Adolescent Behavioral Health Care Act

HB 1874 & 2883

What am I presenting?

- Why me?
- Define behavioral health
- Define child
- Explore cultural values and expectations
- Proposal for improved process

Why me?

- Intersectional parent
- LGBTQIA family
- Mixed race family
- Adoptive family
- Private insurance but used WRAP & CCORS (aka WISe)
- Law enforcement family (trauma)
- Parent of 2 special needs children with behavioral health disturbances
- “Elderly” i.e. post menopausal, nearing Medicaid eligibility
- Female (primary caregiver rant)
- Technically disabled
- Highly capable, gifted, upper middle class, privileged American citizen
- Sent my children out of state after CPS threats and now they are thriving
- Over 1000 hours of advocacy time spent discussing this topic in meetings and conversation between 2016-2023

This presentation is brought to you by:

- Countless unpaid volunteer hours
- Social isolation, burn-out, and serious suicidality
- Perception by others as a “difficult person” and racially hostile
- Fresh trauma every time I send an email to HCA begging them to advocate for the spirit of the law
- Fresh trauma from supporting families who face homelessness, overdose, student dropouts, jail and serious health consequences because the spirit of the law does not have an advocate.

Define Children: The Ages of Consent

- 0-12 (minor children)
  - born 2011-2023 & turn 13 between 2024-2036
- 13-17 (minor adolescents/youth)
  - Born between 2006-2010, began turning 13 in 2017
- 18-25 (youth/young adults)
  - born 1998-2005 & turned 13 2011-2018
- 25+ (adult)

Prevalent Bias and Stigma Assumptions

- Bad kids have bad parents
- Parents aren't willing to do the work
- Lack of participation is the child's problem
- Wait and see or "alive 'til 25" are reasonable strategies
- JR or foster care are acceptable system of care alternative pathways
- Inpatient and residential programs are overused in our state
- Mother's tend to exaggerate problems
- A child has to want to engage in treatment for it to work
- Primary care-givers are not viewed as a key partner in the system of care
- There are no developmental differences that impact a 13 year old's ability to provide informed consent

Types of BH Interventions for Minor Children

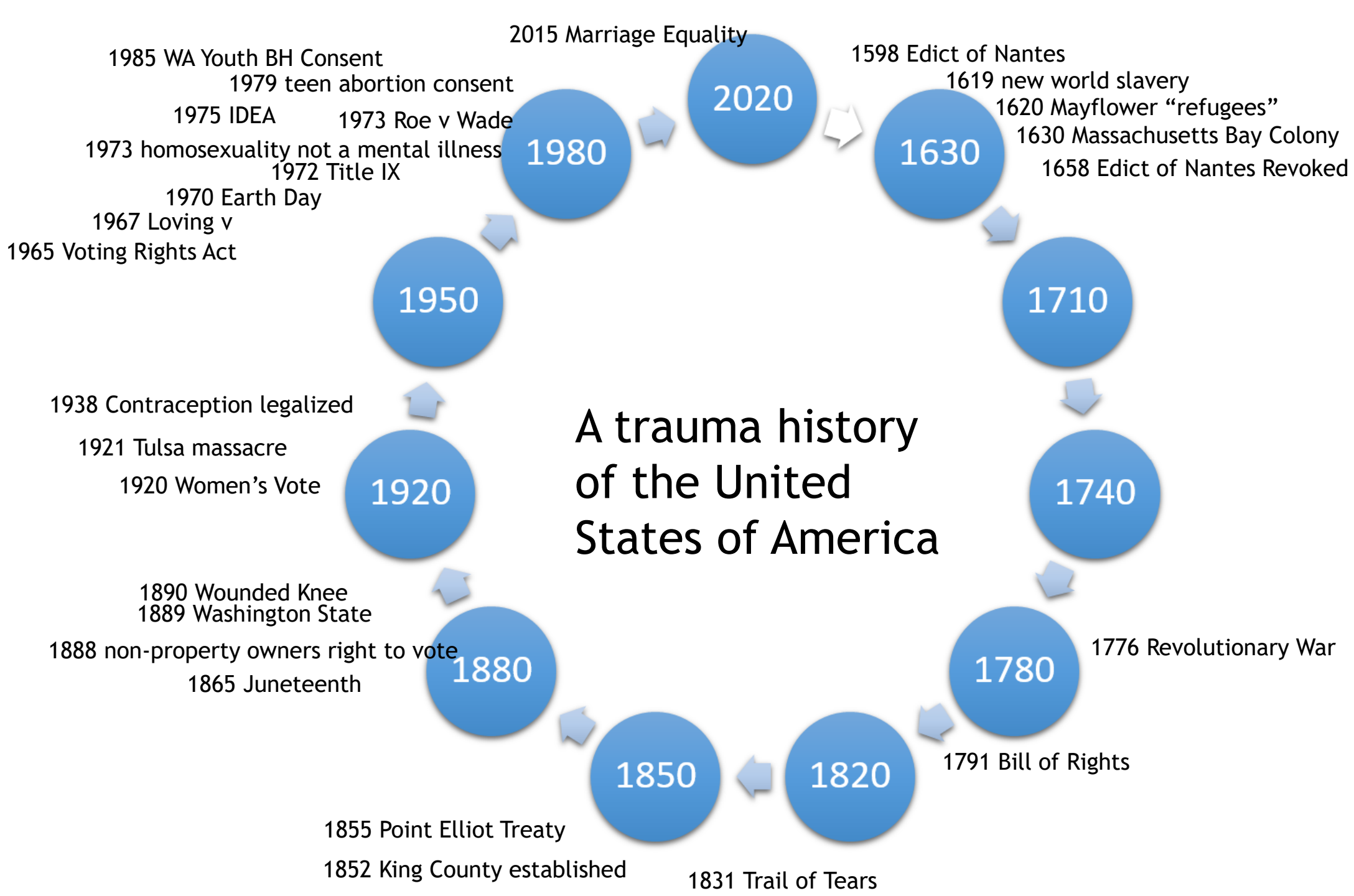
- Parent education, support and skills training
- Occupational and physical therapy
- Speech therapy
- Friend groups
- Community engagement with family
- Classroom accommodations (ex smaller class size, exercise ball for chair, extra teacher attention, individualized education plans)
- Equine therapy
- EMDR
- Executive functioning skills training
- Large motor sensory processing opportunities included in all child therapy environments
- Art & play therapy
- Restorative justice circles
- Home based problem solving

