Parent Initiated Treatment/Age of Consent Stakeholder Breakout Group

July 16, 2018 Meeting

3:00PM-5:00PM

<table>
<tr><th colspan="3">PIT WORKGROUP HB2779</th></tr>
<tr><td colspan="3">(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.</td></tr>
<tr><td colspan="2">(1) Welcome</td><td>Lead: Kathy Brewer, MS, LMHC, Seattle Children’s Hospital</td></tr>
<tr><td>• Introduction of participants</td><td colspan="2">Attendees:
Karen Kelly, Amanda Lewis, Evelyn Maddox, Mary Clogston, Paul Davis, Lisa Daniels, Kevin Black, George Petzinger, Kathy Brewer, Brad Forbes, Melanie Smith, Jim Theofelis – On the phone: Chelene Whiteaker, Robert Hilt, Kalen Roy, Peggy Dolane, Shannon Simmons, Laurie Lippold</td></tr>
<tr><td colspan="2">(2) Review Parameters of subgroup</td><td>Lead: Kathy Brewer</td></tr>
<tr><td>• Discuss recommendations to address the following issues</td><td colspan="2">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</td></tr>
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(3) Review survey questions		**Lead: Kathy Brewer**
• Discuss survey questions generated from the initial PIT/Age of Consent phone call discussion	Time was spent editing and incorporating additional questions for youth and parent(s)/guardian(s). Substance Use Providers will be added to the list of potential participants to send the survey to. There is an ongoing list that captures all groups.	
(4) Brainstorm Pro's and Con's about potential Age of Consent change		**Lead: Kathy Brewer**
• Discussion about potential impacts on youth, parent(s)/guardian(s), providers, and hospitals if change in Age of Consent	While in the Emergency Department (ED), parents are informed through talking with the social workers on how Parent Initiated Treatment (PIT) is applied. Designated Crisis Responders (DCR) often times will not detain. What is a decision point that a youth comes into a hospital via Involuntary Treatment Act (ITA)? A staff person would ask the referring department to do an ITA. In King County it has been hard to get an ITA, rather than using PIT. Options will change depending on what the outpatient options are. The concept of least restrictive alternatives (LRA) following discharge, if a parent could authorize treatment for up to 90 days; would this work? Parents have very little tools. At-Risk-Youth (ARY) and Child in Need of Services (CHINS) petitions are not always helpful. Having the option of PIT gets the youth into services, and doesn't pin a parent against the youth. Parents have raised these issues, sharing that there is not a robust enough process. What would an ideal system look like? Question asked: Why has the age of consent law failed to proceed with the changing of age? Is there anyone who disagrees with the age of consent and how it stands currently? Committee member stated that there has been a lot of community resistance, speculation, as well as other factors. Another committee member shared their perspective as to why there has been resistance to changing the law. Some want the ability to ensure youth can initiate their own treatment, maintain and improve relationships, and interactions with schools, districts, etc. "big bucket being mental health", so the door can be as wide as possible. Another reason having to do with reproductive health. Mental health and reproductive health are two separate laws in terms	

	of age of consent, both of significant importance. There is the ability to change one without impacting the other. A committee member stated it has been years since the age of consent has been discussed. Some of the group adding this is not the answer to the issues raised. There has been a lot of time spent discussing this topic, and there has not been a law change over the years. Improvements need to be made in getting youth into outpatient and inpatient treatment, advocating to keep it at 13, work on the loopholes, and improve areas identified as we continue with this workgroup. Under the Health Insurance Portability and Accountability Act (HIPAA), there is language in regards to the age of consent that defaults to state law, parental notice for example and how it is structured with information sharing. HIPAA is for healthcare, 42 CFR is for Substance Use Disorder (SUD). If we change information sharing for PIT, do we want to look at ITA? Under ITA, information is shared with parents, because the court has the right and jurisdiction. A Release of Information (ROI) does not have to be signed. There should be guidance written somewhere that speaks to this. DBHR/HCA staff volunteered to reach out to SUD clinicians and providers, to request more involvement in future meetings. SUD providers will also be added to survey list. Other states are pretty creative when they approach the age of consent. Some allow either the parent or minor to consent. Others with age of consent, have a parent initiated process until 18. If there were a change in the age of consent, how would this look if a parent were to take their youth into an Evaluation and Treatment center (E&T)? There would still be the same clinical guidelines and could create a huge risk for youth if it were to change to 18, in regards to confidentiality, because the parent would have access to their medical records. The impact on clinicians was also shared as it would pertain to outpatient treatment for PIT, and changing the age of consent would really have an impact. If it becomes too difficult to serve youth, clinicians may stop serving youth. As the law is currently written for outpatient, the only requirement is to complete an assessment. There would have to be some kind of liability language to compel the provider to treat. This could be a significant change that could potentially scare providers about serving youth. Another concern shared is disempowering parents when they believe their child needs treatment, not having the right avenues and processes. There would be significant cause of concern if the same language for inpatient is applied for outpatient, solely based on the unwillingness to consent. Requiring outpatient without the minor being in

