

# Family Initiated Treatment and Engaging Families in Treatment of Youth

---

**Kathy Brewer, MS, LMHC and Peggy Dolane, MSW**

**Washington Behavioral Healthcare Conference**

**June 13, 2019**

# Goals and Objectives

---

## **Attendees will:**

- **Learn about current laws for Parent Initiated and Minor Initiated Treatment, including Inpatient mental health and substance use treatment and Outpatient mental health and substance use evaluation**
- **Learn the history of age of consent for mental health in Washington State and limits of the current laws**
- **Learn about changes to current laws, based on recommendations given to the Children's Mental Health Workgroup**

# Disclaimer and Terms

---

**DISCLAIMER: Information shared in this presentation should not be considered legal advice. Please consult with an attorney about interpretation of the WAC and RCW changes.**

## **Terms**

**Teenagers ages 13-17 will be referred to as “adolescents”.**

# Why is this an important topic?

---

**Increased mental health needs for adolescents in WA and US**

**Increased Pediatric Emergency Department visits for mental health concerns**

**Adolescent suicide attempts and completed suicide are on the rise**

**Parents and family members are vital partners helping adolescents access and participate in treatment**

**New legislation will change how providers evaluate and treat adolescents, and authorizes greater collaboration with parents and family members**

# PIT & Age of Consent Background

---

# History of the Washington State Mental Health Age of Consent law

---

**Current law that allows adolescents to request and receive mental health services without parent/legal guardian consent was passed in 1985**

**Why? Concerns that some adolescents tried to access mental health treatment and parents were unwilling to consent (i.e. when mental health age of consent was 18)**

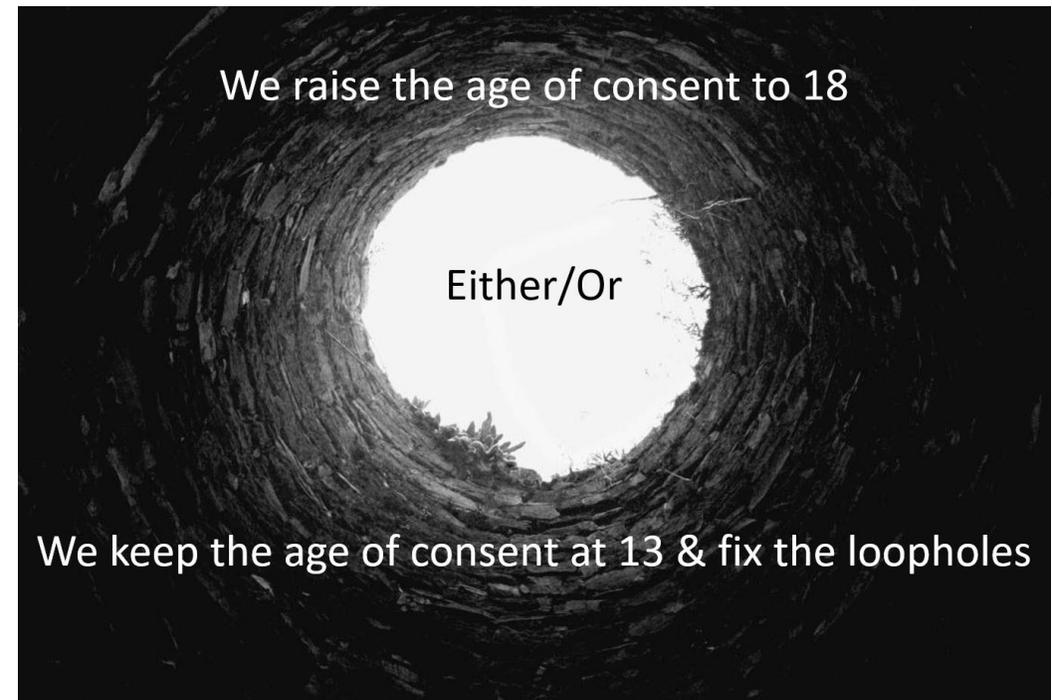
**Intent was not to exclude parents from their adolescent's mental health treatment, but that is what happened**

# History of the Washington State Mental Health Age of Consent law

---

**Between 1989 and 2017, there were at least a dozen different attempts to change the mental health age of consent and improve parent involvement.**

