

Parent Initiated Treatment Stakeholder Advisory Workgroup

Report to Children's Mental Health Workgroup

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Executive Summary

Parent Initiated Treatment (PIT) is an admission pathway for minors in Washington State that currently includes inpatient (IP) hospitalization and outpatient (OP) evaluation and treatment services for both mental health and substance use disorders. The current law reads that “minors in need of mental health care and treatment receive an appropriate continuum of culturally relevant care and treatment, including prevention and early intervention, self-directed care, parent-directed care, and involuntary treatment” per [RCW 71.34.010](#). “Additionally, all mental health care and treatment providers shall assure that the minors’ parents are given an opportunity to participate in the treatment decisions for their minor children. The mental health care and treatment providers shall, to the extent possible, offer services that involve minors’ parents or family.” For age 13 and over, mental health care providers are required to protect the rights of minors while also assuring that minor’s parents and/or guardians are provided the opportunity to participate in treatment decisions for their children.

Parents in Washington State have openly discussed their struggles in accessing behavioral health treatment in state, with some eventually accessing treatment outside of the state for their youth, specifically for substance use disorders. Parents are particularly concerned with the age of consent for behavioral health treatment beginning at 13 years of age. Conversely, youth and youth advocates have spoken about the need to continue to have age of consent protections in place so that youth can access treatment on their own in situations where it may be detrimental to them if their parent or guardian were to know or be included in their treatment.

This project, directed by 2017-18 [HB 2779](#) part 9, directly reviewed the current PIT process while exploring the challenges with the age of consent for parent directed behavioral health treatment. The stakeholder workgroup (from here forward referenced as “the group”) also explored ways for added parental involvement in treatment planning and decisions, as well as more clearly defined medical necessity for emergency behavioral health care and the exploration of the use of PIT for Commercially Sexually Exploited Children (CSEC). The Department of Social Health Services (DSHS), now Health Care Authority/Division of Behavioral Health and Recovery (HCA/DBHR), must submit a report of findings and recommendations from the group to the Washington State Children’s Mental Health Workgroup by December 1, 2018.

The project had three main stakeholder components: in person meetings, statewide community survey, and feedback from regional Family Youth System Partnership Round Tables (FYSPRTs). Stakeholder participation included individuals from varying mental health and substance use disorder state and behavioral health agencies, hospitals, associations, and youth and parent advocates. Twenty-one Parent Initiated Treatment Stakeholder Workgroup meetings, including two separate survey calls, took place April through October 2018. Meetings consisted of three breakout workgroups, one to focus on Age of Consent/Parental Involvement, another for Admission Practices in terms of Medical Necessity, and lastly, exploration of service options; including PIT and Involuntary Treatment Act (ITA) for Commercially Sexually Exploited Children (CSEC), as well as full workgroup meetings. Participants were invited to all meetings and new participants were welcomed throughout the project. The

Community Survey questions were developed by stakeholder representatives in the workgroup and nearly 700 individuals responded in some fashion. Community feedback requests on PIT/Age of Consent (AOC) recommendation drafts were conducted in order to gain additional feedback from regions across the state through the Family Youth System Partner Roundtables (FYSPRTs). Washington State [FYSPRTs](#) provide a forum for families, youth, systems, and communities to strengthen sustainable resources by providing community-based approaches to address the individual behavioral health needs of children, youth and families. The comprehensive discussions, survey results, and community outreach during the project informed the recommendations in this report.

Recommendation Highlights (Full recommendations begin on page: 8)

- **Around Age of Consent:**

The group considered another state model that if adopted would change age of consent. To help think through the impact of a change like this, one of the nine Educational Service Districts (ESDs) in Washington State was invited to share information about their school-based behavioral health services and report the impact in their services with a change in the age of consent.

For children under 13, referrals for school-based behavioral health services are initiated by the school. Schools are often the first to bring up the idea of behavioral health services to families. It takes time to engage families in the discussion and gaining consent for treatment can take several weeks to months. For youth over 13, access to behavioral health services generally take place the same day, or shortly after. Youth are able to initiate and consent to behavioral health treatment on their own, without their parent/guardian's consent or involvement with the expectation the family is brought into service coordination when/if the youth is ready. In response to the impact of a change in age of consent, it is expected that for those over 13, there would be a decrease to access and a delay in services. Due to wanting to maintain access for youth seeking services, the group decided to address changing the existing language in the PIT law, instead of a change in the age of consent.

