Parent Initiated Treatment/Age of Consent Stakeholder Breakout Workgroup

September 11, 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	**Lead: Kathy Brewer**
• Welcome and Introductions • Participation of Ground Rules	**Attendees:** Kathy Brewer, Peggy Dolane, Lisa Daniels, Avreayl Jacobson, Kevin Black, Danielle Cannon **On the Phone:** Kalen Roy, Melanie Smith, Mary Clogston **HCA Staff:** Blake Ellison, Mandy Huber, Paul Davis, Diana Cockrell, Patty King, LaRessa Fourre, Gary Hanson, Amanda Lewis, Lois Williams Blake discussed and shared the list of ground rules with the group. **Participation Ground Rules** -Take turns talking one at a time.

	-Refrain from side conversations. -Ensure opportunity for people on phone 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 is on what we are doing now – not what has happened in the past. -Goal is to find common ground – which will mean compromise for everyone. -If you can't agree – please offer a solution!
(2) Work through items on the Ideas Under Consideration document	**Lead: Kathy Brewer**
• Review last week's survey feedback on consensus • Continue to work through Ideas Under Consideration document-in order now by closest items with consensus • Modify language as needed to reach consensus	Kathy informed the group that she sent out a survey monkey to determine consensus on the questions. She created a document she named "Ideas Under Consideration," for the workgroup to use to discuss the results of the survey. The questions were based on the amount of agreement, with the assumption that it would facilitate discussion to start with the questions where there is the most agreement. She decided that 'Agree' and 'Strongly Agree' meant 'Yes.' **Question #1**. The results of the survey show that 92% are in agreement to keep age of consent. **Question #4** revealed that the majority think that information should be shared with the parent even without the consent of the minor. The group agreed that resources and guidance to providers regarding conversations with the families should be provided. Kathy offered to consult with the Partnership Access Line (PAL) and put something on the website to support this. **Question #5**. The workgroup agreed with the recommendation. A parent stakeholder asked if the provider determined that releasing information would be detrimental to the minor, how does the provider document? There was a question as to when it would rise to the level of mandated reporting to Child Protective Services (CPS). **Question #7**. The workgroup agreed, as long as it was not violating 42 Codes of Federal Regulation (CFR) part 2. It was pointed out that question #11 relates to that issue. A sentence can be added about not violating 42 CFR for Substance Use Disorder (SUD) treatment. **Question #19**. The group agreed but suggested a change so that information can be released ***unless,*** the DCYF social worker objects, since social workers are busy and difficult to reach. It would make the provider more comfortable if consent for care was sent by the provider for signature. It was mentioned that providers would be more comfortable if they had a signed release of information

	(ROI) from the youth. It was recommended this be consistent statewide. It was further suggested to look at how other states work with release of information. More information is needed. Diana suggested asking the Assistant Attorney General (AAG) to review CFR 42 in regards to SUD treatment. The workgroup agreed on Question #9 on the rights of a provider to accept a patient or give a referral. **Question #10**. The group agreed that for mental health treatment, adding the definition of "parent" to include kinship caregiver for PIT. It was mentioned that for kinship care there is an RCW. Kinship care givers cannot currently initiate treatment and the group was in agreement that the kinship care givers need to be allowed. **Question #12.** It was agreed that it was a Best Practice to include both parents in their youth's care. The custody/parenting plan should be included in the records if possible, but it might hold up the care plan if parents don't submit the plan timely. It may be good to request the plan if there seems to be a problem. A stakeholder commented that if the parenting plan is violated then it would be on the parents, as the providers only know what they are told. **Question #6**. The group agreed but was concerned about the liability on the providers. A stakeholder asked about an appeal process for a provider's decision to withhold information? Maybe the Ombudsperson can intervene? This will be a change for the providers, so it was suggested to evaluate in the future to see if this change is helpful. It was suggested for this to be a parking lot discussion. **Question #11**. The group agreed that more information is needed on 42 CFR limits so we are not in violation of the federal requirements. **Question #8**. There was general agreement, but need to change mental health to behavioral health, to include SUD. The current Washington Administrative Code (WAC) has outdated language and this would be a change in the law, if moved forward by the legislature. There is a need to limit who the providers are for BH treatment. Types of providers suggested to be added are certified Chemical Dependency Professionals (CDPs), physicians, Physician's Assistant (PA), Licensed Social Worker (LICSW), and Nurse Practitioner (NP). Also, add in providers "covered under supervision of licensed providers." Questions about adding school programs and peers. What about tribal and faith

	providers? Do we need tribal representation? If we are expanding the ability of parents to place in treatment, do we need to list of preferred provider types? **Question #21**. There was general agreement for minor initiated treatment. Questions included should we change parents to singular, so parents who are not involved, are not required to be included? Other choices were to add custodial parent, parents involved with decision making, or keep as parents. A stakeholder commented that getting involved in the custodial agreement can be difficult. Should it reflect parent/legal guardian/kinship guardian? Should the clinician have the discretion to not share information with a "parent" if it could be traumatizing for the youth? **Question #2.** There was general agreement but concerns were expressed about an arbitrary number of sessions. Clinician needs to have decision making ability and youth need a voice if they don't want to participate. Should the provider be allowed to connect with the patient with no set number of treatment sessions? Concerns were expressed about therapist shopping and preventing inappropriate use of MH treatment. Guidance should be given to the provider about releasing the patient for other treatment provider options. Recommending to add a check-in with all parties involved to ensure effectiveness of treatment. It was suggested to define each level of care and the need for a check-in time, while recognizing that each level of care may not need to check back in at the same lengths of time. For example, Wraparound With Intensive Services (WISe) uses an entire team to engage the client, not sure how that relates/breaks down to number of sessions. Also considering that insurance plans may have different benefit packages. Recommend a follow-up to review how the law change is working. **Question #3**. There were concerns about language. With the use of the term residential and not using acute or long term care. We need to be thoughtful and cautious for due process, meeting our mandates and providing the least restrictive alternative (LRA) treatment and how far we extend this. The recommendation should not be vague about what is needed. Look at the length of time for the different types of services. Do we need additional oversight? Relationship between what is medically necessary and what the youth will comply with. If parent initiated, provide for a discharge meeting and treatment plan. Possibly bring peer support and other services into treatment. The group agreed that more conversation is needed. There is a mandate to provide LRAs. There is a need to ensure that paperwork is not overwhelming, while still keeping parents involved. The role

	for DCYF social workers to initiate PIT needs to be defined. Providers need to be clear in their responsibilities. There is a need for due process and an outside review process. The group was asked to consider whether an increased access to Intensive Outpatient (IOP) and partial hospitalization would reduce the need for long-term residential/IP. It was suggested that tribes need to be included in conversations so we are not speaking on behalf of tribal communities.
(3) Wrap-Up and Next Steps	**Lead: Kathy Brewer**
• Discuss planning an additional meeting	Kathy thanked and appreciated the group for the progress. There will be dates offered later today for additional meetings. Kathy asked the panel to look at options and bring recommendations. The conversation will continue at question **#14**. The meeting adjourned at 12:00.
End Meeting	