Parent Initiated Treatment/Age of Consent Stakeholder Breakout Workgroup

October 12, 2018 Meeting

9 AM – 11 AM

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:** Avreayl Jacobson, Laurie Lippold, Kevin Black **On the Phone:** Kathy Brewer, Peggy Dolane, Lisa Daniels, Natalia Koss Vallejo (on behalf of Noelle Frame), Danielle Cannon, Melanie Smith, Justin Johnson, Brad Forbes, Robert Hilt, Erin Edelbrock, Mary Clogston **HCA Staff:** Blake Ellison, Mandy Huber, Paul Davis, Diana Cockrell, LaRessa Fourre (by phone), Amanda Lewis, Lois Williams The meeting started at 9:06. Paul asked everyone in the room and on the phone to introduce themselves. Blake reminded the participants about the ground rules, which are particularly important to include for those on the phone.

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	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 inpu.t -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) Review items that are listed as **APPROVED** on the AOC_PIT	**Lead: Kathy Brewer**
• Recommendations document, with updates in red from our last meeting. Any additional revisions to make?	Kathy thanked everyone for all of their work and said she was pleased with the progress that has been made in this Parent Initiated Treatment (PIT)/Age of Consent breakout workgroup. The purpose of this meeting is to finalize recommendations, as these will be presented to the full group on Monday. She started with a review of the currently approved recommendations. A parent stakeholder asked about number 2 and the involvement of the parent in developing the treatment plan. It was explained that usually there would be a co-development of the treatment plan with the youth and parents. It was suggested to include it in the Best Practices workshop/training that is proposed to be developed. A lead stakeholder asked about number 1, as it is overarching but relates to this item. She has concerns that the focus will still be on the age of consent after the recommendations are presented. There have been conversations with legislators who have shared they are still hearing about wanting to change the age of consent and there not being support for the group's agreed upon recommendations. We should agree as a group to not focus on changing the age of consent, but rather committing to our recommendations. This lead stakeholder would like commitment to the agreement on not changing the age of consent as this process would be disingenuous if we cannot agree to this. Another lead stakeholder agreed that if we want to have system change, we need a

	unified voice. Despite youth and parent advocates wanting something different, we need to find a middle path. There are reasons to enhance good treatment for youth who reside at home and for the youth who do not, and do not want to consent. A parent stakeholder agreed with the idea of talking about it as a middle path. There are good reasons to keep it at 13 for those who do not have safe home situations. A stakeholder commented that there hasn't been a summary of the recommendations until today and it is helpful. A stakeholder spoke to the complexities, and recognized the difference in perspectives from clinicians, parents, providers, etc. Not all groups bear the same weight or complexities of the system. Blake confirmed that everyone appears to be in support of moving forward. Kathy moved to discuss page 2. Number 10 now shows that it is recommended that kinship caregivers are given the same rights as the parent in treatment. Laurie has convened the Commercially Sexually Exploited Children (CSEC) workgroup and there is some back and forth about anyone, other than a kinship caregiver, parent, and DCYF social worker; having the ability to file a PIT. There is still some focus that there could be an addition of other individuals who could file a PIT. The group was informed that the CSEC group will want more people involved in the treatment decisions. A stakeholder shared that they weren't commenting on policy but could comment on drafting. For all these recommendations to be translated into bill language, there will be a process. As long as the intent is here, the group should not get bogged down in getting "perfect expertise," in regards to wording. 42 CFR is the same. If the Washington state policy is the same as 42 CFR, then you could freeze state policy language. If not, you could add something about "if there are changes in federal law." Paul clarified, that in the meantime, even if the youth is in treatment unwillingly, they are still the client, so information cannot be released without consent. Once they reach the age of consent, they are the client. Kevin discussed the possibility of writing the law to do a workaround and find some maneuvering room. A lead stakeholder suggested we need to look at how we approach

	mental health to create leeway. A stakeholder stated they could write something about how federal law should be interpreted in the state law. A question was asked to clarify who was releasing information in number 9. Kathy informed that it is meant to be the clinician who is providing the treatment at the time who would decide whether or not it is detrimental to the client to release information. Kathy will further clarify this in the recommendation. A stakeholder questioned if we need to specifically add agencies and individuals. Will it be a training burden to the agency? Kathy further stated that inpatient (IP) and outpatient (OP) should also be added to number 9. Should we make it more explicit? The question was posed, do we keep language as specific as possible so the group's intentions are understood potentially by people who would be writing the bill or are more general references enough? A stakeholder suggested keeping it as specific as possible, so intent is known and it will be written out in legalese. A parent stakeholder wondered on number 9 if this issue is right for parents to expand access? And the CFR, does it apply when parents are getting access to care? She would like more review. The group moved on to numbers 12-19 and were asked if there was feedback. Kathy informed that number 13 needed to change to *parent*, not parents. Avreayl asked if we can change from "not able to engage" to also adding "willing to engage." It was agreed to add. A stakeholder asked if the 30-day review requirement in 16 is too often. Would this have a negative effect on smaller providers? A question was asked about number 15. Is there any way we could recommend any metrics and expanding diversity to capture the experience of the youth. Set a bar for how many youth would participate, so it can be a diverse group with increased numbers for a broad group of youth. A stakeholder agreed, this should be defined more for future evaluation. It should also be defined what will be done with the information. Will it be evaluated for effectiveness and published for the