**Despite significant input from parents/families with very tragic stories of adolescents losing their battle with their mental health issues, nothing worked...until 2019**



# What about the Becca Bill and the At-Risk Youth Petition?

---

**In 1995 the At-Risk Youth (ARY) petition was created as part of the Becca bill, to help parents ask the Juvenile Court to establish more control over adolescents engaging in unsafe behaviors**

**Becca Bill also allowed parents to admit an adolescent to inpatient mental health treatment with CDMHP and/or DSHS review. ARY has not been very effective in helping adolescents with mental health needs**

**Washington State ended up incarcerating children who actually needed behavioral health care**

# Parent-Initiated Treatment law history

---

**Senate Bill 6208 passed in 1998 and is the foundation for the current PIT statute. The law was not followed. Between 1998 and 2011, there were only 2 documented PIT inpatient psychiatry admissions**

**Senate Bill 5187 passed in 2011 that required emergency departments and inpatient psychiatric facilities to document that they are informing parents about PIT, with stiff penalties for not complying**

**Data shows that the number of PIT admissions grew significantly after this law was passed and became more common. *However many providers still do not follow PIT statues***

# Current Parent Initiated Treatment Law

---

**Under RCW 71.34.600-670, a parent (biological or adopted parent, or DCYF social worker for a dependent child) may consent for the following evaluation and/or treatment without the consent of the adolescent (age 13-17), as long as a mental health professional determines medical necessity is met:**

- Acute Inpatient Psychiatry Admission**
- Outpatient Mental Health Evaluation ONLY**

# Current Parent Initiated Treatment Gaps

---

- **Adolescent consent is a huge barrier to accessing care for our most vulnerable children**
- **Kinship caregivers, stepparents or other family members caring for adolescent's are unable to initiate care**
- **Outpatient evaluation alone only is not helpful when parents could not obtain the information, or take recommended action, without adolescent's consent**
- **Release of information for PIT admissions is unclear due to different laws that address what information may or may not be disclosed**

# Current Parent Initiated Treatment Gaps

---

- **If an adolescent voluntarily agrees to psychiatric admission but doesn't authorize release to parents, treating providers may not be able to share critical information about diagnosis and treatment**
- **High risk adolescents with oppositional defiant disorder, emotional regulation struggles, and attachment disorders are able to opt out of treatment or restrict parents from understanding their diagnosis or treatment plan**
- **Providers may end up further driving a wedge between parents and adolescents which often leads to adolescents refusing life-saving care**

# Current Parent Initiated Treatment Gaps

---

- **Parents are not able to collaborate – nor confidentially share information – in their child’s care, thus a therapist is unable to fully understand the child**
- **Requires involvement with the courts and bureaucratic hoops to get long term treatment**
- **Prevents parents from being able to bill insurance when a child refuses to share records.**

# Current Parent Initiated Treatment Gaps

---

- **Stigmatizes parents. System that assumes parents are the problem and do not understand their child's needs. (Sometimes nobody understands!)**
- **System-focused illness-based model instead of trauma-informed, family-centered wellness**
- **Consent forms trigger trauma-responses in youth and can even lead to suicide or runaway attempts**
- **Limits access to early interventions and access to safety net services (WISE)**