As a result of this conversation, among others, the group reached consensus for the age of consent for behavioral health services to remain at 13 years of age, and focus on the need for addressing the portions of PIT that aren't working for parents while ensuring youth in need of access have it without barriers.

Additional Recommendation Highlights: (Full recommendations begin on page 8)

- Treatment providers for minor-initiated, parent initiated, and involuntary treatment of minors be able to share a limited amount of basic information without the consent of the minor for both inpatient and outpatient treatment at the discretion of the clinician.
- Allow individuals, in addition to a parent, to file a PIT.
- Only licensed mental health professionals are to provide treatment.

- Additional funding access, including a possible increase in the Medicaid rate, and strengthening safeguards in place for hospitals and Evaluation and Treatment (E&Ts) Centers to encourage the provision of PIT within their service array.
- Indications of a youth being commercially and sexually exploited, in and of itself, should not be the sole qualifier for the use of PIT. However, PIT should be explored if the youth is confirmed to be experiencing sexual exploitation and experiencing BH issues, is determined to be a danger to self or others, or gravely disabled.
- A variety of service options should be available for CSEC youth including secure detox, psychiatric facilities, receiving centers, outpatient treatment, and any Least Restrictive Alternatives (LRAs).
- Training to be developed and offered for treatment providers regarding Washington State Law and best practices when working with children, youth, and families.

Project Summary and Recommendations

During the 2018 legislative session, the Washington State Legislature passed [House Bill 2779](#) part 9, which tasked the Department of Social and Health Services (DSHS) with convening an advisory group of stakeholders to review the Parent Initiated Treatment process and develop recommendations in several areas. The DSHS/Division of Behavioral Health and Recovery (DBHR) Child, Youth, and Family Team convened this PIT Stakeholder Advisory Workgroup (referenced in this report as “the group”). The group developed recommendations regarding the age of consent for the behavioral health treatment of minors; which includes mental health and substance use disorders. The group developed options to include parental involvement in treatment decisions, recommended specific information that should be communicated to families and providers regarding the PIT process, gained further understanding of how medical necessity for emergency BH services is defined, and considered options for parental involvement in those determinations. The group also explored and developed recommendations for how to best serve Commercially Sexually Exploited Children (CSEC) using PIT, Involuntary Treatment Act (ITA), and other treatment services.

The group was organized into three breakout workgroups; Age of Consent/Parental Involvement, Admission Practices (medical necessity), and CSEC. In regards to defining medical necessity, it was decided to focus on **admission practices** for emergency Behavioral Healthcare. Stakeholders volunteered to be leads for the above noted subgroups. Leads facilitated the breakout groups throughout the project. HCA/DBHR supported facilitation, and scheduled and organized the group’s meetings. PIT stakeholder meetings were routinely held in the Lacey DBHR office, and remote access was offered to any participants who wanted to dial-in to participate in meetings. One CSEC meeting took place in Seattle at Partners for Our Children. Full stakeholder meetings included presentations from subject matter experts from DBHR regarding age of consent and the PIT Process. A presentation was given by Kevin Black, Senate Committee Services, regarding the legal history of age of consent, Becca Laws, and PIT. Other presentations were provided to the group by Kathy Brewer with Seattle Children’s Hospital, LaRessa Fourre and Lisa Daniels with Health Care Authority’s CLIP Administration,

and individuals with Educational Service District 113, in combination with Office of Superintendent of Public Instruction regarding school-based mental health and substance use disorder services in relation to the age of consent. Progress and updates on the subgroups were provided to the larger group during full advisory meetings. The full group meetings also discussed project timelines, agenda building, and progress toward recommendations with consensus. Stakeholders chose which subgroups to participate in. Some stakeholders participated in all or most of the subgroup and full group meetings.