	legislature or Website? A lead stakeholder thought it should go to the Children's Mental Health Workgroup (CMHWG). The group was reminded that CMHWG expires in 2020, so may need other options to reach those who are responsible for making treatment decisions. Maybe add CMHWG while in existence, but then provide to IP treatment providers. The group decided it is not necessary to decide right now, but need to make sure the information doesn't get lost. An HCA/DBHR stakeholder suggested that the data would be used to inform process within the HCA/DBHR Children's Behavioral Health team. Peggy suggested adding Family Youth System Partner Roundtables (FYSPRTs) and the group agreed. It was also suggested that the data be shared with the advisory board for the mental health block grant, Behavioral Health Advisory Committee (BHAC). A lead stakeholder said the group needs to ensure that the survey is sent to a variety of youth and other diverse groups including the CMHWG and the HCA/DBHR Children's team to review data and inform process. It was asked what kind of metrics are needed. Are we talking about how communities are engaging youth in PIT? It was said that we want to ensure enough youth voices are heard, with a diverse sampling of youth who have experienced PIT in different ways. Metrics would be about capturing youth experiences. The most vulnerable populations will be the most difficult voices to capture, so we need to do our best to get their input. Metrics needs to be specific to the survey, not to the treatment. A clear goal is needed with the bar set high. It was suggested that the five workgroup leads be part of a workgroup that develops metrics. It was suggested that the metrics include the engaged providers. It is important to demonstrate there is not a preference for parent vs. youth initiated. It was commented that some of the recommendations are not what the youth requested, so we want to see how youth respond to what is adopted. Blake informed that there seems to be agreement. Kathy has captured this and will wordsmith. A stakeholder commented that numbers 16 and 13 may be subsections once the law is written. The periods of time are different. This is the least restrictive, Kathy agreed that 16 and 17 could be collapsed together since the review process is similar. Kathy will collapse these. A stakeholder suggested the consent form needed to be organized for ease of understanding.

	A parent stakeholder asked about Wilderness programs and adding this within number 17. The stakeholder stated that these programs are not licensed in Washington and must be licensed with the Department of Health (DOH) as a Residential Treatment Facility (RTF). Amanda Lewis, DBHR said that Great Wolf Substance Use Disorder (SUD) residential is licensed for males and has a wilderness program that uses private insurance. As long as programs are licensed in the state, then we are covered. A stakeholder asked about number 18, allowing parents to initiate so the parent can submit a request without the youth's agreement. It doesn't need "will still," since there is medical necessity. The group agreed. Let the family go through the process, but do ask if youth is willing to participate. It was commented that the intent is for PIT to be allowed to submit the initial application but admission process would still apply. A parent stakeholder commented that more specificity is needed as to what is available to the parents. The group was reminded that there are only five Children's Long Term Inpatient (CLIP) programs. The providers will be concerned about how they will be admitting the youth, voluntary or not, because this is the most restrictive setting. A concern was expressed that a log jam will occur. A stakeholder said that it will create administrative conflicts, so maybe policy is we either exclude or include CLIP in PIT. A middle ground was suggested. The concern is that CLIP is long-term treatment and review timelines being shorter does not match up with longer Lengths of Stay (LOS). Another stakeholder commented that parents want to involuntary commit, but CLIP is voluntary and needs consent. A lead stakeholder asked if we want the parent to have the ability to involuntarily commit to CLIP by submitting an application without youth's consent. It was suggested there is a need to keep looking at it, and maybe this can be referred to the CMHWG. Kathy said we were expanding CLIP to OP and residential. The intent was about the application, but there are a lot of other implications the group should talk about. It was suggested to leave at initial access of application. This would be good middle ground. A parent/guardian can bring the CLIP application forward and community and cross system individuals can do what they can to engage youth into the voluntary process. There is limited bed capacity for those who are certified for CLIP. A parent stakeholder said

