Parent Initiated Treatment/ Age of Consent Stakeholder Breakout Group

August 10th, 2018 Meeting

9:00 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	**Lead: Diana Cockrell**
• Settle in • Cover meeting objectives	Framing: Diana welcomed the group and discussed the importance of breakout groups coming to consensus on recommendations. There is time to discuss various lanes during the meeting, and the goal is to find areas of consensus that will be helpful for moving this forward. Attendees: George Petzinger, Peggy Dolane, Diana Cockrell, Kathy Brewer, Ellen Escarcega, Lisa Daniels, Paul Davis, Noell Frame, Natalia Koss Vallejo, Liz Trautman, Patty King, Mandy Huber, Melanie Smith, Brad Forbes On the phone: Laurie Lippold, Christine Kapral, Liz Venuto, Lee Collyer, Jerri Clark, Miriyah Sachs, Nelson Rascon, Zosia Stanley

Parent Initiated Treatment/ Age of Consent Stakeholder Breakout Group

August 10th, 2018 Meeting

9:00 AM-12:00 PM

(2) The Parent Perspective	**Lead: Peggy Dolane**
• Looking at the Age of Consent • Solution Building	Peggy Dolane shared a PowerPoint presentation on the parent's perspective. A proposed model to change Age of Consent to 18 was shared and how minor initiated treatment component would be considered. The PowerPoint included a presentation from Jim Volendroff. Peggy shared that at times she has been told not to share her story. Shared her family of origin story and current composition of her family. Asked the question: apart from them, do you know me and why I'm here? Voiced that parents can be so affected by their experience that their message can get lost. Questions the group is considering to either change the age of consent or fix the loopholes with Parent Initiated Treatment. Feeling like she is in the hole in between. Defined parent (including caregiver and guardians). What are people afraid of when we talk about changing age of consent? People say that youth won't confide if they aren't guaranteed confidentiality. This may be more of a sign of clinicians not knowing what to do with that confidential information. There is a clinical issue involved. Shared Goals: children get care and support to grow into healthy adulthood, keep families intact, and we don't want to revisit this issue again. When speaking of parents, also speaking of caregivers/guardians/foster-to-adopt parents. • What we hear the system telling us. • Rep. Frame clarified one bullet "of not adequately funding special education, school counselors and family support workers." We do understand this adequately but are in a budget fight. Proposal to fund went through last year and was opposed/not funded. This is not adequately funded but not because we don't understand the need. • Coordination • Parents say "our experience shows us the single biggest barrier to Behavioral Health (BH) treatment is age of consent. "Can't even get in the door" and "children are dying." • False assumptions: Children have the cognitive/emotional ability to provide consent. *Some are not able to do that well.* Children have to hit bottom to receive help. Child will not trust the parent if they think therapists will share the information. "*Therapist fear" is what is shattering the family".* Police are the best response when people are out of control.

	The only person impacted by the age of consent is the youth. Involuntary residential treatment doesn't work. *We heard from ESD on 8/2/18lthat it does.* Shared statistics including a child checking himself out of Children's Hospital and within 24 hours was in jail. "No one is tracking data on what happens when they leave." Shared stories of individual family and children's situations, including "Ellen" who attended and shared story of her daughter. Our system spends money making our children worse. The system requires multiple failures, unhealthy children are treated like juvenile offenders and expected to act like adults; not all unhealthy children meet the standard for medical necessity. Youth brain development is not a place where teens should be able to make decisions about mental health, consent, and parental involvement. "Parent to the system: we don't trust you." Our kids are struggling in the system, they are homeless and addicted, etc. We don't trust the system to make decisions for our children. Needs beyond acute stabilization need to be addressed. Want the vision of mental health to include trauma, brain disorders, and special education. Would like to look at Behavioral Health through a Healthcare lens. • Address needs beyond acute stabilization: several bullets included in slide. • Expand vision of BH to include, Substance Use Disorder (SUD), MH, Special education, Trauma/Adverse Childhood Experiences (ACEs) (all Brain Disorders) • View problem from a public health lens. • Parents Want: family centered approach, ability to make behavioral health care systems for minor children, in-home services, functional family therapy, respite care, school-based services, and not be shamed.

	Peggy requests to focus on access to care and reflects on Hawaii model and highlights points below: • The minor is mature enough to participate intelligently in the mental health treatment or counseling services • Mental health and counseling services provided to minor shall include involvement in the minor's parent or legal guardian, unless the licensed Mental Health Professional (MHP), determines that the involvement would be inappropriate • Parents be involved in medication prescription • Parents be involved in inpatient/outpatient residential treatment • Provider involves the parents or documents the attempts to involve the parent and documents why, if not involved • Neither parent nor child can abrogate (override) the other on consenting to care • Legal guardian is not liable for payment for MH treatment, unless the parent or guardian participate (unaccompanied minor). • Who can provide controversial treatment such as conversion therapy? Possibilities: Child Initiated Treatment rather than parent initiated treatment. A child of any age could initiate. Raise the age of refusal. Peggy provided her contact information. PowerPoint available on website.
(3) Transition	**Lead: Diana Cockrell**
• Review NARAL States, i.e. Hawaii • Response and Feedback	Diana thanked Peggy and a participating parent for sharing their story. Diana informed that the next 30 minutes are for discussing the synopsis, fixing the loopholes, Child Initiated Treatment, and Hawaii model, (Peggy requested-addition of NARAL) Minor is mature enough to participate intelligently in the mental health treatment or counseling service. Shall include parents in treatment unless it is determined that the parent's participation will be inappropriate. Comment: Consider funding mechanisms for these legislative asks. In other states, the Department of Education is funding these initiatives due to law suits.

