Parent Initiated Treatment/Age of Consent Stakeholder Breakout Workgroup

September 27, 2018 Meeting
3:00 PM - 5:00 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
- Reminder about Participation Ground Rules

Attendees: Peggy Dolane, Lisa Daniels, Avreayl Jacobson, Kevin Black

On the Phone: Kathy Brewer, Laurie Lippold, Kalen Roy, Mary Clogston, Patty King (HCA), Lee Collyer, Camille Goldy, Natalia Koss Vallejo, Kalen Roy, Danielle Cannon, Melanie Smith

HCA Staff: Blake Ellison, Mandy Huber, Paul Davis, Diana Cockrell, Patty King, LaRessa Fourre, Gary Hanson, Amanda Lewis

Blake reminded the group of ground rules for the meeting and shared the list of ground rules.

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) Final Discussion about the Items Discussed at Last Meeting	**Lead: Kathy Brewer**
• Final discussion about the items discussed at last meeting and identified as **APPROVED** on the Ideas Under Consideration document. • Any recommended adjustments based on state survey feedback?	Kathy informed that great progress has been made since the last meeting. The survey results were helpful. The updated list of Ideas Under Consideration was shared. The group discussed the list of approved ideas to ensure there are no further needed adjustments. It was acknowledged that there are still Youth Advocates and youth expressing concerns regarding confidentiality. The concerns are how to ensure confidentiality for youth and also make sure parents have the information they need for their youth. There are two groups of how youth participate in treatment: ○ The parents who bring youth to treatment, and how to share information with parents. ○ Youth who come to treatment on their own, without a parent or guardian. These youth could be emancipated, etc. This stakeholder group may need to look at confidentiality differently for these groups. A stakeholder commented that it is important to look at both subsets of youth who are seeking services and treatment. Also, look at differences between outpatient (OP) and Inpatient (IP) treatment. A parent stakeholder stated that she has advocated since the beginning of this workgroup, to change title to "youth initiated treatment," with the group deciding to compromise to expand current PIT. The idea is still to protect youth, but could be called Youth Initiated Treatment in terms of confidentiality concerns for this subgroup. If the parent is bringing the youth it could continue to be called PIT, and if youth is coming to services unaccompanied, it could be Youth Initiated Treatment. Another parent stakeholder stated that her dream was joint consent. If there is

not parental involvement, there will still be concerns about not sharing information with parents. If a youth is still living with their parent, why would the parent not have information shared with them?

A lead stakeholder expressed confusion because this conversation has to do with confidentiality and then a concern was brought up about youth initiated treatment. Kathy clarified that some recommendations will become an online training to be developed if the legislature passes it. The group should talk about the concept of confidentiality. There is no desire to eliminate confidentiality. If a parent and youth live together and the parent accompanies the youth to treatment, then the listed information should be shared with parents, just as when the youth has a medical condition. Most therapists can get youth to consent to sharing information early on and want the youth to be invested in treatment. It is helpful for the therapists to be able talk with the parents openly about what can be done to help the youth at home. When a youth is coming to treatment on their own, then confidentiality should be carved out separately.

For example:

- Youth is accompanied by a parent, then disclosing specific information is authorized.
- Youth presents without parent, then no disclosure of information until consent is signed.

A stakeholder agreed with having the distinction of parents involved with youth and youth who are accessing treatment on their own. There shouldn’t be disclosure when it would put the youth in a dangerous situation, because there is potential for abuse and neglect. A stakeholder commented that he was not expressing an opinion, but as an attorney, shared that there is a situation where the therapist can share information, which is when there is a threat of harm or death. There could be something else proposed that allows clinical judgement, etc.

A stakeholder said that a parent expressed concern that some youth are quite capable of manipulation. There have been situations where the treatment provider would not share information in Washington that would have been helpful. The group felt that providers know where that line is and professionals know when to share.

