Parent Initiated Treatment/Advisory Stakeholder Workgroup

August 24, 2018 Meeting
10:00 AM - 12:00 PM

PIT WORKGROUP HB2779

(1) The Department of Social and Health Services must convene an advisory group of stakeholders to review the parent-initiated treatment process authorized by chapter 71.34 RCW.25. The advisory group must develop recommendations regarding:

(a) The age of consent for the behavioral health treatment of a minor
(b) Options for parental involvement in youth treatment decisions
(c) Information communicated to families and providers about the parent-initiated treatment process
(d) The definition of medical necessity for emergency mental health services and options for parental involvement in those determinations.

(2) The advisory group established in this section must review the effectiveness of serving commercially sexually exploited children using parent initiated treatment, involuntary treatment, or other treatment services delivered pursuant to chapter 71.344 RCW.

(3) By December 1, 2018, the department of social and health services must report the findings and recommendations of the advisory group to the children's mental health work group established in section 2 of this act.

(1) Welcome/Introductions	**Facilitator: Blake Ellison**
• Introduction of participants	**Attendees:** Karen Kelly, Lisa Daniels, Kathy Brewer, Brad Forbes, Melanie Smith, Jim Theofelis, Peggy Donlane, Natalia Koss Vallejo, Lorrin Gehring, Timothy Miller, Laurie Lippold, Melanie Smith, Lisa Daniels **On the Phone:** Robert Hilt, Kalen Roy, Lee Collyar, Miriah Sachs, Cary Hamilton, Ellen Escarga, Shannon Simmons **HCA Staff:** Mandy Huber, Lois Williams, Paul Davis, Diana Cockrell **Staff on Phone:** LaRessa Fourre, Patty King
(2) Overview of Participation Ground Rules	**Facilitator: Blake Ellison**
• **Cover ground rules:** *Talk one at a time *Refrain from side conversations	Paul started with ground rules to facilitate using the mike for the benefit of the people on the phone, in order to ensure everyone has the opportunity to talk and the discussion is open to those on the phone. Please, no side conversations. If stuck on a topic, we will move forward and come back if there is time. The group agreed to ground rules.

*Ensure opportunity for people joining remotely to ask questions and give input *If we get stuck on a particular topic, we will move ahead and come back to it later today or next meeting *Focus on what we are doing now-versus how the system used to work *Goal is to find common ground-listen to understand and clarify *Approach concerns with solution focused lens * Others?	
Parent Webinar Update	**Patty King**
• Patty gave her update early due to her schedule	Patty updated on parent webinar and discussed overview of questions that were presented in April by Rep. Senn at initial PIT workgroup. She shared the comments from 20 parents at the meeting. Parents benefit from the input of others. Majority of parents feel PIT is not effective. Increased support for parents is needed. The parent meeting notes will be posted to the website. It was asked if there was opportunity for youth to have a voice in this. Diana will contact Lauren for this.
Review of Handouts	**Kathy Brewer**
• **Review handouts:** *grid of minor and parent engagement and connection with key aspects of consent, release of information, etc. *ideas under consideration	Kathy facilitated review of handouts, beginning with minor and parent access and consent for acute inpatient treatment. A chart was shared that showed various combinations of minor and parent engagement levels. Kathy summarized each of the three categories and indicated where there is the least and most consensus. She reminded the group that there is no single definition of youth or parent. Kathy reminded the group that there needs to be common ground to provide recommendations to the legislature. Kathy reviewed ***Ideas Under Consideration handout***.

1. **Age of consent in Washington for mental health and substance use treatment remains 13, at which age a youth ages 13-17 may request mental health or substance use treatment without their parent's consent (i.e., Minor Initiated Treatment):**
   The group agreed that there is high potential for consensus in not recommending to change the age of consent.
2. **Parents also have the authority to request mental health and substance use treatment for a youth ages 13-17 (under current Parent Initiated Treatment law):**
   a. **Proposal to expand the scope of the PIT law to include medically necessary outpatient treatment (beyond current scope of current law that limits outpatient PIT to evaluation only).**