Parent Initiated Treatment/ Age of Consent Stakeholder Breakout Group

August 10th, 2018 Meeting

9:00 AM-12:00 PM

(4) Agreements Tracking	**Lead: Kathy Brewer**
• Continued discussion of the proposal to keep age of consent at age 13 and fix loopholes:	Stakeholder comment: Can we make a column where we list the things that we agree on so that we can have clarity and then we'll have the other information that we can comment on and try to ask the right questions about? Parent: Agreed. Then spoke on her experience of sending a child out of state, and how the child thanked her later. Added, parents need to be able to access inpatient care for their children in this state. Parents should be given oversight of their child's care as soon as inpatient treatment begins. It would be great to get into that level of detail, but we need to identify some areas of agreement that can be moved forward. It was proposed that admission should be either/or – minor can initiate and parent can initiate. Law reads minor initiated treatment, parent initiated treatment, and /involuntary treatment act. It was noted that the parent not being liable comes with a fiscal note that is important to consider when making a recommendation. It was said that currently when a minor initiates treatment without parent involved, then a confidential "guarantor" is used so that parents are not informed-Seattle Children's uses financial aid for these youth. The vast majority of youth that come to Children's Hospital are brought for treatment by their parent/guardian. The group, Mothers Of Mentally Il, is working with government policy makers on ITA law. There is a need for treatment standard that can be clinically recognized when youth does not have the ability to recognize need for help. Family involvement is medically necessary for a youth to heal, could potentially work this into the conversation. It was recommended the group be as unified as possible, moving into the afternoon with everyone's voice heard and equally balanced. It's important to hear parent voice and also provider/clinicians voice. Important to balance work to ensure there is enough support to make recommendations move forward.

	It was pointed out that it is important that youth who are past the age/but still closely related, have a discussion. What is agreed upon? Minor access: Mandate limited sharing of information to parent to address sharing Diagnosis, treatment plan, medication, psychoeducation about mental health referrals made, and still some discretion of the provider on what information they may provide if they felt it was detrimental to client. Provider would document reasons for not sharing. For outpatient treatment (OP), establishing perimeters; if discharged from IP- parent can request OP as clinically necessary, also parent included in this, as is the clinician. Treatment to youth provided by licensed providers only. No provider is required to provide treatment, they can offer referrals (need to be able to say, this is not my expertise). Modify parent definition to include kinship care provider, legal guardian- (Need to address custodial step parent, non-custodial parents, and medically involved parents.) For ITA- When youth are on ITA, the same subset of information can be provided. Residential Treatment: Issues more closely related to funding and payer not authorizing more time that is needed- this is being addressed in separate work group (Admission Practices). Question as to whether there is a law under Children's Long Term Inpatient Program (CLIP) that can preclude a minor/parent initiating treatment? If there was enough long-term inpatient treatment in Washington, do we recommend applying PIT? Categories: Acute and long-term treatment. A parking lot issue is the category of concerning behaviors when youth are exhibiting "scary/risky" behaviors. Conduct disorder is a mental health diagnosis but not covered by payers as medical necessity. Unless diagnosed with a severe anxiety disorder, thought disorder, etc.; youth can't usually get inpatient care due to longer term care being needed. Conduct Disorder behaviors can also be a sign of children/youth who are being abused and abuse can come from the parent or someone else.

	Parents should be looked through a trauma-informed lens. Should clarify law about need to notify "parent(s). What is the obligation to notify the noncustodial parent? This is a grey area. Parenting plans usually specify who makes medical decisions and if the parents are joint custodians. Summary: Recommendation: • Documentation of why/where parent involvement is placed. • Involved in medication prescriptions. • Ability for IP or OP decision, made in concert with provider. • Neither the adult, youth, nor provider can override. • Want to ensure the minor consents and is covered for funding – funding challenges – who pays and is legally liable? • Define who is relevant – who can provide services and include licensing requirements for providers. Things we agree on: - Mandated sharing (may be some discretion by provider). Provider may share: o Diagnosis o Medication o Psychoeducation about condition - Things to not share: o Specific details that youth asked not to be shared Not in agreement: Parking lot request regarding medication- current PIT law does not allow to compel medication so would have to move to ITA. When compelling meds, hospitals usually use antipsychotics (category of medication). Do we want to address medication such as in the Hawaii law? Sometimes conflict with parent/youth comes up when in IP as there are misunderstandings/research conducted online by parent, etc.

	There is not agreement with either/or age of consent – either minor or parent can consent. Only licensed providers can see these youth- would hope that ethical standard is in place, secondly, can't keep a youth in IP or OP without MH diagnosis. Are we considering review process for youth in IP changing? Do we need extra PIT review process through CLIP Administration? Not talking about the youth who end up going to CLIP as the recertification process. Currently CLIP review process for those that don't end up going to CLIP, is used for data tracking and connection to parent to educate on resources, etc. Is there an opportunity to do more side by side comparison to clarify the intersection? Recommendations for the group going forward: It would be helpful for someone to manage those participating over the phone so people can express and finish their thoughts. Request made for people to work on not interrupting each other. Diana suggested working with the leads to lay out potential agreements, more discussion on the rest of issues (not sure where certain things landed- and stay on the table) Diana said it was a great conversation with some agreements but other things will need to move forward. Also, does CLIP review process need to stay in place, go away, etc. Recommendation - Peggy could submit a list to Kathy to edit and volunteered to follow up with Kathy who had to leave ten minutes early.
(5) End Meeting	**Diana Cockrell**