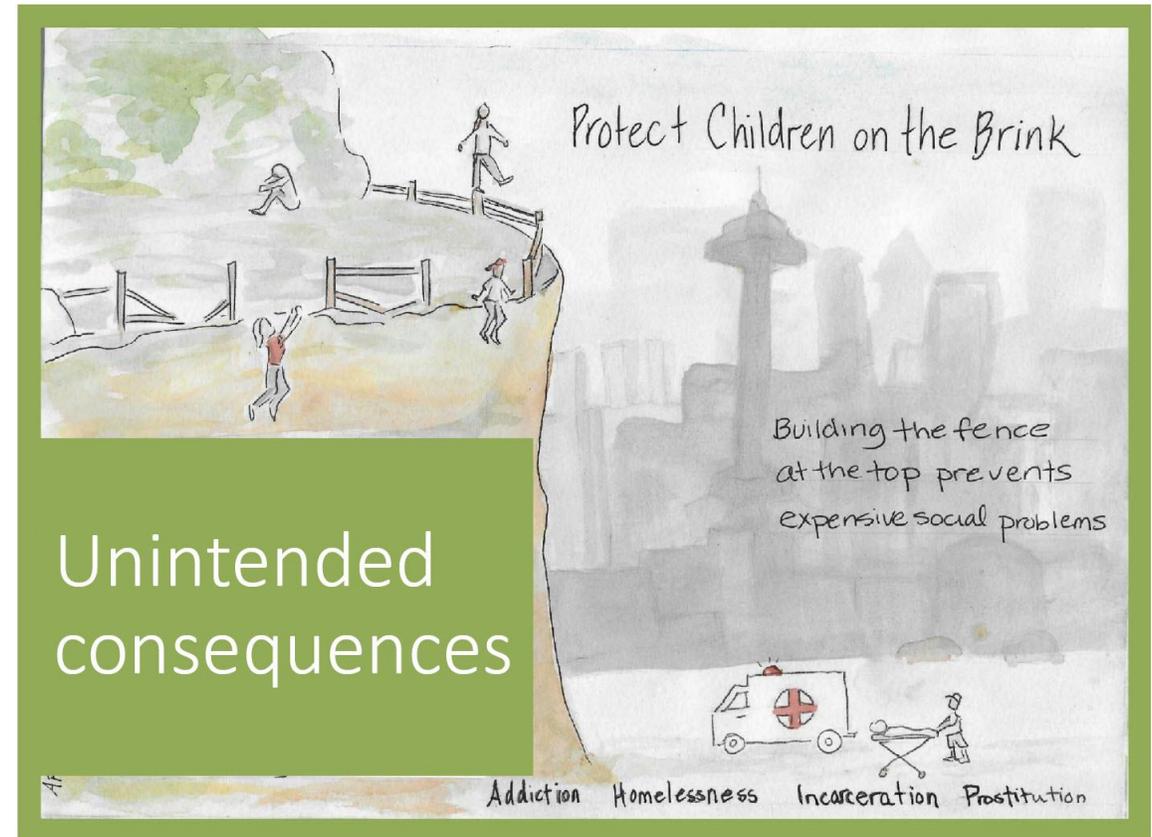
# Current Parent Initiated Treatment Gaps

---

- **Excludes the most knowledgeable person (the child's care manager) who also has the most to lose**
- **Only provides short-term stabilization**
- **Assumes all children are capable informed consent – and discounts the importance of trauma-informed interventions & adolescent brain development (that the US Supreme Court has recognized)**
- **Parents are not able to collaborate – nor get information – in their child's care, thus a therapist is not effectively able to fully understand the child**

# Parent Advocacy leading to change

**“It is also the purpose of this chapter to assure the ability of parents to exercise reasonable, compassionate care and control of their minor children when there is a medical necessity for treatment and without the requirement of filing a petition under this chapter.”**



# The Path to a New Law

---

# 2018-2019 effort to modify behavioral health age of consent law

---

**In 2018 – the Children’s Mental Health Workgroup was tasked by House Bill 2779 to establish an advisory group of stakeholders to develop recommendations regarding (1) age of consent for behavioral health treatment of a minor, (2) options for parent involvement in youth treatment decisions, and (3) information communicated to families and providers about the parent-initiated treatment process**

**Advisory group included individuals representing parent/families, youth, clinicians, and hospitals. The group met 21 times and provided a comprehensive list of recommendations**

# 2018-2019 effort to modify behavioral health age of consent law

---

**The PIT advisory group took a very thoughtful and practical approach to their task – and the effort required IMMENSE amounts of compromise, particularly between parent/family and youth advocates**

**Parent/family advocates would have preferred to have joint consent**

**Youth advocates were focused on past efforts of families to raise the age of consent, so they did not see there was a middle path – joint consent – where both adolescents and parents could consent for care**

# 2018-2019 effort to modify behavioral health age of consent law.

---

**Clinician and hospital advocates were in favor of compromise - that allows greater ability to talk with parents/family members about important aspects of their adolescent's diagnosis and treatment recommendations, even if adolescent is not fully in agreement**