	Kathy clarified we're only talking about mental health, only 42CFR. A stakeholder lead commented that we're talking about a fairly narrow group where this is going to come up. Overall there is information regarding where we want to share information. It was stated that federal law will default to state law to determine age of consent, as long as state law is clear. A parent stakeholder had concerns about substance use disorder (SUD) information that is also important to be shared. The group agreed that providers can be trusted to not share information, they are already doing that. Can improvements can be made in regards to mental health. Treatment provider is allowed to share clinical information without consent of the minor, when it would not be detrimental to the youth. Clarifying that when a youth is seeking treatment on their own, this language change would not apply. It was stated that this group can't solve the issue of SUD rules, in the limited time left of the workgroup. A parent stakeholder asked the group to not separate out accompanied or unaccompanied youth. It was clarified that the group has already agreed to clinical judgement. We are trying to make it more explicit to those concerned, for youth advocates and youth who are disconnected from families and for whom it can be harmful. It may be best if there is a focus on best practice training to make sure clinicians understand. It was asked about the judgement of the clinicians, from a legal perspective. Who holds the judgement? There are concerns about liability for individual clinicians and the agencies who employ them. Is there another element/implementation piece that should be added for clinicians and what are the implications? There is language to cover this in one of the recommendations. Kathy stated that she is hearing a majority agreement with best practice training added. The majority agreed to not change language. A parent stakeholder asked if the issue of what are the barriers to involving parents in treatment for training purposes could be moved to the parking lot, rather than just asking youth do you want to involve your parents-yes or no. It was reiterated to the group, that youth advocates really want to differentiate so it's clear to clinicians, parents, and youth, when it's PIT or not. The response from the youth population was very overwhelming in that if they felt their approach to therapy was not going to be kept confidential, they would not access treatment. Is there potential to ensure youth voice is heard? A

	parent stakeholder stated that confidentiality is different than information sharing. There is still concern that this is a compromise parents have already made and hopes that youth and youth advocates could see this as a compromise. Can the group also parking lot other ways to address SUD and information to be shared. Maybe the recommendation is we would like to be consistent but cannot, and make a note to the workgroup about this. Kathy asked if the group could move to questions that have not been addressed and would the group agree to the recommendations we have approved consensus on. Parent stakeholders said that they had concerns about #9. It was clarified that we're talking about OP and can add that. There is concern that not everyone has the training to work with children and adolescents, so a clinician should not be required to treat a youth. There is a need to ensure the youth are treated by providers who have great training and want to work with these youth. A concern was expressed that if we add this recommendation and it becomes law, it adds a barrier to accessing PIT. It was also said under current law, no medical provider has to serve a patient and can decline for any reason; it may be that they don't have training, expertise, or because there is no natural fit. There are many reasons for declining to provide treatment. We should not be in a position of telling providers who they have to treat. Clarification about the law for providers was asked. It was informed that a provider can refuse to serve a patient for various reasons, but ***not*** for PIT. Kathy said she believes this law applies to IP. The OP law is only about evaluation - not treatment. The group expressed the opinion that there is already a workforce shortage and we don't want to create more of a workforce shortage. A stakeholder asked if there can be parameters around wording, by adding something about appropriate treatment/medical necessity, etc. Also, have language to help support providers in wanting to treat youth. A parent stakeholder commented that if it's already in the law that providers can chose not treat for a variety of reasons, then it doesn't need to be in this law. Concerns were expressed around this issue, if it is really the need to expand PIT to have more hospitals and OP providers that can provide this service. Is there a way to increase the safeguards for providers so that it may expand the number of providers who want to treat youth. Kathy shared that in looking at #9 and #6, we have already added information on #6. Is the language in #6 sufficient to address concerns in #9? A parent stakeholder wanted to know that if it's common

