient's admissions to a law enforcement agency.

9 If Sam committed a crime on program premises (such as burglarizing the program) or against program personnel (by attacking his counselor in the municipal parking lot, for example), the program could report the crime to law enforcement agencies without going through any of these steps.

should he tell, and can he report this threat without violating the Federal confidentiality regulations?

A. For most treatment professionals, the issue of reporting a patient's threat to commit a crime is troubling. Many people feel that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is a serious one.

A developing trend in the law would require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff* v. *Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn the victim when his patient threatened to (and did) kill him. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

While strictly speaking the *Tarasoff* ruling applies only in California, courts in a number of other States have followed *Tarasoff* in finding therapists liable for money damages when they failed to warn someone threatened by a patient. Most of these cases are limited to situations where patients threaten a specific identifiable victim, and they do not generally apply where a patient makes a threat without identifying the intended target.

If Sam's counselor thinks Sam poses a serious risk of violence to Rob or the girlfriend, he may well have a duty to warn either the potential victims or the police.

However, as the careful reader will have noticed, the *Tarasoff* case apparently conflicts with the Federal confidentiality requirements. The Federal confidentiality laws and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require, unless the disclosure is made pursuant to a court order or is made without identifying the individual who threatens to commit the crime as a patient. Moreover, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations. (§ 2.20) In the only case we could find that addresses this conflict (*Hasenie* v. *United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

Confronted with conflicting moral and legal obligations, what should Sam's counselor do? A program that learns that a patient is threatening violence to a particular person or persons may be well advised to seek a court order permitting a report or to make a report without revealing patient-identifying information. If a counselor believes there is clear and imminent danger to a particular person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual. This is especially true in States that already follow the *Tarasoff* rule.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when he believed in good faith that a particular individual was in real danger. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should at least try to make the warning without identifying the individual as having an alcohol or other drug problem.

Right to Treatment; Parental Consent

When can minors enter counseling or other treatment for alcohol and other drug problems without getting their parents' consent? State law determines the answer to this question. The laws of all 50 States are summarized in the appendix.

More than half the States have statutes that permit minors of any age to obtain treatment for alcohol and drug problems without parental [10] consent. However, in many States, the law either requires or permits alcohol and other drug programs treating minors to notify parents even though they may provide treatment without parental consent. Programs must remember that if they are subject to the Federal confidentiality regulations, they cannot notify a parent without obtaining the minor's written consent on the standard Federal confidentiality form.

One of the most difficult problems in this area arises when a minor applies for treatment without parental knowledge in a State where treatment can be provided only with the parent's authorization. In this situation, the program can contact the parent to obtain that authorization only if the minor has signed a consent form, or the program director determines that the minor "lacks the capacity to make a rational choice" as to whether to give consent and the situation poses a substantial threat to the life or well-being of the minor or any other person. Otherwise, the program must explain to minors that while they have the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent. (§ 2.14(d))

In States where parental consent is not required for treatment, the regulations permit a program to withhold services if the minor will not authorize a disclosure that the program needs to obtain financial reimbursement for that minor's treatment. The regulations add a warning, however, that such an action might violate a State or local law. (§ 2.14(b))

Programs should also be aware that a Federal statute and regulations prohibit schools funded under certain Federal programs from *requiring* any student to obtain treatment, counseling, or assessment for psychological problems (defined broadly enough to encompass alcohol and other drug use) without first obtaining parental consent. (20 U.S.C. § 1232h; 34 CFR Part 98) If a student's participation in a program is voluntary, parental consent is not required under this law (but may still be required under State law).

[10] "Parent" or guardian or other person legally responsible for the youth.

Child Abuse and Neglect Reporting

All 50 States have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. Most States now require not only physicians but also social service workers to report child abuse. Most States require an immediate oral report, and many now have toll-free numbers to facilitate reporting. (Half the States require that both oral and written reports be made.) All States extend immunity from prosecution to persons reporting child abuse and neglect. Most States provide for penalities for failure to report. [11]

Because of the variation in State laws, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance. Since many State statutes require that staff report instances of abuse to administrators, who are then required to make an official report, programs concerned about this issue should establish reporting protocols to bring suspected child abuse to the attention of program administrators, who in turn should shoulder the responsibility for making the mandated reports.

