Date: 5/21/18

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.	
(1) Welcome	**Lead: Blake Ellison & Paul Davis**
• Settle in • Introduction of new participants • Opening remarks	Attendees: Amanda Lewis, Mandy Huber, Blake Ellison, LaRessa Fourre, Lisa Daniels, Kathy Brewer, Kevin Black, Patty King, Liz Venuto, Lois Williams, Brad Forbes, Melanie Smith, Chelene Whitecar, Luke Wickham, Dawn Eychener, Chris Blake, Liz Trautman, George Petzinger, Paul Davis, Sheena Tomar, Eric Kiffe, Judy Hooyen, Carrie Waterland, Peggy Dolane, Tim Shields, Rep. Noel Frame, Laurie Lippold, Christy Peters, Gina Cumbo, Leila Curtis
(2) Legal History: Age of Consent, Becca Laws, and Parent-Initiated Treatment (PIT)	**Lead: Kevin Black**
• Parent Initiated Treatment • Becca Laws • CHINS • Minor Initiated Treatment, • Age of consent, and why 13 is the age of consent	Kevin Black, Legal History: Age of Majority Age of Consent, and Parent Initiated Treatment. Kevin searched in the Archives to find old bills, etc., to try to answer the question of how we got to the current understanding of PIT. Defined: • Age of Majority • Age of Consent (behavioral health) • Minor initiated treatment • Parent Initiated treatment (exceptional procedure since 1995 or 1998) without invoking voluntary treatment options • Voluntary or involuntary status trigger due process rights • Federal Law defers to state law

	Age of Majority a look back: • 1854 adopted age of majority • Males age 21, females age of 18, females married become full age of majority. Recodified 1923 age of majority fixed at 21 for both male and female. • 1971 formally changed to 18 for male and female and has not changed since. • 1969, an exception made. Now age 14 is designated as the age of consent for sharing diagnoses of STD (this is separate- not linked to 1975 reproductive healthcare changes done by courts). • 1950's Behavioral Health Mental Health Hospitalization Act in 1951 allowed parents to sign a child into care (unless the youth turned 18) at Western, Eastern and Northern State Hospitals. This evolved some years later into our behavioral health age of consent law. • 1973- ITA process County Mental Health Evaluations began. • 1974 first Minor Consent and commitment was changed from only state hospitals to now include private settings. You can admit your child only if the child also gives consent. • 1985 Age of Consent law was finally formed- Phil Talmage WSSB 3099 (1985) SUD fairly similar merged with mental health in 2016 **Q: Why couldn't parents admit their child into substance use disorder treatment prior to April 1, 2018? That is when they were given the ability to consent, which gives them the ability to decline. Prior to April 1, parent could admit their child to inpatient substance use treatment, and the youth should not have been able to decline but that was not community practice.** **R:** Age of consent has been on the books for substance use since 1970. Parents have exceptions for medical procedures that are outside of the age of consent. With something like detox, it is unclear if that would fall under substance use intervention or medical intervention. **R:** DSHS materials- last meeting it was discussed that parents could consent unless the child filed a CHINS. Parents have the right to consent to their child's treatment unless there is a carve out (exceptional) **R:** Under 70.96 child could consent to outpatient but not inpatient. The issue Peggy is trying to get to is the "Child could not consent to inpatient"- parents could but not the practice of the community. With the integration of MH/SUD, parent and/or child can consent to inpatient but there is a lack of access to inpatient facilities/providers to provide the service. The question moving forward is, "what can we do to resolve this now?", and that is the work of this committee.

	Resume Presentation: • Sometime after 1985 dissention around the age of consent had risen and many bills were written to address it that did not get traction. <u>Becca Bill</u> • The Becca Bill was developed in 1994 by Senator Hargrove as a result of Rebecca Hedman's murder in 1993. This allowed parents to voluntarily admit a minor for inpatient mental health treatment without the consent of their child. This bill led to the creation of At-Risk Youth (ARY) Petition and Child In Need Of Services (CHINS) petition processes that focusses on runaway and truant youth. • In 1996 the State vs Fairfax Hospital challenged the age of consent law and the Becca bill was struck down for various reasons, including being overall confusing to interpret. Appellate Court Ruled in favor of the plaintiff. Justice Sanders questions whether a child could be incarcerated in a hospital without the child's consent and without a court process. • In 1997 it was reformulated and created Parent Initiated Treatment. Vetoed by Gov. Locke. • In 1998 the current Parent Initiated Treatment bill passed, SSB 6208, and sustained a partial veto. • The provider community failed to implement the bill consistently, and in some cases not at all. • 2011 Substitute SB 5187 Inform parents and document doing so of all available options. • 2017 substitute expansion of substitute SB 5706 • 2018 E2 SHB 2779 **Q: Is there any record of outpatient parent initiated treatment**? **R:** None known of, but there is a statute with a provision for parent initiated treatment for outpatient. There are no records but that does not mean it hasn't happened.