Sources for describing children's BH

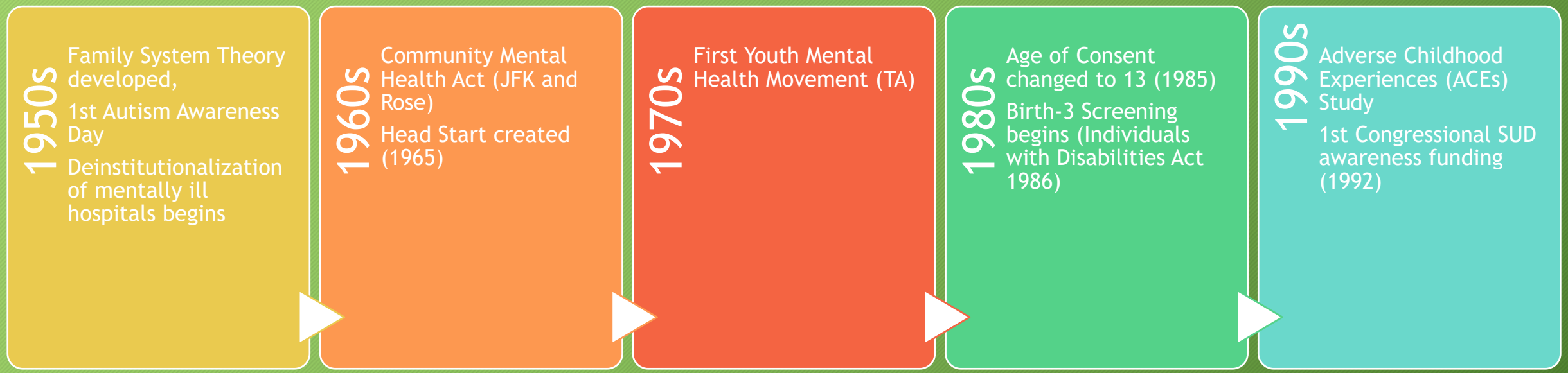
- Family:
  - the issue at hand the family needs help solving
- Religious:
  - sin, punishment now and in afterlife, choices, belief systems not science concerning abortion, gender, etc.
- Social/Cultural:
  - Truancy, RCW, court interpretations, social determinants of health, education interventions, public health
- Medical:
  - diagnosis, treatment of physical symptoms, pharmacology, surgery, Band-Aid-type fixes

Note: serious mental illnesses typically don't develop in minor children, however, *how we respond* to their developmental challenges may create a mental illness (depression/anxiety/SUD).

