Age of Consent/Parent Involvement Workgroup – Ideas Under Consideration
Working Document- Parent Initiated Treatment Stakeholder Advisory Group

Items where the workgroup has consensus thus far:

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

2. Parents also have the authority to request mental health and substance abuse treatment for a youth ages 13-17 (under current Parent Initiated Treatment law).
    a. Proposal to expand the scope of the PIT law to include medically necessary outpatient treatment (beyond current scope of current law that limits outpatient PIT to evaluation only).
    b. Proposal to expand the scope of the PIT law to include medically necessary partial hospitalization, intensive outpatient program, residential (AKA long-term intensive treatment), and/or Voluntary CLIP treatment.

3. Add language in minor initiated treatment, parent initiated treatment and involuntary treatment that the treatment team may share the following clinical information without the consent of the minor.

    PROPOSED LANGUAGE (from prior workgroup meeting):

    1) The professional team treating the minor may share the following information about the minor with the parent or guardian who authorized treatment, even if the minor does not consent to the release of this information:
        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 abuse condition
        e) Referrals to community resources
    2) The above information may be released to the parent or guardian, subject to the professional team's determination that it is in the best interest of the patient.

4. Either a minor or a parent can authorize release of 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.

5. 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) or a provider that provides care through a licensed community mental health agency, under the direct supervision of a licensed mental health provider.

6. No provider is required to accept a patient into treatment under parent initiated treatment.
   a. Providers are able to decline to treat for clinical reasons or because they do not treat youth in their practice.
   b. If a provider is not able or willing to treat the patient, it is expected that the provider will offer the parent referrals to other community mental health centers or licensed independent practitioners.

7. A parent of a minor child shall have no cause of action against a provider of outpatient mental health treatment or outpatient substance use disorder treatment for declining to treat a patient under parent initiated treatment at any point in the treatment process. It is recognized that not all mental health or substance abuse providers have training or expertise to work with all youth.

8. Do not authorize disclosure to the parent of information relating to the substance use disorder treatment of a child to the extent that this disclosure is prohibited under federal law. NEED MORE INFORMATION ON 42 CFR limits.

9. 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).

Items requiring further discussion due to the group not having consensus or insufficient time to discuss:

1. Consider new language to describe minor initiated or parent initiated treatment. Parents are sharing that the term "parent initiated" has become stigmatizing from a parent/family perspective. Consider language relating to minor or parent being able to access care.

2. Consider if language for minor initiated treatment should include: "If, in the opinion of the licensed behavioral health professional, the minor is mature enough to participate intelligently in the mental health treatment or counseling services."

3. Consider if language for minor initiated treatment should include "If a child who seek care without a parent's consent, the treatment provider must involve the parent in the treatment plan or document why that is not in the child's best interests." (i.e. the Hawaii model).

4. Consider if minor initiated treatment without parent involvement or consent requires new funding opportunities – if we are going to add a clause about parent not being responsible for cost of treatment (i.e. the Hawaii model).

5. External oversight for parent initiated treatment:

    a. Do we keep current DSHS review for inpatient treatment under PIT as it is currently written? Modify? Or remove?

    b. If we expand to additional intensive treatments such as partial hospitalization, intensive outpatient program, and residential (AKA long-term inpatient) do we add a DSHS review for these services also, or leave this to the treatment team to decide (along with payer input on medical necessity).

    c. Do we need any oversight or limits for outpatient parent initiated treatment other than what is recommended by the evaluating and treatment provider. In the prior meeting we had set some time limits (i.e. 180 days) but no external review. *NOTE: external review could be very challenging to implement due to potential volumes.*

6. Do we add in language about medication and whether parent consent is required, or only minor consent is required. If parent consent is not required, would expect to involve parents in the decision making process. *Need more input from prescribing providers on current practice.*

7. Neither child nor parent may abrogate (maybe use revoke?) the other's consent (except in the case of medications the child must consent).

8. Consider changing the minor initiated treatment law to hospitals only being required to notify the custodial parent(s) or parent(s) with medical decision making. Currently the law says "parents" and hospitals end up notifying parents that aren't involved in their youth's care and this can be traumatizing for the youth.

9. When a parent has initiated care, the parent may authorize release of information to step-parent that is involved in 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 patient.

10. When a caseworker has initiated care, the case worker may authorize release of information to a foster parent that has been 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 patient.