[11] For a digest of State child abuse and neglect laws, see *Child Abuse: Governing Law and Legislation* by Irving J. Sloan, New York: Oceana Publications, Inc., 1983.

Screening Potential Employees and Volunteers

The Hiring Process

Setting Up Safeguards

All agencies working with youth appreciate how important staff qualifications and integrity are. Good agencies cannot exist without talented staff of excellent character. This is particularly true for agencies working with young people. Moreover, agencies that work with youth have a special responsibility: to do no harm. If employees or volunteers do not do their job, that is bad enough; if they also abuse or harm a child, the agency could face a lawsuit.

Many States now have child abuse registers and require agencies working with children and/or youths to check the names of potential employees and volunteers against the registry. However, agencies clearly cannot rely on the registry as their only screening tool.

Agencies working with youth are well advised to establish job descriptions and employment criteria that are related to those job descriptions. Agencies should carefully screen prospective employees and volunteers—and closely supervise those currently working or volunteering—to ensure that everyone is qualified to do the job and that everyone is trustworthy.

This is always easier said than done, but there are ways to improve screening and, at the same time, limit agency liability if the worst happens and a staff member or volunteer harms or abuses a child. First, agencies should have written job descriptions for all positions—paid and volunteer. When applicants apply, these descriptions will help the agency hiring team weed out people without the experience or qualifications to do the job. Second, all applicants should be interviewed, preferably by more than one person. An interview can often set off warning bells when something is not quite right. Third, all applicants should be required to supply employment and/or personal references, and these references should be checked thoroughly by the agency. Finally, a written record should be kept of the hiring process for each employee so that if a claim later arises that the agency negligently hired someone, the agency has a record of the reasonable screening steps it took in each case.

Staff—both paid and volunteer—should be closely supervised and periodically evaluated. This serves two purposes: supervision may prevent an abusive situation from occurring and evaluation provides a record that the agency took reasonable steps to ensure proper conduct by staff.

Avoiding the Pitfalls: Fair Employment Laws

In establishing employment criteria and screening prospective employees and volunteers, a few basic rules should be kept in mind.

Federal and many State laws prohibit employment discrimination on the basis of race, gender, religion, national origin, or disability. Nowadays, most agencies do not establish policies that explicitly discriminate on the basis of race, gender, and so forth. However, agencies can run into trouble if the employment criteria they establish and the way they screen prospective employees are not strictly job-related and exclude a disproportionate number of, say, women or blacks. For example, if a program required all applicants to be able to lift 60 pounds, this requirement might well exclude large numbers of women. Unless the program could justify the requirement by showing that it was an essential part of the job, it would be in violation of the laws against sex discrimination.

Many agencies working with youth, particularly around the issues of alcohol and other

drugs, are concerned about alcohol and other drug abuse among staff. This is clearly a proper concern, and staff should be screened and monitored to ensure they are not abusing alcohol or other drugs. However, this does not necessarily mean that a program can have a policy of refusing to hire anyone who ever had an alcohol or other drug problem.

Programs should also be aware that while most States permit employers to ask prospective employees questions about convictions, asking applicants about arrests may run afoul of State law. Asking about arrests has also been found to violate the laws against race discrimination, because minorities are disproportionately subjected to arrest. Programs should consult an attorney knowledgeable about their State's law in this area.

The Federal Rehabilitation Act of 1973, as amended in 1978, and many State laws prohibit discrimination against people with alcohol and other drug abuse histories. They also protect current substance abusers who can perform the duties of the job and whose employment would not constitute a direct threat to the property or safety of others. (29 U.S.C. §§ 706(7)(B), 794) These laws also protect those who are erroneously perceived as abusers. While current abuse would clearly disqualify anyone from working with youth, a history of abuse would not. Programs are probably justified in setting up requirements of some minimum time in recovery, which might vary depending upon the job in question.

Establishing a Disciplinary Process

Programs should develop a written code of conduct for employees that includes—at a minimum—a strict prohibition on alcohol or other drug use on the job; the agency's policy with regard to physical contact between staff and clients; and a graduated set of sanctions for violations.