   The group agreed on the necessity to add outpatient and acute outpatient to the proposal. They also wanted to add limited treatment so clinician can assess if the fit is right for clinician and youth. Parent offered concern about current PIT law and inability to access records. There was a feeling that the law, as it stands, is not being well utilized. Parent stakeholder provided example of their youth being admitted to hospital, was told by hospital that parent could not initiate PIT. When the parent pushed the issue, the youth was discharged early. Another parent said they were unable to get their child into Mary Bridge because her child wouldn't consent. Parents cannot call for Designated Crisis Responder (DCR) formerly Designated Mental Health Professional (DMHP), to get a child into treatment. It was mentioned that there will be a meeting this afternoon about medical necessity. It was said that there is a problem with law because parents are not aware of what children are being told and five states have better parents' rights and they are not having problems. It was said that there are different perspectives and stories. Sometimes it is heart breaking for the youth as well as the parent Once youth turns 13, they are easier to get into treatment, because they don't need to wait for parent approval. Need parents to have better access to treatment for youth, but youth also need to be able to access treatment on their own. Kathy suggested that yes, there are barriers, but it's not a problem with the law, it's more of an education issue with hospital social workers. Not always the fault of the law, but other factors, such as medical necessity requirements are determining factors. . It was commented that youth who do not think there will be confidentiality are hard to get into services. National research shows that more than 50 percent of youth won't access treatment if they don't think it will be kept confidential. A stakeholder commented on the Educational Service District (ESD) 113 presentation about how youth can access behavioral health (BH) treatment as soon as they turn 13. It was suggested that all can agree that parents should have more access to information. A clinician said that he makes the assumption of good intent that parents care about their children, but there are youth who need to access treatment without their parent knowing.

This poses a risk to the provider. In these cases, the youth feels that if their parent finds out that they are talking, something bad is going to happen. Clinician needs to have a good relationship with youth and credibility before asking to invite the parent(s) in. This clinician recommended six sessions in six weeks for a youth that is resistant, to allow time for engagement. It was asked if there a way in the law to make it less about parent initiated and more about the minor not being able to decline treatment? It was said that this is exactly what we are trying to make a recommendation on. Right now, just an evaluation and not treatment is in the PIT law. The question was asked about 2a, could the option be limited to a number of sessions per episode? Or per person for a lifetime limit? Or per provider? It was said that currently options are very limited, often jail or foster care by Child Protective Services (CPS) comes into play, and there is a need for family centered law.

It was pointed out the issues of inpatient and outpatient are being mixed and the law is different and we need different expectations for inpatient and outpatient. Limited sessions in a period of time per episode was suggested. A provider shared her experience as a youth who accessed treatment when she was 13 because she knew her rights. A recommendation for outpatient treatment with limited time constraints was requested. It was stated we are looking at expanding parent involvement and trying to engage the youth to establish a treatment path. The group was reminded that PIT was created to include parent access as a solution and we are hearing that PIT is not working. A provider commented that PIT access is working from Children's Long Term Inpatient (CLIP) perspective and there are referrals from every hospital. PIT has increased significantly and they are getting about ten referrals a week. It was noted that the group seemed close to an agreement and a possible solution was offered to include option of talking with parents about referrals after an initial six sessions. It was noted that that was a part of #3. It was said that there needs to be options for clinicians because clinicians are not trained on everything. There is a need to be careful to not add on requirements for clinicians. It was suggested that the youth needs some autonomy in how they can be "the driver," so they can be motivated to engage. Sometimes, it would be the youth requesting a new clinician. It was said that we need to remember the families that are struggling with youth with intellectual disabilities. Primary care physicians can be a referral source and that some children have problems, like attachment problems, but they don't quality for disability treatments.

b. **Proposal to expand the scope of the PIT law to include medically necessary partial hospitalization, intensive outpatient program, residential (AKA long-term intensive treatment), and/or Voluntary CLIP treatment.**