Stakeholder participants generally fell into five groups; Youth, Parents, Clinicians, Hospitals/ Emergency Departments, and Child System Advocates. The five participant groups included those from various organizations:

- Seattle Children's Hospital (SCH)
- Office of the Insurance Commissioner (OIC)
- Washington State Hospital Association (WSHA)
- Tacoma General Hospital
- The Mockingbird Society
- National Alliance on Mental Illness (NAMI)
- Senate Committee Services (SCS)
- Washington House of Representatives
- Children's Long Term Inpatient (CLIP) Administration Office
- Thurston County Prosecuting Attorney Office
- A Way Home Washington (AWHWA)
- Partners for Our Children (POC)
- Behavioral Health Organizations (BHOs)
- Comprehensive Healthcare-Two Rivers Landing
- Washington State Society for Clinical Social Work (WSSCSW)
- House Democratic Caucus
- Excelsior Youth Center
- Committee for Children
- Center for Children & Youth Justice
- Office of Superintendent of Public Instruction (OSPI)
- Apex Foundation
- Youth Sound, Washington State Community Connectors (WSCC)
- Educational Service Districts (ESD 113)
- Association of Washington Healthcare Plans (AWHP)
- Department of Children, Youth, and Families (DCYF)
- HCA/DBHR Child, Youth, and Family Team program administrators
- Parent advocates
- Youth Advocates

Many of these stakeholder organizations and individuals participated regularly in the breakout focus groups and full group meetings. There were multiple reach-outs to parents, youth, advocates, and other interested parties throughout the entire project. Stakeholders personally reached out to individuals and organizations and HCA/DBHR sent regular calendar invites to any interested stakeholders. Throughout the project, additional interested stakeholders were added to the meeting invite list. The PIT Stakeholder Advisory Workgroup was always open to anyone interested in attending and providing insight and feedback.

Age of Consent/Parental Involvement, Admission Practices (medical necessity), and CSEC stakeholder meetings took place from April through October 2018. Meetings took place on April 24th, May 21st, June 11th, July 16th, July 19th, August 2nd, August 10th, August 24th, September 11th, September 27th, October 2nd, October 12th, and the final meeting on October 15th. On some dates, multiple subgroup meetings took place, in addition to a full stakeholder meeting.

An age of consent and school based behavioral health services conversation was conducted by the group. The group considered another model from Illinois that if adopted would change age of consent, and create allowances for a specific number of services the youth could initiate before the provider would be required to connect with the youth's parents. To help think through the impact of a change like this, one of the nine Educational Service Districts (ESDs) in Washington State was invited to share information about their school-based behavioral health services and report the impact in their services with a change in the age of consent.

Capitol Region ESD 113 provided information on the five county region they serve for substance use disorder, mental health and co-occurring services for K-12. ESD 113 currently employs counselors/therapists to provide behavioral health services through a certified behavioral health provider, True North. ESD 113 shared their perception of how services in schools in their region are accessed and potential impacts to changing the age of consent on their work. ESD 113 was clear, schools and ESDs are not all the same in what services they provide from region to region.

For children under 13, referrals for school-based behavioral health services are initiated by the school. Schools are often the first to bring up the idea of behavioral health services to families. It takes time to engage families in the discussion and gaining consent for treatment can take several weeks to months. For youth over 13, access to behavioral health services generally take place the same day, or shortly after. Youth are able to initiate and consent to behavioral health treatment on their own, without their parent/guardian's consent or involvement with the expectation the family is brought into service coordination when/if the youth is ready. In response to the impact of a change in age of consent, it is expected that for those over 13, there would be a decrease to access and a delay in services.

As a result of this conversation, among others, the group reached consensus for the age of consent for behavioral health services to remain at 13 years of age, and focus on the need for addressing the portions of PIT that aren't working for parents while ensuring youth in need can access services without barriers. As much as the group wanted to incorporate a PIT process for both mental health and substance use disorders, the federal confidentiality laws around substance use disorder services are too stringent to allow for some of the recommendations below to be applied to the PIT process for substance use disorders. For this reason the following recommendations are for the Mental Health System. In the event that federal law allows, the group recommends the PIT process include substance use disorders.