Discipline should be applied in a consistent manner and should be documented. For example, if it is essential for agency operations for staff to report to work on time, it is important to be consistent in disciplining employees who are late. Any other practice may lead to charges of favoritism and discrimination. If a staff member seems incapable of getting to work on time and the agency decides it must fire him, it is important to have a record of the steps it took to warn the individual and to apply gradually increasing penalties. Again, if an agency cannot document its reason for terminating someone, it is vulnerable to being sued for discrimination.

What To Do if the Worst Happens

No matter how careful an agency is, the worst might happen: an employee or a volunteer might hurt or abuse a child. What should—or can—the agency do then?

A number of steps should be considered:

1. Obtain help for the injured youth and speak to his or her parents.
2. If the incident is serious, separate the employee/volunteer from clients (at least temporarily).
3. Investigate the facts and circumstances.
4. Consult an attorney immediately.
5. Document the investigation.
6. Provide the employee/volunteer with an opportunity to respond to the accusation.
7. Report the incident to the State child abuse authorities, if required.
8. Do not publicize the incident. It does not help the agency's reputation if attention is drawn to a problem with staff, and if the allegation against the employee is publicized but turns out to be untrue, the employee could sue the agency for libel.

Quality of Care

Agencies working with youth are often concerned about the standard(s) to which they may be held. If, despite everyone's best efforts, a youth returns to drug use, will the agency be sued for malpractice?

Agencies must be concerned with two different kinds of standards. First, programs funded or regulated by State agencies may be required to adhere to certain standards of care. For example, regulations may require a particular client/staff ratio or that certain kinds of equipment be available in emergencies.

Agencies should consult an attorney familiar with State regulations regarding quality of care to ensure that they meet these requirements. Agencies should meet State regulatory requirements not only to avoid lawsuits, but also because failure to meet such requirements might result in a loss of funding.

The second kind of standard is more difficult to describe. In this litigious society, people do sue when they expect certain results and are disappointed. An agency could be sued, for example, by a parent who is angry that while attending the program his daughter did not stop using drugs and, in addition, moved in with her boyfriend.

Although this is small consolation to an agency that is facing a lawsuit, malpractice *is* hard to prove, particularly when it is based on failure to produce the desired results. If an agency bases its services on an accepted treatment model, and if its "failure" rate is not appreciably greater than that of other agencies in its area, it is unlikely that a parent disgruntled because his child did not stop using drugs could win a malpractice case.

Checklist

Throughout this technical report, a number of issues have been raised that require consultation with an attorney familiar with State law and regulations. Agencies can use the following checklist when consulting with a knowledgeable attorney:

1. Is the program subject to the Federal regulations?
   a. If so, are the program's consent forms in order?
   b. Is parental consent required for treatment of minors? (If it is, it will also be required for making disclosures to others.)
   c. Is the program subject to FERPA? (If it is, the parent as well as the youth must consent to disclosure to others and the program might well be subject to a conflict in obligations if a parent requests records and a youth withholds consent.)
   d. If the program needs to communicate with a school district, how can this best be structured:
      (i) using consent forms for each disclosure;
      (ii) using the exception for internal program communications (if appropriate); or
      (iii) establishing a QSOA with the district.
2. What are the program's obligations with regard to reporting child abuse?
   a. When do reports have to be made and what form must they take?
   b. Who must make the reports?
   c. If the program is subject to the Federal confidentiality regulations, is its reporting procedure in compliance?
3. Are the program's mechanisms for screening employees and volunteers adequate and in compliance with Federal and State fair employment laws? Is the program's disciplinary process adequate?
4. Is the agency complying with State and (where applicable) Federal regulatory requirements with regard to quality of care?