	Q: Is Washington the only state that has PIT? **R:** There is research to see what 50 states are doing in regards to Age of Consent and PIT. There was a lot more variation in other states than he expected to find. Washington State did not follow a model from another state. There is more research to be done in this area. **Q: Have there been any other studies done exploring the differences between types of admissions? Outcome-based studies or other types?** **R:** While there may be concerns about PIT, it is hard to study. One reason is that there are capacity challenges. Another issue is that the law refers to E&T centers and not emergency rooms. There is PIT for Outpatient, however, its unknown if it's being used. Parents can have their child evaluated for outpatient treatment. Seattle Children's Hospital has very rarely used that for outpatient treatment because language in the law stops at evaluation and doesn't go into treatment. Parent reported accessing outpatient PIT with Ryther. One of the advantages was not to have to get an ROI to make the appointment. The consent process was done well and facilitated engagement. Would like to see a system where things can be addressed before the child or youth is suicidal in an emergency room. **At the outpatient level, clinicians need to consider how the parent should be involved and what message is being sent to the youth regarding that. It can damage the relationship.** **Q: What role does insurance play in Parent Initiated Treatment?** **R:** Statute does not discuss insurer's role in PIT. Payers have no obligation to pay and it's based on medical necessity. Ex. In 2017, King County Medicaid would give a 3 day authorization period, but then moved to 5 days. North Sound and Great Rivers are doing a 24 hour holds for evaluation. Certain BHOs are trying to reduce timeframes again. The insurer can also decide if the youth should be there at the end of the stay and can retroactively deny the service. Disincentive for providers when there is a review done at the back end of the process. PIT and voluntary treatment both work this way. Time frames on PIT statute is up to a 12 hour hold.
(3) P.I.T. and Children's Long Term Inpatient (CLIP)	**Lead: Lisa Daniels & LaRessa Fourre**

• State-Overview • PIT Process • Statewide PIT Data	<u>Overview of Parent Initiated Treatment Presentation</u>: Please refer to PowerPoint if needed. • 71.34.610 doesn't happen that often that medical necessity is not met. Whether or not a youth met medical necessity for CLIP started being tracked about a month and half ago. Since then there have been two cases where medical necessity has not been met. PIT flow chart was presented to show decision points and lengths of time for the PIT Process. See PP. Data Charts: PIT Admissions & Reviews from 2005-2017. They demonstrate the increase in PIT use. **Q: Is there data on what happens to youth that don't stay long enough for review process?** **R:** Data is not collected by the state. Hospitals are tracking Length of Stay. **Q: Medical Necessity: how sick does one have to be to be admitted?** **R:** It is not generally understood how high the bar is for Medical necessity**.** **Q: Has the definition of Medical Necessity changed recently?** **R:** No, however there are differences of opinion/perception that affects the determination. Providers are not always making the decision. Insurance companies can make or deny the determination as well. Lack of capacity is also an issue. Healthcare is a supply and demand effect and "we" have decided that hospitals are for the most sick. The definition of medication necessity is: Danger to self/danger to others and gravely disabled. Unfortunately, it is a statement in the law and not an equation. Medical necessity is difficult to define. **Q: Do we have numbers of comparing outpatient (continuum) how great of penetration is the market and how far off are we?** I.e. With youth under 18, how many are accessing WISe? How many are accessing outpatient treatment? How many are getting admitted to CLIP (based on the estimation of 1 in 5 have a disorder)**?** **R:** Need for data in this area**.**