	we need more resources to expand access/bed capacity, so this is not a hindrance to admittance. It was asked that a recommendation be added that we review the CLIP process and adjust to reflect the intent for parents to be more directive. Not change the voluntary process now but look at ways to do the involuntary process without it being ITA. A lead stakeholder commented that it makes sense to keep looking at addressing this. Something could be added to continue under the CMHWG purview to address. Kathy summarized that the group landed on mostly keeping language as is, just saying "parent can request to have the voluntary CLIP application submitted without the minor's consent." It was commented that this is a good recommendation that will not put too much stress on the CLIP program. It was asked when the last time was that the program was looked at for expansion. The CLIP Administrator informed that there is expansion happening with CLIP, but it will take some time. Child Study and Treatment Center (CSTC) is adding a fourth cottage and at least two more community CLIP programs are expanding bed capacity. The legislature provided a bed rate increase for CLIP programs during the 2018 legislative session. Diana informed group that on number 19 there is a need to discuss this recommendation with Wraparound with Intensive Services (WISe) staff to ensure this will not create unintended consequences. A lead stakeholder said that WISe can be accessed by parents. A parent stakeholder said FYSPRTs are happy about the change. A DBHR staff said that WISe pushes youth choice and voice and asked how this balances out if the parent is accessing WISe and the youth does not want to participate voluntarily. A parent stakeholder commented, this would create a shift with less control for the child. Furthermore, WISe does work with the parents and the family.
(3) Discussion of the Wording of Parent Initiated Treatment	**Lead: Kathy Brewer**
• Consideration of changing wording to reduce stigma for parents, while ensuring that language clearly	Kathy asked about medication. Do we need to add any language? There are medical, legal implications in treatment. Minors don't need to get parent's consent for medications. A recommendation was made about best practices training to cover some of the complexities. A stakeholder asked if this should be left out of the statute and included in Best Practices training and webinars. How does the group want it reflected in the statute? It will increase liability if the youth does not want parents involved and if medical reporting is required. It was stated that it is a best

identifies differences in treatment access (i.e. youth vs. parent).	practice for clinicians and medical providers to communicate with parents about medication. Kathy suggested adding in as Best Practice training and discussing complexities. A parent stakeholder said she has spoken to parents and they are okay with youth getting medication without parental knowledge. A concern was expressed about "must be shared" and it seems fine to leave alone.
(4) Discussion of Remaining Items on the Document	**Lead: Kathy Brewer**
• Are there any that we can add to our list as APPROVED recommendations?	Kathy moved to a parent stakeholder regarding concerns about the stigmatism of language and the suggestion of the overall statute name being "Adolescent Treatment Access." The parent stakeholder believes there is too much emphasis on parent initiated and recommends that the emphasis be on access. Also suggested was accompanied minor and unaccompanied, rather than parent initiated. Diana said that she is not opposed to the concept but concerned about a domino effect. A concern was expressed that unaccompanied has other uses in other legal concepts. We may not need to have exact language but a brief description of our intent to destigmatize language in this statute. A stakeholder commented that whichever direction, need to make clear that youth can still initiate their treatment. Family Initiated Treatment was suggested. A lead stakeholder said it needs to be clear so people know that it is open to them. Blake asked if anyone is opposed to looking at the name. The group agreed to consider it. Number 17, is this statement necessary. A stakeholder advised that it needs to have some language that neither can veto. A stakeholder asked why we need this language. We're leaving consent mostly in the hands of the minor, we have made a pathway for a parent/guardian to be involved. Does this add anything? A stakeholder said they just wanted it thought about, not necessarily put in the recommendations. Another stakeholder further commented that if the concern is being as clear as possible, then this specific language isn't adding to clarity. Number 18, Does stepparent need to be authorized to get information? It was asked if a child is under age 13, how would stepparents be authorized for consent. A Seattle Children's Hospital (SCH) stakeholder said the parent could release information to other relative, whether it's a stepparent, grandparent, etc. It was asked if we are treating a stepparent as a parent for information. In

	practice, SCH would ask the legal guardian to sign a Release of Information (ROI) to provide information to stepparent, other relative, etc., when a child is under 13. If the parent consents to release limited information to the stepparent or other relative, it could cause conflict for youth. Can we add in a clause that it would be at the discretion of the clinician? It was asked if youth advocates have concerns about this on behalf of youth. Adding provisions that when a parent has initiated care, they may consent to limited information, when in the best interest of the youth. It was suggested this would be good because several parents have expressed the concern. A question was asked about the 27 percent of individuals on the survey response who did not agree. Was this because of youth who have tension with the stepparent? Kathy said the comments were 'can parent release information, if there wasn't a strained situation.' The provider and parent may need to work it out. It was suggested this can create a united front with the family. Kathy asked the youth advocates for their input. No concerns were expressed. This language will be approved as written with provider best interest.
(5) Wrap Up	**Lead: Kathy Brewer**
• Plans for report out to the full group on Monday 10/15/18.	**Next steps:** Kathy at SCH, has received a call for presentations for the Behavioral Health (BH) conference. Do we want to kick off the PIT training aspect? Should we do a presentation on this? Would anyone like to help with this? There can be three presenters and Kathy is willing to be one. A parent stakeholder would like to help present. It was suggested this could be a tri-lead opportunity by adding a youth system partner. Kathy will reach out. At Monday's last full meeting, the plan is to go through each recommendation and take any feedback. Kathy was thanked for the incredible job throughout this process, as well as the group being open to sharing thoughts and putting it on the table to share. A parent stakeholder expressed being thankful for all the work that was done.