Appendix

Summary of State Parental Consent Laws for the Treatment of Minors

Age at which a minor* does not need parental consent	Number of States	States
Treatment for alcoholism or alcohol abuse		
Any minor	27	Alabama, Arizona, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, Virginia, West Virginia
12	5	California, Delaware, Illinois, Vermont, Wisconsin
14	3	North Dakota, Oregon, Washington
15	1	Mississippi
16	1	South Carolina
18	2	Kansas, Massachusetts
(12 States have no statutes that specifically address the treatment of minors for alcoholism or alcohol abuse.)		
Treatment for drug addiction or drug abuse		
Any minor	30	Alabama, Colorado, Connecticut, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Virginia
12	7	Arizona, California, Illinois, Massachusetts, New Hampshire, Vermont, Wisconsin
14	3	North Dakota, Oregon, Washington
15	1	Mississippi
16	2	Idaho, South Carolina
(8 States have no statutes that specifically address the treatment of minors for drug addiction or abuse.)		
Outpatient mental health services		
Any minor	4	Montana, New Mexico, North Carolina, Virginia
12	2	California, Florida
14	4	Alabama, Illinois, Michigan, Oregon
15	1	Colorado
16	3	Maryland, Massachusetts, Tennessee
18	3	Missouri, Oklahoma, Texas
19	1	Nebraska
(32 States have no statutes that specifically address outpatient mental health treatment of minors.)		
Medical treatment		
"Mature minor"	5	Arkansas, Idaho, Louisiana, Mississippi, Nevada
15	1	Oregon
16	2	Kansas, South Carolina
18	10	Alaska, Arizona, Delaware, District of Columbia, Indiana, Kentucky, Missouri, Oklahoma, Pennsylvania, Texas
19	2	Nebraska, Wyoming
(17 States have no statutes that specifically address medical treatment for minors.)		

NOTE: Compiled in December 1988. Laws may vary after this date. *Age may vary by State; see State-by-State survey.

State Laws: Need for Parental Consent for Treatment of Minors

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Alabama	A minor may consent to health services for drug dependency or alcohol toxicity. §22-8-6	A minor 14 or older may consent to any legally authorized medical or mental health service. §22-8-4
Alaska	No specific regulations exist.	Minors under 18 need parental consent for medical and dental treatment unless an emergency exists or parents refuse to give consent to a necessary medical or dental service. §09.65.100(2)
Arizona	*Alcohol*: Any minor may apply for treatment of alcoholism. *Other Drug*: Any minor 12 or older, under the influence of a drug or narcotic, may be treated without parental consent. §44-131.01	Minors under 18 need parental consent for hospital, medical, and surgical care. §44-132
Arkansas	No specific statutes exist. "Mature minor" provision may permit certain types of treatment. §82-363	A minor of "sufficient intelligence to understand and appreciate the consequences" may consent to any medical treatment or "procedures not prohibited by law which may be suggested, recommended, prescribed or directed by a duly licensed physician." §82-363
California	A minor 12 or older may give consent to "the furnishing of medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." Parents may be informed at the discretion of the treating professional. Minors cannot receive methadone treatment without parental consent. §34.10	A minor 12 or older may consent to mental health treatment or counseling on an outpatient basis if a professional person determines the minor is mature and (1) would present a serious danger of physical or mental harm to himself or others, or (2) is a victim of incest or child abuse. §25.9
Colorado	*Alcohol*: A person intoxicated or incapacitated by alcohol, including a minor, may consent to emergency treatment. §25-1-309 An alcoholic, including a minor, may voluntarily apply for treatment at an approved facility. §25-1-308 *Other drug*: A minor may give consent for treatment for drug use. No notification requirement. §13-22-102	A minor 15 or older may consent to mental health treatment. The professional person providing services may, without the minor's consent, inform the parents of the services being provided. §27-10-103

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Connecticut	*Alcohol*: A minor may apply for treatment for alcoholism at a public treatment facility. §17-155t *Other drug*: A minor may request and consent to treatment for drug use. Such request and/or treatment shall not be disclosed to parents or guardians, law enforcement agencies, and is not admissible in administrative, grand jury, and court proceedings. §19a-382	No specific statute found.
Delaware	A minor 12 or older who professes to be an alcoholic may give written consent for treatment at an approved public facility. Voluntariness of consent is subject to challenge. §2210	A minor must be 18 to consent to medical treatment. No mental health specific statute found. §707
District of Columbia	No specific consent statute found. The mayor, however, is authorized to establish and maintain programs for the treatment and rehabilitation of juveniles. §24-532	No specific statute found.
Florida	*Alcohol*: Any minor may consent to treatment for alcoholism by private or public treatment resource. §396.082 *Other drug*: Any minor may consent to treatment for drug use. §397.099 (Law is subject to repeal and review in 1993)	Medical treatment generally requires parental consent. A minor 12 or older may apply to a residential or day treatment mental health program provided a hearing is held to determine voluntariness. §394.56
Georgia	*Alcohol*: A minor may consent to treatment for alcoholism. §37-8-31 *Other drug*: A minor may obtain treatment for drug use. Treatment should involve procedures and therapy related to "conditions or illnesses arising out of the drug abuse." The treating professional may inform the parents without the consent of the minor. §37-7-8	No specific statute found.
Hawaii	A minor may consent to counseling services for alcohol or other drug use. The treating professional may inform the parents without the consent of the minor. 31 §577-26	A minor must obtain parental consent for medical or surgical treatment.