**All advisory group members were concerned that the law still allowed youth voice and clinician discretion in what type of information is shared and when during the course of treatment**

# 2018-2019 effort to modify behavioral health age of consent law

---

**The Key = BALANCE or WALKING THE MIDDLE PATH. Walking the Middle Path is a DBT concept that means replacing “either-or” thinking with “both-and” thinking**

**Recommendations provided a balanced approach to:**

- **Allow parents to seek treatment for non-consenting adolescents, while ensuring treatment is medically necessary**
- **Allow treating providers to share important information with parents about diagnosis and treatment, while ensuring adolescents retain some confidentiality**

# House Bill 1874 – The Adolescent Behavioral Health Care Access Act

---

**The recommendations from the Parent Initiated Treatment workgroup were written up as House Bill 1874 and ultimately passed through the House on 3/11/19 with 89 in favor and 8 against**

**A “companion” version of the law passed in the Senate on 4/15/19 with 48 in favor and 0 against**

**The bill was signed into law by Governor Inslee on 5/13/19 and goes into effect July 28, 2019**

# House Bill 1874 – The Adolescent Behavioral Health Care Access Act

---



# What to expect from the revised laws about adolescent mental health care?

---

## ***Transformation to whole-family treatment***

**Under the new law, adolescents may access behavioral health care as individuals or together with their parents, as a family**

**Parents, youth and clinicians working as partners**

**Evolution of thinking about family and parents as important parts of the solution in mental health treatment of adolescents – particularly when adolescents are living with their parents/family members**

# New: Changes to legal definition of parent

---

**The legal definition of parent now includes:**

- A person to whom a parent has given a signed authorization to make health care decisions for the adolescent**
- A stepparent who is involved in caring for the adolescent**
- A kinship caregiver who is involved in care for the adolescent or another relative who is responsible for the health care of the adolescent**

# Outpatient treatment: Parents can still consent for outpatient evaluation.

---

Language changes now allow a parent to bring or authorize the bringing of the adolescent for:

- Outpatient mental health evaluation
- Outpatient substance use evaluation

Consent of the adolescent is not required for evaluation if a parent provides consent

# New: Parents may provide consent for outpatient treatment

---

**If the evaluating provider determines the patient has a MH/SA diagnosis and needs treatment, a parent of an adolescent may request treatment for the adolescent**

**Limited to up to 12 outpatient sessions occurring within a 3 month period. After this period ends, the adolescent must consent to continue with that provider. This doesn't prevent seeking out a different provider if there is not a good match**

**Rationale is that within 3 months/12 sessions, many adolescents will end up consenting to treatment**

# New: Parents may consent to partial hospitalization or intensive outpatient treatment:

---

**If a MH or SU provider determines an adolescent meets medical necessity for partial hospitalization (PHP) or intensive outpatient treatment (IOP), a parent of an adolescent may consent to treatment even if the adolescent doesn't consent**

**For mental health PHP/IOP, the provider/facility must have a treatment review with the adolescent, parent and treatment team at least every 30 days to assess medical necessity**

# New: Partial hospitalization or intensive outpatient treatment requirements

---

**When a patient is in *mental health PHP/IOP*, the facility has to notify the designated DSHS employee within 24 hours of admission, and a clinical review is conducted every 45 days for a second opinion about medical necessity**

**This same review happens for substance use PHP/IOP only if the adolescent provides written consent to disclose information to DSHS about his/her substance use disorder treatment**

# Protections for providers and facilities providing treatment under the new law

---

**If a provider or facility admits and treats an adolescent for outpatient, PHP or IOP services with parent consent only in good faith, there is no cause of action by an adolescent against the provider or facility, based solely on the fact the adolescent did not consent**

# Changes to release of information guidelines: RCW 70.02.230 and 240

---

**RCW 70.02.230 and 240 Mental health services—Minors—Permitted disclosures. This law has been in effect since 2013**

**Providers can share mental health treatment information to another treating provider (including care coordinator)**

**Providers can release information to the minor, the minor's parent, and the minor's attorney**

**UPDATE: And to the minor's parent, including those acting as a parent as defined in RCW 71.34.020 for purposes of family-initiated treatment**