Recommendations

In order to develop clear recommendations, three subgroups were formed to focus on Age of Consent/Parental Involvement, Admission Practices (medical necessity), and exploration of how to best serve Commercially Sexually Exploited Children (CSEC) through the use of PIT, and for CSEC specifically, also looking at Involuntary Treatment Act (ITA), or other services. The following recommendations achieved consensus and are broken out by each of the three subgroups.

The following are recommendations for changing existing law, implementing system adjustments, and the addition of training.

- **Recommendations for Age of Consent/Parent Involvement Workgroup**

Age of consent for the behavioral health treatment of a minor:

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

Options for parental involvement in youth treatment decisions:

1. For parent initiated treatment, involuntary treatment, or minor initiated treatment where a parent/legal guardian, kinship caregiver is actively involved, a treatment provider is allowed to share the following clinical mental health information with the parent/legal guardian/kinship caregiver without the consent of the minor, subject to the professional provider's determination that the sharing of this "limited release of 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.

The youth must be informed of the decision to release the “limited release of information” and have opportunity to express any concerns about the release. Any objections by the youth will be documented in the medical record in the event that the provider makes the decision to release the records despite the youth’s expressed concerns.

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.

NOTE: We would like the above recommendation regarding limited release of information without minor consent to include substance use evaluation and treatment, if this is possible and remains compliant with 42 CFR part 2.

NOTE: We would like legal consultation to confirm that the sharing of this “limited release of information” without minor consent is compliant with HIPAA.

2. When a parent has initiated care, the parent may authorize the “limited release of information” as defined in item #1 to a **step-parent who is actively involved in caring for the youth**, even if the minor does not consent. Information about the youth’s care may be released subject to the professional provider’s determination that it is in the best interest of the youth.
3. 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 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.

NOTE: We would like the above recommendation regarding release of information to current treatment provider or potential treatment provider for the purpose of facilitating referrals without minor consent to include substance use evaluation and treatment, if this is possible and remains compliant with 42 CFR.

4. If a child is in foster care with a shelter care or dependency court order in place, and a Department of Children, Youth, and Families (DCYF) social worker has initiated care, the social worker may authorize a limited release of information to a foster parent/relative/fictive kinship caregiver who

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.

5. 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](#)).
6. 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 who 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.
7. 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, and/or 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 by the youth. 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.
8. 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 (DOH) 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.*

NOTE: Additional resources will be needed to expand HCA/DBHR review for these admissions.

9. A parent/legal guardian/kinship caregiver may request to have a Voluntary Children's Long Term Inpatient (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. The group recommends the Children's Mental Health Workgroup consider how to expand the CLIP resource to better meet the needs of Washington State youth.
10. 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.

Information communicated to families and providers about the parent-initiated treatment process:

11. 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 the minor's 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.
12. 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](#)."
13. It is recommended that the Children's Mental Health Workgroup consider 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 the youth is not willing to consent. Some suggestions to consider include:
 - a. Changing the header for RCW 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.

Recommendations for Provider Training and Evaluation:

14. It is recommended that HCA/DBHR develop a free online training for providers regarding Washington State law and best practices when working with children, youth, and families. The training would be recommended for all providers who work with youth and families. The training curriculum should be developed by a workgroup composed of clinicians, youth, parents, hospital providers, and HCA/DBHR staff. Potential topics could include:

Parent Initiated Treatment:

- Overview of the law and roles for parents, youth, providers, and hospitals.
- Clarification of Designated Crisis Responders' (DCRs) role in explaining PIT to families of youth they are evaluating who do not meet Involuntary Treatment Act (ITA) admission criteria.
- How to gather treatment history and address multiple episodes of unsuccessful treatment for youth and families.
- Clarification of PIT for Department of Child Youth and Families (DCYF) social workers and their role. 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 any barriers to involving the parents in treatment instead of asking “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.
- If parents are separated or divorced and are both actively involved with the minor’s care, it is best practice: (a) 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); (b) For providers to request a copy of the parenting plan if there are custody related concerns and; (c) For providers to obtain training on working with parents who have severe mental illness and are divorced or separated.
- Engaging families in crisis prevention planning and how to find appropriate community referrals.