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Idaho	*Alcohol*: A minor may apply/consent to treatment for alcoholism at a public treatment facility. §39-307 *Other Drug*: A minor 16 or older may consent to treatment for drug use. Professionals may inform parents of treatment of minors under 16. §37-3102	Idaho has a provision that permits any person of "ordinary intelligence and sufficient awareness" to give consent to hospital, medical, dental, or surgical treatment. It is unclear whether this covers outpatient mental health services. §39-4302
Illinois	A minor 12 or older may receive treatment for alcohol or other drug abuse. *Alcohol*: Professionals shall notify parents after the second treatment session unless this would jeopardize the treatment. *Other drug*: Professionals treating minors for drug use may, but are not required to, notify parents. In either case, parents must be notified after 3 months. 11 §§4504, 4505	A minor 14 or older may consent to outpatient counseling or psychotherapy for up to five 45-minute sessions before parental consent is required. 91/2 §3-501
Indiana	A minor may consent to treatment for alcoholism, or alcohol or other drug use. Treating professionals may inform parents at their own discretion. §§16-13-6.1-19, 20, 23	A minor 18 or older may consent to medical treatment. No statute addresses mental health treatment. §16-8-3-1
Iowa	A minor alcohol or other drug user may consent to treatment. Parents may *not* be informed by treating professionals without the minor's consent, nor may information be disclosed to law enforcement officers or admissible in any administrative, grand jury, or court proceeding. §125.33	No specific statute found.
Kansas	*Alcohol*: A minor must obtain parental consent for treatment of alcoholism. 65 §4025 *Other drug*: A minor may consent to treatment for drug use. 65 §2892a	A minor 16 or older may consent to medical or surgical treatment when a parent or guardian is not immediately available. 38 §123b
Kentucky	A minor may consent to treatment for alcohol or drug abuse or addiction at a public treatment facility. The treating professional has discretion to inform parents. §§222.440, 214.185	A minor 18 or older may consent to medical treatment. No specific statute found regarding mental health services. §214.185

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Louisiana	*Alcohol*: No specific statute found. *Other drug*: Minors may consent to treatment if they "believe themselves to be addicted to a narcotic or other drug." Professionals may, but are not required to, inform parents even over the express objection of the minor. 40 §1096	Minors "who believe themselves to be afflicted with an illness or disease" may consent to receive medical treatment. Professionals may, but are not required to, inform parents even over the express objection of the minor. The statute does not explicitly mention mental health treatment. 40 §1095
Maine	A minor may receive medical, psychological, and other counseling and treatment for substance abuse without parental consent. 32 §§2595 (osteopaths), 3292 (medicine), 3817 (psychologists), 6221 (substance abuse counselors), 7004 (social workers). If minor remains in hospital or drug or alcohol facility for more than 16 hours, parents must be notified and their consent must be obtained. 22 §1823	No specific statute regarding medical or mental health treatment of minors was found.
Maryland	A minor may consent to treatment for or advice about drug abuse or alcoholism. A treating professional may, but is not required to, inform parents, even over the express objection of the minor. §20-102	A minor 16 or older may consent to treatment of an emotional or mental disorder. A treating professional may, but is not required to, inform parents, even over the express objection of the minor. §20-104
Massachusetts	*Alcohol*: A minor must have parental consent to obtain treatment for alcoholism. 111B §10 *Other drug*: A minor 12 or older may consent to hospital and medical care relating to treatment and diagnosis of drug abuse if two or more physicians find the minor to be drug dependent. Minor cannot receive methadone maintenance therapy without parental consent. 112 §12E	A minor 16 or older may consent to outpatient mental health treatment. 123 §10(b)
Michigan	A minor may consent to treatment for substance abuse. A treating professional may, but is not required to, inform parents even over the express objection of the minor. §333.6121	A minor 14 or older may consent to outpatient mental health treatment. The treating professional may not inform parents unless there is a compelling need to do so and the minor is notified that the professional intends to inform the parents. §330.1707