	practice, why do we need to have it in this law? It was clarified that it's when someone else is forcing a youth into treatment, so it's a more risky situation. It was asked if there was consensus to eliminate #9 and keep #6, which addresses the concerns. There was consensus to eliminate #9.
(3) Discuss Remaining Items	**Lead: Kathy Brewer**
• Discuss remaining items and try to find consensus where possible to lead to a recommendation.	The group moved to the next section and looked at 3b-1 and 3b-2. The new language discussed last time had been added and does the group think the new language is ok? A stakeholder said that the group had already stipulated that treatment can only be conducted by a licensed provider. The group approved it, except for payer portion. Should we add an end date like there is in Children's Long Term Inpatient (CLIP)? A stakeholder expressed discomfort in putting a lot of the medical necessity decision making on the payer, because there could be a thought that payers have other incentives. Maybe some decisions could be made outside of The CLIP Administration review, in order to decrease potential burden on The CLIP Administration who would have to review for OP. With OP, there aren't independent reviews and there is no end date. It was proposed in 3b- that there should be a treatment review every 30 days. It was suggested that a length of stay (LOS) of 90 days be added and could be taken out, as long as that program is paid for by a commercial insurance or Medicaid plan. The addition of "by MH and SUD providers licensed with the Department of Health (DOH)" was suggested. Kathy will update with the proposed language and send out to the group. A stakeholder said the goal is to have least restrictive options and not add more restrictions/bureaucracy. A stakeholder commented having no problem with adding 90 days when IOP can include Wraparound With Intensive Services (WISe) and wraparound. There is a natural process where OP treatment-WISe could last two years or end quickly. She suggests separating out OP and IOP. IOP can be handled by IP laws. Lead stakeholder said there is a need to keep WISe as a separate service, because it's a type of treatment. The group is talking about partial hospitalization, not services being provided in the home. It was asked if we are adding maximum of 90 days. Parents feel it should be needs based. It was said the language doesn't obligate in any way, this is simply a way for parents to access for their youth without consent. Kathy asked the group if they were ready to proceed with IOP-partial hospitalization and agree with review concept. It was

	suggested to add in a 45-60 day review and take out the 90-day arbitrary limit. Setting a periodic review if treatment continues was suggested. Also to add in language that is protective, supportive and based on a three-year period where data can show how it's working. Consensus language will be added in. Kathy asked about residential long-term inpatient including eating disorder programs, SUD, some CLIP programs and some non-CLIP beds and explained that we're not talking about CLIP specifically yet. It was suggested to talk about community residential before CLIP because CLIP is the most restrictive level of treatment in this state. It was again reiterated that the group needs to be clear we are not talking about CLIP in this section. The question is for primarily commercial residential and whether we want to add the same provisions as above in regards to review. There is a difference in acute care and longer term care. What about medical necessity. If reviewer does not determine there is medical necessity, the youth, family, and program would need to be informed and the youth could be placed in a program through a different pathway. Something such as clinical standards need to be developed. The group was asked to talk about voluntary CLIP language. The CLIP Administrator added in new language. It was said there is no need to add in as long as all other LRAs have been utilized, because it is a built in process. It was asked how the process is different with an ITA or with a parent accessing PIT? When a parent is asking for PIT, they are asking for a panel to determine medical necessity, rather than a court order via ITA. It was further explained that with ITA, it is a youth experiencing an acute crisis so they cannot go through the voluntary process or leave the acute IP facility to wait for CLIP. It was asked if the CLIP Administrator has concerns about taking out the added language. The language change was meant to be transparent so parents know that all LRAs need to be tried first, rather than finding out later. It would be a safeguard so parents are not frustrated. It was said that since it's a safeguard already in CLIP, it probably doesn't need to be stated in law. It was asked if there is general consensus to remove wording because it is part of the application process and on the application. Agreed consensus. A parent stakeholder said that WISe is a voluntary service like any other voluntary services. This has also been discussed at King County FYSRT and the thought was that it was a good idea for WISe to be open without youth consenting. Do we need to spell out WISe differently than any other LRA? It

	was commented that it just shows as a continuum of care. Kathy said it needs to be clear and explicit. If language is vague, there are too many loopholes and therefore recommends specific language. It was suggested to have it different by saying Wraparound, which is national and not say WISe.
(4) Wrap-up and Next Steps	**Lead: Kathy Brewer**
• Wrap-up and next steps to present recommendations to the full group on 10/15	**Next steps:** Does the group want to have another breakout meeting on 10/12 or just use information from FYSPRTs? Additional time to discuss further was requested. The question was asked if we need to find out something legally about “abrogate” language? Group would like to have another breakout meeting on Oct. 12th, proposing 9-11 a.m. Invite has not yet been sent out, but Diana will be sending out to the stakeholder group. A parent stakeholder would like to talk more about stigma and rebranding the name. The parent stakeholders were asked to come to the meeting with language proposals. Kathy can send out the updated version of the Ideas Under Consideration document after the meeting. Diana confirmed these ideas are going to go to the FYSPRTs.
End Meeting	