Youth Involvement:

- Strategies to engage a reluctant youth in treatment.
- Youth engagement in release of information and determination of detriment to youth if records are released.

15. It is recommended that HCA/DBHR create and send out a survey on an annual basis to youth, family, clinicians, and hospitals to determine impact of the changes for the first three years after the above recommendations have been implemented. The survey should be sent to a representative sample of youth and families to ensure appropriate voice of experience. Several methods of obtaining information may be needed such as focus groups for youth in addition to a survey. 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 Family Youth System Partner Round Tables (FYSPRTs) 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.

- **Recommendations for Medical Necessity/Admission Practices Workgroup**

1. Recommend that funding be made available for additional services, such as transitional services after release from an in-hospital stay and development of facilities to offer such transitional services.
2. Recommend safeguards or other supports for hospitals and E&Ts that encourage, rather than discourage, the provision of PIT. How can hospitals be encouraged to offer PIT as an admission option? How can the current safeguards be strengthened for hospitals and Evaluation and Treatment Centers (E&Ts) to encourage them to consider offering PIT admissions?
3. Raising the Medicaid reimbursement rate for PIT should be considered and researched to understand if it would expand the number of hospitals who are willing to provide PIT beds and what the current impact is on Behavioral Health Organizations (BHOs) and Managed Care Organizations (MCOs) who are making up the gap between the Medicaid rate and what hospitals are currently charging for PIT beds.
4. An education and communication plan be developed so that hospitals, BHOs, MCOs and the same services areas are aware of what services are available for the population serviced by PIT, on an ongoing basis. In addition, a consistent way of making sure parents and guardians are aware of what services are available in their area should be developed (web pages, materials for organizations that interact with parents, etc.).

- **Recommendations for Commercially Sexually Exploited Children (CSEC) Workgroup**

1. We should not make indications of CSEC a stand-alone qualifier for PIT for both outpatient and inpatient. Factors such as the child demonstrating acute symptoms that are endangering themselves and/or others, family stability, as well as whether the child/youth also has a mental health or substance use disorder diagnosis, should be taken into consideration when determining whether PIT or another approach would be the most appropriate intervention.

While signs of CSEC should not be the qualifying standard for a PIT admission, it should be an option if the youth is confirmed CSEC and is at-risk of danger to self or others.

Further, as options for admitting via a PIT are explored, it is essential to be mindful of payment mechanisms. The diagnosis/criteria for PIT admission needs to allow for payment under the existing structure or a new payment structure would need to be established.

2. A variety of service options should be available for CSEC, such as secure detox, receiving care (under the work of the Safe Harbors group), psychiatric facilities, community based counseling and support services, Least Restrictive Alternative (LRA) type programs, and others. Safe, secure, therapeutic programs need to be available in communities.
3. It would be beneficial, however not mandatory, to have receiving centers in very close proximity to, perhaps co-located with, hospitals that are E&T centers (as long as that would not inhibit an engaging and therapeutic response).
4. While there wasn't unanimous consensus around this, the majority of those involved in the discussion agreed that the expansion of who can file a PIT on behalf of a child/youth should be very limited but at least include kinship caregivers. It should not include law enforcement or receiving care providers.

If the youth does not have a parent or kinship caregiver available, the appointment of a guardian should be explored. Additionally, attention needs to be paid to language and other barriers that might exist with respect to filing a PIT on behalf of a CSEC.

NOTE: Considerable work is underway through other organizations, coalitions, etc. It is not this stakeholder advisory group's intent to duplicate efforts but rather address the specific directive from the legislature per [HB2779](#) to determine the viability of using the PIT process for the CSEC population.

PIT Survey Development

The five participant groups that included the voices of youth, parents, hospitals/emergency departments, clinicians, and child system advocates were asked to provide feedback to inform the final recommendations contained within this report. The group developed survey questions for each of the system groups. Significant time was spent on survey development to ensure the survey results would advise recommendations regarding the tasks of the PIT Workgroup. There were survey calls outside of the in-person scheduled meetings to discuss survey questions and to aid in finalizing the questions. The questions were sent to Health Care Authority's (HCA) epidemiologist to provide feedback and edits to the questions. The survey was ultimately finalized by HCA staff and included feedback from key stakeholders: parents, youth advocates, hospitals, those representing clinicians, and other stakeholders. The survey was extended to many individuals including youth and parents who have experienced Parent Initiated and various behavioral health treatments, organizations who advocate for youth and families, hospitals and agencies who provide behavioral health treatment services, and youth state agency partners. The PIT survey was sent to stakeholder workgroup participants and shared widely.