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Minnesota	A minor may consent to medical, mental, and other health services to determine the presence of or to treat conditions associated with alcohol and other drug use. The treating professional has discretion to inform the parents where failure to do so would seriously jeopardize the health of the minor. §144.343	No specific statute found.
Mississippi	A minor 15 or older may receive treatment for mental or emotional problems caused by or related to alcohol or other drugs. The treating professional may, but is not required to, inform parents even over the express objection of the minor. §41-41-14	A minor of "sufficient intelligence to understand and appreciate the consequences" may consent to medical or surgical procedures. § 41-41-3(h)
Missouri	A minor may consent to treatment for alcohol or other drug use. A treating professional may, without the minor's consent, inform parents of the treatment only in cases where the minor is actually found to be suffering from drug or substance abuse. §§631.105, 431.062	A minor under 18 must obtain parental consent for medical, surgical, (§431.061) or mental health care. §632.110
Montana	A minor afflicted with drug and substance abuse, including alcohol, may consent to services for prevention, diagnosis, and treatment. Treating medical professional must either counsel the minor or refer the minor to counseling services. Parents may be notified at the discretion of treating professional. §§41-1-402, 403	A minor may consent to outpatient mental health care when the need for such counseling is urgent in the opinion of the physician or psychologist involved. §41-1-406
Nebraska	A minor may receive alcohol or other drug use treatment or counseling. Family involvement is encouraged, but not required. §71-5041	A minor 19 or younger must obtain parental consent for medical or mental health care.
Nevada	*Alcohol*: No alcohol specific statute found. *Other drug*: A minor under the influence of a controlled substance or dangerous or hallucinogenic drug may consent to treatment. Treating professional should make "every reasonable effort" to inform parents within a reasonable time after treatment. §129.050	A minor "who understands the nature and purpose" of proposed treatment may consent. Treating professional must make "prudent and reasonable" efforts to obtain minor's consent to communicate with parent. §129.030

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
New Hampshire	*Alcohol*: No specific statute found. *Other drug*: A minor 12 or older may consent to treatment for drug dependency or "any problem related to the use of drugs." Reports of treatment are not discoverable in a criminal prosecution. A minor of "sound mind" may consent to medical treatment as long as the minor is "of sufficient maturity to understand the nature of such treatment and the consequences thereof." §318.B:12a	No specific statute found.
New Jersey	*Alcohol*: No alcohol-specific statute found. *Other drug*: A minor may consent to treatment for drug use or abuse. Treatment is confidential between the physician and patient. §9:17A-4	No specific statutes found.
New Mexico	*Alcohol*: No alcohol-specific statute found. *Other drug*: A minor may consent to treatment for drug abuse. Records are confidential and are not discoverable in criminal prosecutions. §26-2-14	Any minor may consent to individual psychotherapy, group psychotherapy, guidance, counseling, or other forms of verbal therapy which do not include any aversive stimuli or substantial deprivations. §43-1-17
New York	*Alcohol*: A physician may authorize any minor to receive services without parental consent; otherwise, parental consent is required unless parental involvement would have a detrimental effect. Mental Hyg. Law §21.11 *Other drug*: No specific drug statute found.	No minor may consent to medical or health care services.
North Carolina	A minor may consent to "medical health services for the prevention, diagnosis, and treatment of...abuse of controlled substances or alcohol. §90-21.5(a)(iii)	A minor may consent to services for the prevention, diagnosis, and treatment of "emotional disturbances." §90.21.5(a)(iv)
North Dakota	A minor 14 or older may consent to an examination, care, or treatment for alcoholism or drug abuse without parental approval. §14.10.17	No specific statute found.
Ohio	A minor may consent to treatment or diagnosis for any condition believed to be caused by a "drug of abuse, beer, or intoxicating liquor." §3719.012	No specific statute found.