	inpatient, when there isn't a clear line, can put a lot of the burden on the clinician; the clinician forced to be both the arbiter and the provider all at once. There needs to be some kind of process that's not putting the clinician in the middle of the youth not wanting treatment and the parent requesting the provider treat the youth. Looking at the current age of consent, what are all of the elements we would want to improve? If a minor had an inpatient stay, perhaps making it a requirement that they are admitted to outpatient treatment. When someone is committed, they have an option for an LRA. Are there any repercussions if they don't follow it? With PIT, there is no revocation process. Improve parental involvement and loop them into the treatment process under PIT. If minors are not in the mindset to make their own decisions, there's still clinical judgement that needs to be made. One parent suggested to keep age of consent at 13, clean up and improve what already exists. From this parent's personal experience, the youth did not sign releases of information (ROI) so was unaware of medical incidences and hospital visits that had occurred. If she was made aware the first time her youth went to the doctor or ED, she would have been able to help, know about medications and help with transportation. This parent has received bills and doesn't know what they are for, due to her youth not being willing to release any information. This parent feels there is something terribly wrong with situations like this. Parents who are engaged, need to be included. Providers have policies that outline parental involvement and what this looks like throughout their treatment. It is a separate issue if a youth doesn't want their parent/guardian involved. How do we respect those who want to access treatment, but also work to involve parents in the best interest of the youth? Improve reimbursement – family therapy – the youth would have to be a part of some of the conversation but there is also opportunity to have independent time with the parent. It has been difficult to extend treatment and provide reasoning, if at that moment they don't meet medical necessity, however are vulnerable or may quickly deteriorate. The hospital would have a lot of unpaid days if they feel they are vulnerable, and can't be discharged. This does happen with minors.

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<tr><td></td><td colspan="2">Idea of Children's Long Term Inpatient (CLIP) having parent information sheet.

Assisted Outpatient Treatment (AOT) passed in March for adults, with a LRA order for care coordination. Unsure of the effectiveness with adults. There is a court order, but it doesn't seem like it holds much weight. It could apply to youth, but there are prerequisites.

A need for agency based providers and teams with multiple members to help take the pressure off.
Idea of lowering the threshold of need.</td></tr>
<tr><td colspan="2">(5) Additional questions</td><td>Lead: Kathy Brewer</td></tr>
<tr><td>• Review of additional questions from group</td><td colspan="2">• Do providers know how to share information that is mentioned under PIT and what treatment options there are?
• Is there a way we could recommend effective ways to bring their youth in when they need treatment. Possible development of Frequently Asked Questions (FAQ)?
• Could we identify an avenue to the help a parent(s)/guardian(s) be a part of the process who has been caring for them, but is no longer involved?
• What about youth in foster care? The youth can initiate, but not the foster parent. The Department of Children, Youth, and Families (DCYF) social worker can consent when youth is a state dependent. Kinship care providers cannot consent.

Links to kinship care documents below:

https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/22-1119.pdf

https://www.washingtonlawhelp.org/files/C9D2EA3F-0350-D9AF-ACAE-BF37E9BC9FFA/attachments/1783934F-C75C-44F3-9FA3-A85708E95BC9/5940fr_kinship-caregiver-declaration.pdf</td></tr>
<tr><td colspan="2">(6) Recommendations and End Meeting</td><td>Kathy Brewer</td></tr>
<tr><td>Please see attached DRAFT recommendations document</td><td colspan="2">Please note: This workgroup will continue to get feedback from key stakeholders and meeting participants in regards to PIT and Age of Consent. The group may not reach full consensus on all items outlined in draft recommendations document.</td></tr>
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