# New: Information sharing when an adolescent initiates treatment

---

**Providers are able to share information with parents when an adolescent has consented to treatment but does not consent to release information to parents, if there is an imminent threat to the health and safety of the adolescent or others (be aware of Duty to Warn law)**

**If there are no concerns about health and safety, the provider tells the adolescent prior of the plan to share information, and the adolescent can share concerns. The provider needs to document the concerns and if the provider chooses to share information with parents despite concerns**

# New: Information sharing when a parent brings adolescent for treatment

---

**For adolescents receiving care with parent only consent, the provider is encouraged to only release mental health information that is necessary to assist the parent in understanding the nature of the evaluation or treatment and in supporting their child**

**It is important that adolescents have some confidentiality in treatment to help them trust and engage in the process. Clinician discretion is the key to finding the right type and amount of information to share**

# New: Specific MH info that providers are encouraged to share with an involved parent:

---

**Information that is recommended to be shared includes,**

- (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 child's mental health;**
- (e) Referrals to community resources;**
- (f) Coaching on parenting or behavioral management strategies; and**
- (g) Crisis prevention planning and safety planning**

# Release of MH Information guidelines: provider discretion

---

**Providers can decide not to release information verbally or copies of records to a parent/guardian/caregiver, if the provider believes that the release of mental health records would be detrimental to the adolescent**

**In these cases, the provider needs to document the reasons they are choosing not to disclose**

***Clinicians still retain discretion of what information will be released in collaboration with the youth and using clinical judgement***

# Protections for providers and facilities releasing MH information:

---

**A mental health professional providing inpatient or outpatient mental health evaluation or treatment is not civilly liable for the decision to disclose information or records related to solely mental health services or not disclose such information or records so long as the decision was reached in good faith and without gross negligence**

# Release of Information to foster parents

---

**DCYF case workers may share these mental health treatment records with a care provider, even if the adolescent does not consent to release, if the adolescent is being treated under Family Initiated Treatment: (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 child's mental health; (e) Referrals to community resources; (f) Coaching on parenting or behavioral management strategies; (g) Crisis prevention planning and safety planning**

# Release of Information to foster parents

---

The department may not share substance use disorder treatment records with a care provider without the written consent of the adolescent except as permitted by federal law

"Care provider" means a person with whom a child is placed in out-of-home care, or a designated official for a group care facility licensed by the department

# Changes to Release of SU Info guidelines:

---

**Substance use treatment laws are different than mental health laws because of a federal law, 42 CFR part 2, which requires the person receiving substance use treatment to authorize release of information**

**Providers may seek the written consent of the adolescent to release information to a parent as long as the provider determines that both seeking the written consent and sharing the substance use disorder treatment information or records of the adolescent would not be detrimental to the adolescent. Written consent is still required**

# Changes to Release of SU Info guidelines:

---

**A substance use treatment provider is not civilly liable for the decision to disclose information or records related to substance use disorder treatment information with the written consent of the adolescent or to not disclose such information or records to a parent without an adolescent's consent pursuant to this section so long as the decision was reached in good faith and without gross negligence**

# Parent Perspective – Peggy

---

# Parents want providers to:

---

**Understand most parents want our children to succeed, but we may not have the skills to effectively help our struggling adolescents**

**Stop blaming and shaming us for our inability to effectively help our struggling children**

**Understand that adolescent defiance can be a symptom of a behavioral health or developmental issue – ex. Autism, ADHD, Attachment Disorder – and parents must be part of the treatment approach to effectively address these symptoms**

**Help us build trust and healthy behaviors with our children and with you, the provider**

# Parents want providers to:

---

**Understand that a child that is living at home has not yet proven their ability to live independently in the world. They should not be expected to make decisions that require a fully-functioning ability to understand long-term consequences**

**Continue to protect our children's trust in the therapeutic process. Just as parents also want providers to be able to safeguard confidential information we share with you**

**Remember adolescents are part of a family system which has the most to gain, or lose, when the adolescent is unhealthy**

# Parents need to:

---

**Be part of the treatment plan in order to effectively help the family heal**

**Understand why sharing the clinical file is not appropriate**

**Be taught how our anxiety and fears for our children may be contributing to our children's unhealthy behaviors**

**Have access to explicit information and training about how to manage our own emotional responses to our adolescent's dangerous behaviors**