	The discussion was started with the question does the group want to expand scope to include partial hospitalization, IOP, and residential treatment? They were reminded that this would only apply to a service provided in Washington state. It was asked if this would expand to CLIP and change the voluntary application process. It was indicated that all three areas have the medical necessity (MN) requirement. Parents can ask for services, but still need to meet MN requirement. With CLIP, youth has to consent to referral. It was asked if CLIP would be an initial access point, as it is the most restrictive option. It was indicated that we are not changing referral patterns, just that parents can initiate without the youth's consent and there is an assumption that Least Restrictive Alternatives (LRAs) would already be accessed. A stakeholder on the phone commented on the need for youth peers in the process. Youth engage with youth partners, so involving more youth peers in the intake process to provide education will increase youth engagement. It was commented that the law looks at entire system, not just for community mental health where a youth peer can be offered. Stakeholder on the phone asked if we could include adults who experienced the system as a youth. It was reminded that the current PIT survey can be accessed for those to have a voice. Clarification was requested about combining SUD and MH. It was said that we are integrating the two and sometimes Involuntary Treatment Act (ITA) is needed to get the youth involved in treatment. A question was asked about youth who have completed CLIP and access. It was noted that we are talking about access, but total refusal to go is another issue that will need to be addressed at another time. The group was reminded how complicated this is, that there is no magic in getting youth into treatment, IP or OP. The provider will determine if treatment is needed. There are no treatment guarantees, just hope to change the direction. A new peer group may provide guidance. If youth are put into treatment too often or too soon, it may cause later resistance. There were concerns about expanding the scope because the current law is not big enough. The concern is that the law is not complete enough. It was noted that there is generally agreement. Are there any feelings of needing additional oversight outside of what the oversight is right now? There is a possible need to look at each type of treatment individually and at OP, after hospitalization. It was indicated that most partial hospitalization and OP treatment options are short term, where residential, (inpatient) is much longer term. It was agreed that there is a need to provide more flexibility in the treatment options and a note was made for later discussion.

3. **Add language in minor initiated treatment, parent initiated treatment and involuntary treatment that the treatment team may share the following clinical information without the consent of the minor.**

   PROPOSED LANGUAGE (from prior workgroup meeting):

   1) **The professional team treating the minor may share the following information about the minor with the parent or guardian who authorized treatment, even if the minor does not consent to the release of this information:**
      a) **Diagnosis**
      b) **Treatment plan and progress in treatment**
      c) **Recommended medications, including risks/benefits, side effects, typical efficacy, dose and schedule**
      d) **Psychoeducation about the minor's mental health or substance use condition**
      e) **Referrals to community resources**
   2) **The above information may be released to the parent or guardian, subject to the professional team's determination that it is in the best interest of the patient.**

   There is a need to share information with parents, but clinicians don't feel they can share information without consent. There needs to be a way to address the gaps. At the minimum, developing a list of items that will be shared with the parent. The list should also be discussed with the youth, so the youth doesn't feel that their whole life will be revealed to the parent. A question was asked about if the minor doesn't sign the form, would the information be shared. There was great enthusiasm from a parent for these options. It was asked to take out first sentence explaining options to share information and it will be taken out. It was said that some language should be provided to release the provider from liability for disclosure. It was also asked to add that youth can only be treated by licensed clinician or one who works for community mental health agency where they are under supervision. A clinician on the phone asked to include associate providers who are Master level and being supervised by experienced, licensed professionals. There were concerns with 'may share' information creating ambiguity. The provider needs to be able to at least ask questions of the parents and there is a need to make it clear that the provider can release to and gather information from the parent. It was said that we don't want to say 'must' and 'allowed to' was suggested. There is a need to document in the record the reasons for not sharing information and the provider should use the best interest test. Also, federal laws need to be complied

	with. Clarification about medications was requested, would methadone treatment need to be disclosed? It was asked what will be done about training providers. Maybe the state can offer continuing education courses for clinicians. Education will be put in the parking lot for now, but agreed to ask for language suggestions and possibly take to Youth Practice Group for language. **4. Either a minor or a parent can authorize release of treatment records to a current treatment provider or to a potential treatment provider for the purpose of facilitating referrals for additional mental health or substance use treatment services.** Kathy shared information from a stakeholder who could not attend. Washington has banned conversion therapy but other states have not. Need to be careful not to cause more harm than good. It was asked if the language needed to be this explicit. The answer was yes, it needs to be explicit in law or it will be open to interpretation. It was asked if consent to release would be determined to be consent to treatment. A clinician commented for release to be consensual if possible.
Overview of PIT	**Facilitator: Blake Ellison**
• Work through each item under Ideas under consideration document • Modify language as needed to reach consensus • Parking lot items if group gets stuck	No time for additional overview and discussion of parking lot items.
Brief Updates on Project	**Facilitator: Diana Cockrell**
• Updates on survey and community forum dates	Diana gave update on who and how many have taken the survey so far. There are 604 responses to survey. There seems to have been good coverage across state and types. Will be sent out again for more responses. The question was asked about making an informational flyer to get more responses.

(6) Other Business	**Facilitator: Diana Cockrell**
Next Meeting	It was asked to make all four questions available with proposed language changes before the next meeting. It was noted that group can move forward and start at number six for the next meeting. There is hesitation about agreement without more youth voice. Diana thanked everyone for all their efforts.
End Meeting.	