Age of Consent/Parent Involvement Workgroup – Recommendations

1. Age of consent in Washington State for mental health and substance use treatment remains 13, at which age a youth ages 13-17 may request mental health or substance use treatment without their parent's consent (i.e. Minor Initiated Treatment).

2. For minor initiated treatment, parent initiated treatment and/or involuntary treatment, a treatment provider is allowed to share the following clinical mental health information without the consent of the minor, subject to the professional provider's determination that the sharing of this information would not be detrimental to the youth:
    a. Diagnosis
    b. Treatment plan and progress in treatment
    c. Recommended medications, including risks/benefits, side effects, typical efficacy, dose and schedule
    d. Psychoeducation about the minor's mental health or substance use condition
    e. Referrals to community resources
    f. Coaching on parenting or behavioral management strategies
    g. Crisis prevention planning and safety planning

    We would like the above recommendation regarding limited release of information without minor consent to include substance use evaluation and treatment, however, are aware that 42 CFR does not allow this currently.

3. When a parent has initiated care, the parent may authorize limited release of information to a **step-parent that is actively involved in caring for the youth,** even if the minor does not consent. Information may be released subject to the professional provider's determination that it is in the best interest of the youth.

4. If a provider feels that the limited release of information would be detrimental to the youth and declines to release information, the reasons for this decision must be documented in the medical record.

5. Either a minor or a parent is allowed to authorize release of mental health treatment records to a current treatment provider or to a potential treatment provider for the purpose of facilitating referrals for additional mental health or substance use treatment services, unless the treatment provider believes that the release of information would be detrimental to the youth.
    a. All efforts should be made for this release of information to be jointly agreed upon by the minor and parent.
    b. If the treatment provider declines to allow release of information the reasons for this decision must be documented in the medical record.
    c. Treatment records **may not** be released for a referral to conversion therapy.

6. If a child is in foster care and a DCYF social worker has initiated care, the social worker may authorize a limited release of information to a foster parent that is caring for the youth, even if the minor does not consent. Information may be released subject to the professional team's determination that it is in the best interest of the youth.

7. For the purposes of parent initiated treatment, the definition of "parent" can include a relative who has signed a Kinship Caregiver's Declaration of Responsibility for a Minor's Health Care (per RCW 7.70.065).

8. If parents are separated or divorced and are both actively involved with the minor's care, it is best practice to obtain information from both parents and involve both in care, unless it is determined that such involvement would be detrimental to the youth (and documented in the medical record). It is recommended that providers request a copy of the parenting plan if there are custody related concerns.

9. A minor or parent/legal guardian of a minor child shall have no cause of action against an individual or agency provider of inpatient or outpatient mental health treatment or substance use disorder treatment for the following:
    a. Releasing limited information to parent without minor consent, if it is determined by the treating provider that the release of information would not be detrimental to the youth.
    b. Declining to release limited information to a parent, if it is determined by the treating provider that the release of information would be detrimental to the youth.
    c. Declining to treat a minor under outpatient parent initiated treatment at any point in the treatment process. It is recognized that not all mental health or substance use providers have training or expertise to work with all youth

10. Mental health treatment to minors under age 18 can only be provided by a licensed mental health provider (psychologist, psychiatrist, psychiatric nurse practitioner, social worker, marriage and family therapist, mental health counselor, chemical dependency professional, physician, physician assistant, nurse practitioner) or a provider that provides care through a licensed community mental health agency, under the direct supervision of a licensed mental health provider or an associate level mental health or chemical dependency provider who is working under the direct supervision of a licensed mental health or certified chemical dependency provider.

11. Revise RCW 71.34.510 to say "The administrator of the treatment facility shall provide notice to the **parent/legal guardian/kinship caregiver** of a minor when the minor is voluntarily admitted to inpatient treatment under RCW 71.34.500."