A trauma history of the United States of America



Key Children's Behavioral Health Milestones



Our children & policy development

Policies for Today's 0-24 year olds

Impact young adults

- 2004 1st ADHD awareness
- 2005 Supreme Court recognizes brain development for sentencing
- 2007 Child Find
- 2007 TR lawsuit filed
- 2008 Great Recession cuts school nurses, counselors to bare bones
- 2010 Sensory Processing Disorder begun to be understood
- 2010s executive functions start to be understood

Impact adolescents

- 2012 McCleary identifies chronically underfunded schools
- 2014 TR settlement creates FYSPRTs
- 2016 Trauma informed system of care training begins
- 2016 Parent Initiated Treatment reform begun

Impact Children under 13

- 2018 TR lawsuit closed
- 2018 Revision of truancy laws for disabled students
- 2019 1st FASD clinic opens
- 2019/2020 FIT passes
- 2019 McCleary ends w/o funding special ed
- 2019 Trauma informed care
- 2020 Me Too & BLM
- 2020 Sensory processing
- 2021 SEL in schools & Special ed finally funded
- 2022 TR federal lawsuit
- 2022 SEL begun in schools
- 2023 Eliminate school restraint and isolation

Relevant FIT System of Care Issues

Importance of information sharing is not yet well understood by providers	Attachment disorder and school refusal treatments unavailable in Washington	FIT is positioned as an outside process, instead of equal to youth	Policies that cause trauma to families are not being actively identified by DCYF and HCA and eliminated
Lived experience voices have not been included as policy decision makers (input isn't enough)	FIT training design needs family input	WISe – the program for highest risk children – is voluntary and fails these children	Transparent process improvement plan. Where is the last FIT survey?
Biased presentation of information sharing	All CLIP programs are inpatient, not residential	Mandatory reporting inhibits BH in families	System of care client rights do not include family

Qualities of most at risk children who receive the least support

- Adoption or foster care
- In-utero trauma including substance use
- Developmental disability or delay including neuro-atypical “developmental” diagnoses like ADHD and ASD that impact behavioral health
- Black, brown, indigenous, non-English speaking children
- Impoverished children

Unaccomplished Intent of RCW 71.34

- Behavioral health care and treatment providers shall assure that minors' parents are given an opportunity to participate in the treatment decisions for their minor children.
- Providers shall, to the extent possible, offer services that involve minors' parents or family and assure the ability of parents to exercise reasonable, compassionate care and control of their minor children when there is a medical necessity for treatment and without the requirement of filing a petition [i.e. At Risk Youth] under this chapter, including the ability to request and receive medically necessary treatment for their adolescent children without the consent of the adolescent."

Evidence of HCA bias: information sharing

- Mental health providers are now allowed to communicate some youth (age 13-17) treatment information to parents, if the provider believes that sharing this information would benefit the treatment process.

HB 1874 on information sharing

NOTE: Information sharing of the mental health record has been avialble to parents since 2014 via **RCW** 70.02.240

2019 clarified:

- When an adolescent receives a mental health evaluation or treatment at the direction of a parent under RCW 71.34.600 through 71.34.670, the mental health professional is encouraged to exercise his or her discretion under RCW 70.02.240 to proactively release to the parent such information and records related to solely mental health services received by the adolescent, excluding psychotherapy notes, that are necessary to assist the parent in understanding the nature of the evaluation or treatment and in supporting their child.

Family Care Act

- Children like Shayla are dying for lack of consent, 1874 & 2883 aren’t enough

- Adds the right to a client to have involvement with their family during treatment (not existing)
- Directs DCYF & HCA to evaluate polices for trauma

- Failed in 2021
- Reintroduced in 2023 as SB 5438 & died in the house

Get Involved/Action Steps

- Identify the quality improvement plan for WISe & FIT?
- Participate in P-25 Behavioral Health Strategic Planning
- Work to design education and support programs for primary caregivers of children 0-14
- Support Family Care Act and Parent Portal/BH 360
- Evaluate Mature Minor Statute and include public facing standards for higher levels of care
- Public process for FIT rollout evaluation: FIT Survey closes May 4, FIT Stakeholder group (for whom?) in June, What will happen to this information that HCA gathers?
- Create child and adolescent standards for DCRs and involve community input in creating those standards and training
- CLIP beds should be residential under FIT
- Fund motivational interviewing for all providers, develop effective school refusal and treatment refusal intervention plans (out of sight should not be out of mind)
- Fix information sharing
- Create materials to help parents navigate consent