The recommendations from the Age of Consent/Parental Involvement workgroup were sent out to the Family Youth System Partner Roundtables (FYSPRTs) in order to reach each region in Washington State. An HCA Parent Initiated Treatment email inbox was created in order to gather feedback from regional FYSPRT members. Feedback from the regional FYSPRTs was limited, but one of the larger counties in the state provided positive feedback and agreement with the recommendations moving forward.

PIT Survey Summary

September 2018

Not all survey respondents answered all questions. The survey contained "skip patterns," so respondents were only asked to provide answers to those questions that were relevant to them. In addition, some skipped over questions that were presented. The following table shows the minimum and maximum number of respondents in each of the survey categories:

Minimum and Maximum Number of Survey Respondents by Category

Respondent Category	Total	Minimum Respondents	Maximum Respondents
TOTAL	684	NA	NA
Youth	70	16	18
Parent / guardian	295	44	239
Clinician	221	104	202
Children's system advocate	84	38	57
Other	14	Not reported	Not reported

Parents/Guardians

- Approximately 30 percent of parent respondents (58) said they have chosen to send their youth out of state because they couldn't obtain services in Washington.
- Nearly 65 percent (132) said the level of service they received was less than required to address the needs of their youth. Nearly 20 percent (37) said lack of providers, and 15 percent (32) said cost kept them from wanting to seek treatment for their youth. Nearly 55 percent (37) said PIT did not connect their youth to the level of services needed.
- Roughly one-third each of parents / guardians were insured through Medicaid / public funding (30 percent), private insurance (25 percent), and employer-financed insurance (38 percent). More than a quarter of parents (62 of 234) said their youth had been denied services because they failed to consent and 36 percent (84) of parent respondents said they had chosen not to take their youth for treatment because they felt the youth would not consent.
- Nearly 90 percent of parents (184 and 183) thought providers should be required to share information about prescribed medication and diagnosis / treatment plan with parents. More than 50 percent (110 and 112) also thought providers should be required to share specific details about youths' behavior and drug / alcohol use history.
- Almost 60 percent of the parents (119) felt that age of consent laws had had a negative impact on their relationships with their youths. Only 5 percent (10) felt the laws had a positive impact. About 45 percent (92) also felt the age of consent laws had negatively impacted their relationships with their youth's therapists.

- About 1/3 of the parents (71) had pursued PIT for their youths. Ninety-five percent (63) said they were active in their youth's treatment processes. Nearly 65 percent (43) said their youth remained engaged in PIT. About 60 percent (40) said that PIT was "helpful." None of the parents said there were barriers in their treatment facilities that would have prevented them from admitting a minor under PIT.

Clinicians

- About 40 percent (78) of clinicians said they had no policy on family engagement when serving youth age 13-17. Most of the clinicians (75 percent or 115) estimated that 0 to 25 percent of youth would refuse to consent to including their parents / guardians in their treatment plans and information. Nearly 20 percent (27) said 26 to 50 percent of youth would refuse to include their parents. However, 75 percent (115) said the majority of youth allow full consent to their parents. Nearly 80 percent (121) said they continue to treat youth who refuse to consent to parental involvement. Only six (4 percent) said they had had insurance claims denied because the minor refused to share medical information with a parent.
- Clinicians were almost evenly split, around 25 percent each, regarding who had admitted youth to inpatient treatment when (1) the youth consented voluntarily, (2) PIT was used, (3) the Involuntary Treatment Act process, or (4) some other method was used.
- The modal (most frequent) number of clinicians (30) said their familiarity with PIT was a one on a scale of one to ten. The next most frequent response was eight (17 percent or 25). The remaining responses were distributed fairly evenly from a low of 4 percent at two to a high of 11 percent at nine and seven.
- Nearly 40 percent (57) had never informed parents about PIT, while 28 percent (43) had informed more than 10 parents.
- More than 80 percent (128) thought relatives and caregivers raising the youth should be able to file a PIT.
- More than 50 percent (82) thought the following were primary barriers to youth obtaining treatment: Lack of youth engagement, 50 percent (75); lack of parent engagement, 55 percent (83); and 43 percent (65) insurance.
- Most (77 percent or 118) did not believe that being commercially sexually exploited should be reason enough to be committed to inpatient.