	Q: For kids served in CLIP, is there a sense of how many are voluntary or ITA? **R:** CLIP office tracks this data and can provide data to workgroup. PIT is primarily used for Acute Care. **Q: Can a Kinship caregiver with a 3rd party custody initiate PIT?** **R.** Yes. 3rd party custody is legal custody and custodian can consent to PIT. Guardianship-most often for adults, is different than legal guardian and excludes mental health **(needs more research)**. Same with Power of Attorney. **Q. Is PIT a less restrictive option than ITA?** King County Designated Crisis Responders (DCRs), (formerly DMHPs) have stated that it is considered less restrictive. **Comments:** When a child/youth is on an ITA "you are taking someone's civil rights away and it is legally documented so in the future, one could be negatively impacted" (ex. if trying to get into the military). Others echo this question to be answered. Ex. In Yakima you cannot get a voluntary admission without a DCR evaluation **(reportedly a rule from the BHO?**). Some regions will not allow a youth to enter treatment through PIT once a DCR becomes involved. It limits them to voluntary treatment or ITA. Historically in at least one region, some DMHP's that were covering for the hospital overnight could either do voluntary or ITA. DCR's are used differently across the state and understanding of PIT varies. **There is inconsistency with implementation of PIT and access to services across the state.**
(4)	**Lead: Kathy Brewer**
• Children's Hospital Presentation	Please Refer to PowerPoint Presentation. • A bill passed to allow video conferencing for ITA/mental health court there are differences between youth and adults. SB 6124

	Q. Do we have an age range of children whose parents are using PIT? **R:** Dates of birth are tracked but have not been broken down to determine average age. **Discussion Point:** LRO option is not available through PIT like it is for ITA **(explore further if this can become an option)**. There was discussion about using the At-Risk Youth Petition as a method of structure commitments after discharge. The challenge is that if commitments are not met, the individual will become court involved rather than receiving treatment. Recommendation to explore Assisted Outpatient Treatment laws. HB 6149- does this include youth or just adults? If it does include youth, are there places that provide day program and partial hospitalization? Are they able to bill for services? AOT is more relaxed than ITA. **Q: If a child is refusing medication, can a court order be used to compel medication?** **R:** Yes, with involuntary treatment. **Q: What about ROI's?** **R:** A parent challenged this and it was said that the type of treatment decides when a release of information is needed. Kathy will send the law the parent used to challenge, which triggered a response from Seattle Children's attorneys. Needs more exploration and clarity as to who has the authority to release records. 70.02.40. **Q. What would it take to involve a parent in treatment planning and decision making in an ITA admission?** **R:** It is unclear to providers and a liability concern. Some providers may feel that they can't include the parent/guardian in treatment planning and decision making. **Discussion Point:** Children's hospital is a high utilizer of PIT, but some other hospitals do not utilize it as often or as well. Parents are not aware that they need to use, or do not have access, to an E&T for evaluation. The same evaluation laws do not apply to emergency rooms (law states E&T and that's a barrier). More intermediate levels of care needed, such as partial hospitalization, assisted outpatient, residential treatment, are needed throughout the state. This will help serve youth not served well by CLIP, ex. Severe eating disorders. **Clarify if partial hospitalization for children is in the state plan (when was it removed if not?)**

	There is a list of recommendations at the end of Children's Hospital slides. Please review. **Q: Should outpatient PIT be monitored and if so, by who?** **R:** Too much for one person to monitor**.** Not answered. **This group may not be fixing the current PIT system. There may be a need to think about how to address things in a new way.** I.E. Keep an open mind that we may be able to not have a term Parent Initiated treatment, may flip it to Minor initiated treatment. Parents take their children to the doctor for other ailments and should include behavioral health without special consideration. Funding needed to increase consistent education across the state on PIT. Specific training to BHO contracted agencies, DCR's, ED personnel, and hospitals.
(5) Work Plan Discussion & Lead Assignment	**Lead: Blake Ellison & Paul Davis**
• Overview of Work Plan • Open to volunteers for each survey group	Surveys: **Review Survey Process for PIT worksheet:** It is recommended that **v**. Child Youth and Family System advocates be combined with **i.** Youth voice and **ii.** Parent/Family voice. After discussing the purpose of the survey questions and the overlaps between sections, the group determined that it would be best to not break off yet. The whole group would like to provide input on more than "one group" of survey questions. Can we look at other existing data such as the Healthy Youth Survey? It was mentioned that the legislature hears about barriers and what doesn't work. It was encouraged to use success stories from mental health counselors that work in schools, etc.
End Meeting.	