12. A parent/legal guardian/kinship caregiver may access medically necessary routine outpatient mental health and substance use treatment for youth ages 13-17 without the specific consent of the minor, for up to 12 sessions, up to a 3 month period with clinician discretion, to give the minor an opportunity to engage.
    a. If the youth is not willing to engage with the current treatment provider after this period, this treatment episode can be discontinued. The parent is then allowed to access treatment with another provider on behalf of the youth for another episode of treatment.
    b. If the youth is able to engage with the provider, then the youth will sign the consent to authorize treatment, and will no longer be under parent accessed treatment.

13. A parent/legal guardian/kinship caregiver may authorize medically necessary mental health and substance use intensive outpatient, partial hospitalization, and/or residential (AKA long-term inpatient) treatment at a facility licensed with the Washington State Department of Health, without the minor's consent. There should be a treatment review at least every 30 days with the youth, parents and treatment team to determine whether continued care is necessary. A discharge meeting with recommendations should be provided at the end of treatment.

    The facility providing the treatment will provide notification of admission to an independent reviewer at HCA/DBHR within 24 hours of admission. Independent clinical review will occur if the youth remains in care after the initial 45 days and every 45 days thereafter. *Clinical standards for independent HCA/DBHR review will be developed.*

14. A parent/legal guardian/kinship caregiver may request to have a Voluntary CLIP application submitted without the minor's consent. All CLIP applications require review by the CLIP committee and CLIP Administration Office to ensure admission and certification requirements are met. We recommend the Children's Mental Health Workgroup considers how to expand the CLIP resource to better meet the needs of Washington State youth.

15. A parent/legal guardian/kinship caregiver may access Wraparound with Intensive Services (WISe) on behalf of a youth and family, without the minor's specific consent, as long as the youth is eligible for the service, and the service remains available in Washington State.

16. It is recommended that HCA/DBHR develop a free online training regarding Washington State Law and best practices when working with children, youth, and families. The training should be required prior to initial licensure and upon licensure renewal. The training curriculum should be developed by a workgroup composed of clinicians, youth, parents, hospital providers, and DBHR staff. Potential topics could include: confidentiality, focus on family centered care, guidelines regarding release of information, community resources, engaging families in crisis prevention planning, etc.

17. It is recommended that HCA/DBHR create and send out a survey on an annual basis for the first three years after the above recommendations have been implemented, to youth, family, clinicians, and hospitals to determine impact of the changes. The survey should be sent to a representative sample of youth and families to ensure appropriate voice of experiences. Results of the survey should be reviewed by HCA/DBHR Child, Youth and Family Behavioral Health Team, and shared with appropriate community groups and providers such as FYSPRT and hospitals treating youth. It is also recommended that an additional workgroup develop metrics to determine impact of the recommendations, in particular on youth engagement and family involvement.

18. It is recommended that the Children's Mental Health Workgroup consider whether language changes to current RCW 71.34 to decrease stigma currently associated with the words "parent initiated treatment". It is important to ensure that youth understand they can still initiate treatment without parent involvement or consent, while promoting greater awareness that parents can access treatment for youth, even if they are not willing to consent. Some suggestions to consider include:
    a. Changing the header for 71.34 could be Adolescent Behavioral Health Treatment Access
    b. Using the terms Unaccompanied youth instead of minor initiated treatment and Parent accompanied youth instead of parent initiated treatment.
    c. Using the terms Youth accessed treatment instead of minor initiated treatment and Family Accessed Treatment instead of parent initiated treatment.

BEST PRACTICE/TRAINING IDEAS:

Confidentiality/Sharing of Information:

- A treating provider is allowed to talk with a parent and obtain clinical information from the parent without signed consent from the minor. Information that a parent shares with a provider does not have to be released to the minor – the provider can keep parent information confidential from the minor.

- Training for providers that the sharing of limited information that is allowed, does not compromise overall confidentiality for the youth.

Parent/Family Involvement:

- At intake, inquire about what are the barriers to involving your parents in treatment instead of "do you want to involve your parents in treatment".

- Providers should make efforts to engage the youth and parent in the development of the treatment plan to address unique youth, parent and family needs.