**Work as allies with providers in developing strategies to support adolescent developmental challenges outside of the therapist's office**

# Providers help struggling adolescents by:

---

**Recognizing the complex marriage and family therapeutic skills needed to function effectively as an adolescent therapist**

**Demonstrating how to build trust and safety through effective boundaries and self-regulation skills**

**Collaborating with parents to help support their children engage in healthy behaviors, risk taking and self-regulation skills in the face of unsafe adolescent behavior**

**Understanding how severely a struggling adolescent can impact the mental health of the entire family**

# Parents need adolescents to know:

---

**We don't want to know everything you tell your therapist**

**You are still a kid and your brain is developing**

**Sometimes hard things are in your best interest**

**Parents are also willing to change to help you get better**

**Everybody struggles at one time or another, you are not alone.**

# Provider perspective – Kathy

---

# Best Practices

---

**Clinicians need to talk with adolescents about the importance of involving their parents and sharing necessary information**

**If parents know diagnosis, treatment plan, etc. – they can understand why their behaviors may need to change and how they can help their adolescent in a different way**

**Providers need to reassure adolescents that they won't share everything with parents – and have an ongoing conversation about what is okay to share and why**

# Best Practices

---

**Be thoughtful about your documentation and stay away from being judgmental. Write documentation as if it might be shared with a youth, a parent/family member, or another treating provider**

**Be vague about issues that the youth may not want to be shared. I use the term “adolescent health issues” to talk about sexual activity or drug/alcohol issues and “relationship issues” to talk about sexual orientation**

**Clinical notes should always reflect medical necessity – why does the patient need treatment**

# Best Practices

---

**Parents live with adolescents 24 hours per day, 7 days per week, 365 days per year – therapists see adolescents about 1 hour per week on average. Parents are vital to adolescent treatment!**

**Don't let consent be a barrier**

**If providers treat the need to consent as a means to exclude parents/family members, then youth will do the same**

**Help youth understand the value of engaging their parents and family members in their treatment**

# Role Play

---

# What's next?

---

# Implementation of the revised law

---

**DCYF is responsible for conducting evaluation of this law being implemented in 2020, 2021, and 2022 and report back to the governor and the legislature**

**One of the recommendations was for DCYF to create a free online training about the new law to help youth, families and providers understand expectations**

**Question: what specific areas would you like more training/information about?**

# Work still in progress

---

**We were not able to address all concerns with this law.**

**Next areas to address include:**

- Continuing discussion of CLIP process and access**
- Use of involuntary treatment for adolescents. Can we phase it out by continuing to enhance/expand family initiated treatment?**
- Medical necessity criteria not taking into consideration unique issues for children and adolescents and using adult criteria**
- Expansion of Family Initiated Treatment for residential & wilderness**

# Vision for the future!

---

**Active collaboration between adolescents, parents/family members, therapist, and primary care provider and other treating providers**

**The distinction between adolescent and parent/family initiated treatment will be lessened as we move towards family-centered care with no wrong door access**

**Focus on early intervention for mental health issues and for therapists to build on initial engagement with youth at the first visit and onward**

# Vision for the future!

---

**Therapists need to shift practice to increase communication and collaboration with parents and engagement with adolescents who may initially be reluctant to engage**

**Parents will have an effective avenue to get help for their adolescents who are not able to seek out help themselves**

**We will save adolescent lives by helping them get treatment when they need it!**

# Vision for the future!

---



**Walking the *Middle Path*:  
balancing adolescent and  
parent/family needs and  
input and bringing them  
together to help  
adolescents and families  
with their recovery**

# Speaker Contact Information

---

**Kathy Brewer, MS, LMHC**

**Kathy.Brewer@seattlechildrens.org**

**206-987-1665**

**Peggy Dolane, MSW**

**peggy.dolane@gmail.com**

**Facebook group: YBHA-WA (Youth Behavioral Healthcare Advocates WA)**

# References

---

## **Guidance on Duty to Warn in Washington State**

<https://www.wsha.org/wp-content/uploads/Volk-recs-FINAL.pdf>

## **SAMSHA Information about 42 CFR Part 2**

<https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs>

# Thank you!!!

---