Children's System Advocates

- Nearly 95 percent (54) of the children's system advocates said they were familiar with age of consent rules. Fifty percent (27) said youth and / or families would benefit from an increase to the age of consent, while 40 percent (55) said keep the age as it is.
- Nearly 90 percent (49) of the advocates also said that relatives / kinship caregivers should be able to file for PIT.
- Nearly 70 percent (38) said that being commercially sexually exploited was not reason enough to be committed to inpatient psychiatric through PIT.

Youth

- The youth questions received a maximum of 18 responses. One-third of the youth said that entering treatment was their own idea. More than 50 percent said their parents thought they should enter treatment; the remainder entered treatment because courts, schools, or friends recommended it. More than 60 percent of those who received treatment said they wanted their parents / caregivers to know.
- Sixteen of eighteen youth respondents rated confidentiality as 10 out of 10 in importance to them personally. The remaining youth rated confidentiality at eight and nine.

Hospital and Emergency Room Representatives

- Response rates in these categories were low, so no findings are reported.

Link to survey: <https://www.hca.wa.gov/assets/free-or-low-cost/Parent-Initiated-Treatment-Advisory-Work-Group-survey-results-2018.pdf>

Commercially Sexually Exploited Children (CSEC) Survey Summary

A CSEC survey, separate from the full PIT survey, was also sent out to those agencies and others groups working on issues related to CSEC. This survey was released on August 1, 2018, and 82 responses were received by time it closed on September 11, 2018.

- Almost half of the respondents (38) indicated that they were unfamiliar with the PIT process, 23 said they know something about the process, and 17 said that they knew a reasonable amount (4 respondents skipped this question).
- When asked if being commercially sexually exploited should be a reason by itself to be committed to an inpatient psychiatric facility through the PIT process, the majority (51) of the respondents said no, with 31 saying yes.
- Of the 80 respondents who indicated the types of treatment services that should be available for CSEC clients, most felt all the options listed should be available. They chose community based counseling (78), secure detox (71), and psychiatric facilities (69). Thirty-nine responses were other. The other comments included providing a secure receiving home with a focus on CSEC and safe long-term, living facilities; education and job training; a full range of supportive, specialized services including short-term and long-term services and community based client-directed advocacy; health care and testing; support groups; and crisis intervention. Also there was an emphasis on self-determination and direction, asking them what their needs are and providing job training outside of the service industries.
- Four respondents felt that only the parent should be able to file PIT for their child. The remaining respondents all felt that relatives and kinship caregivers who are raising the child should also be allowed to start a PIT process (77 respondents to the question, minus 4, equals 73). In addition, some felt that law enforcement (36) or treatment providers (47) should also be able to start the process.

Link to CSEC Survey: <https://www.hca.wa.gov/assets/program/pit-survey-csec.pdf>

Appendix A: The following needs more development

The group developed several recommendations that either did not reach consensus or were areas where questions were raised that the group did not have time to get answered to explore further. The items important to the group that didn't make it into final recommendation are documented below for further consideration and development.

1. Recommend safeguards or other supports for hospitals and E&Ts that encourage, rather than discourage, the provision of PIT. How can hospitals be encouraged to offer PIT as an admission option? How can the current safeguards be strengthened for hospitals and Evaluation and Treatment Centers (E&Ts) to encourage them to consider offering PIT admissions?
2. Are there other issues beyond concerns around litigation, such as concerns around minor's constitutional rights (aka meaningful due process) for the youth?
3. Should a list of criteria be developed that are youth specific for PIT, other than what is in WAC or statute?
4. What are ways to improve hospitals' knowledge of non-hospital treatment pathways when PIT is sought?