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Oklahoma	..minor may consent to care in the prevention, diagnosis, and treatment of drug, substance, or alcohol use. Counseling must be provided to such minors. Treating professionals may, but are not required to, inform parents. If a minor is found not to be afflicted, parents shall not be notified. 63 §2602	Parental consent for mental health and medical services is required for a dependent minor.
Oregon	A minor 14 or older may consent to outpatient diagnosis and treatment for a chemical dependency without parental knowledge. Treating professionals may, without the minor's consent, inform the parents when it would be in the best interests of the minor. §109.675	A minor 15 or older may consent to medical, surgical, or dental care. §109.640 A minor 14 or older may consent to outpatient diagnosis or treatment for a mental or emotional disorder without parental knowledge. Treating professionals may, without the minor's consent, inform parents when it would be in the best interests of the minor. Treating professionals should involve the parents by the end of the treatment unless there are clinical indications to the contrary or the minor has been sexually abused by the parent. §109.675
Pennsylvania	*Alcohol*: No specific statute. *Other drug*: A minor who "suffers from the use of a controlled or harmful substance may give consent" to medical care or counseling related to diagnosis or treatment. Treating professionals may, but are not required to, inform parents. 71 §1690.112	A minor under 18 who has graduated from high school may consent to medical, dental, and other health services. 35 §10101
Rhode Island	*Alcohol*: A minor may apply for treatment of alcoholism at an approved public facility. §40.1-4-9 *Other drug*: Parental consent is required for treatment of chemical dependency unless the minor refuses to contact parents or such contract would be deleterious to minor. Minor can voluntarily consent to noninvasive, noncustodial treatment services. Minor who is voluntarily seeking custodial, invasive treatment for chemical dependency must obtain parental consent. If parents refuse, the determination will be made by a judge after a hearing. §§14-5-3, 4, 13, 14	No specific statute found.

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
South Carolina	A minor 16 or older who is or "believes himself to be chemically dependent" (includes drugs and alcohol) may consent to treatment. §44-52-20	A minor 16 or older may consent to "any health services" except operations. §20-7-280 Any minor can receive health services (excluding operations) without parental consent if they are deemed necessary in the judgment of the treating professional. §20-7-290
South Dakota	A minor may apply/consent for treatment for drug or alcohol abuse at an accredited facility. §34-20A-50	No specific statute found.
Tennessee	*Alcohol*: Department of Mental Health directed to establish comprehensive treatment program for substance abusing youth, including residential care and treatment, day treatment, and outpatient and intervention services. Statute does not address consent. §§33-8-401, 402 *Other drug*: A minor may consent to treatment for drug use. A treating professional has the discretion to inform parents. §63-6-220	A minor 16 or older may consent to outpatient mental health diagnosis, evaluation, and treatment services. §33-6-102
Texas	A minor may consent to "examination and treatment for chemical addiction, chemical dependency, or any other condition directly related to chemical use." §§ 4447i, 35.03(6)	A dependent minor requires parental consent for medical and mental health care not related to sexual and physical abuse or suicide prevention. §35.03
Utah	No specific statutes found related to treatment of minors for alcohol or other drug use.	No specific statutes found.
Vermont	A minor 12 or older, who has been diagnosed as dependent by a physician, may consent to medical and nonmedical treatment for alcoholism or drug dependency. Parents shall be notified only if the condition of the minor requires immediate hospitalization. §4226	No specific statute found.
Virginia	A minor is "deemed an adult for the purpose of consenting to...treatment or rehabilitation for substance abuse." §54.325.2(D)(3)	A minor is "deemed an adult for the purpose of consenting to...medical or health services needed in the case of outpatient care, treatment, or rehabilitation for mental illness or emotional disturbance." §54-325.2(D)(4)

State	Consent provisions for alcohol or other drug-related problems	Consent provisions for general mental or medical health
Washington	A minor 14 or older may consent to counseling, care, treatment, or rehabilitation for conditions and problems related to or caused by drug or alcohol use. §69.54.060	No specific statute found.
West Virginia	A minor may consent to be examined, counseled, diagnosed, and treated for addiction to or dependency on alcoholic liquor, nonintoxicating beer, or a controlled substance. §§60-6-23, 60A-5-504(e)	No specific statute found.
Wisconsin	A minor 12 or older may consent to preventive, diagnostic, assessment, evaluation, or treatment services for the abuse of alcohol or other drugs on an outpatient basis. Treating professionals shall notify parents "as soon as practicable." Parental consent is needed for inpatient treatment, except for detoxification that is less than 72 hours. §51-47	No specific statute found.
Wyoming	No specific statutes found.	A dependent minor 19 or younger must obtain parental consent for medical treatment.

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