Washington State Health Care Authority

Children's Mental Health Work Group
Friday, January 11, 2019
9:00 am – 11:00 am

Navos Mental Health & Wellness Center
Revelle Hall, Burien, Washington
Dial-In: 1-888-407-5039
Host Pin: 65772257#
Participant Pin: 91312278#

Committee Members					
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Agenda Items	Time	Lead
1. Welcome and Introductions	9:00am-9:10am (10 mins)	Representative Noel Frame, Co-Chair MaryAnne Lindeblad, Co-Chair
2. Discussion on Committee member's 2019 final legislation recommendations	9:10am-10:20am (1hr 10 mins)	Various
3. Next steps	10:20am-10:35am (15 mins)	MaryAnne Lindeblad, Co-Chair

4. Public Comment	10:35am-10:50am (15 mins)	All
5. Adjourn	10:50am-11:00am (10 mins)	All

Future Meeting dates				
	Date	Time	Location	Notes
1.				
2.				
3.				
4.				
5.				

Action Items & Decisions					
	Action Item	Assigned To	Date Assigned	Date Due	Status
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Future Agenda Items					
	Agenda Item	Assigned To	Date Assigned	Meeting Date	Status
1.					
2.					
3.					
4.					
5.					

Handout 1

PAL (Dr. Robert Hilt):

HCA has prepared a legislative report in response to SSB 6452 from 2018 in which recommendations for alternative funding models and non-duplication were made for the Partnership Access Line**.** Current PAL services for primary care providers include a telephone rapid access line to consult support with child psychiatrists at Seattle Children's, access to full consult appointments for Apple Health clients, access to mental health education events, an updated mental health care guide, and resource system advice from program social workers. PAL is currently supported by the state legislature and state Medicaid.

In brief, future funding to fiscally support the non-Medicaid side of the PAL service is recommended to come from an existing revenue source to formally pay HCA for the proportion of PAL which is not eligible for federal Medicaid matching reimbursement, ideally to begin January 1, 2021. Just under ½ of the current PAL consult calls support non-Medicaid clients. That existing revenue source which could be assigned to supporting non-Medicaid PAL could be legislatively designated as coming from currently existing fund sources such as the state's 2% health insurance premium tax, from the 1.5% B &O tax on qualifying hospitals, or from an adjusted WSHIP assessment.

Newly added services in 2019 as a 2 year pilot include 1. "PAL for Moms" –a telephone rapid access consult service for providers treating pregnant women and young mothers to reach UW based adult psychiatrists, and 2. "Mental Health Referral Assist, for Washington's Children and Adolescents," which is a new referral assistance service to more directly help parents and guardians through the process of connecting their youth with mental health care services. This was renamed from "PAL for Kids Pilot Program" to have the service name be more self-explanatory for parents. It will be operated by the PAL team, and will be advertised as available for Apple Health Families though will not turn away any requests for people who have private insurance. A plan for non-duplication of this referral assist service with the role of MCO Medicaid Health Plans has already taken place. Ultimately these two new expansion services, if they continue beyond the pilot phase with HCA, would ideally receive similar non-Medicaid fiscal support through the same process as above.

Handout 2

WASHINGTON ASSOCIATION FOR
Infant Mental Health

WASHINGTON STATE
Department of
Children, Youth, and Families

Proposal: Establishment of a Prenatal to Five Relational Health Advisory Group

Submitted by CMHWG members:

Jamie Elzea, MPH, LICSW, Executive Director at the Washington Association for Infant Mental Health
And Judy King, MSW, Director of Family Support, Washington State Dept. of Children, Youth & Families

The Children's Mental Health Workgroup attends to topics of mental health from birth to youth transitioning to adulthood. Given the provider training needs to serving babies, toddlers and young children greatly differ from the pathways found for school age children and teens, in part because of the essential role of caregivers in the early years (including perinatal caregiver mental health and the dyadic nature of services) this proposal recommends the formation of a **Prenatal to Five Relational Health Advisory Group** as a committee under the Children's Mental Health Workgroup.

Composed of public, community-based non-profits, and private leaders in the fields of prenatal and infant/early childhood mental health, the purpose of this Advisory group would be to:

1. Support development of a diverse prenatal to five mental health workforce statewide through:
    a. Capacity building plan: Training, recruitment, professional development, sustainability, public awareness, and reduced turnover strategies
    b. Financing structure: Medicaid and private insurance billing/reimbursement, wages

2. Address strategies to connect historically disconnected systems of parent and caregiver adult mental health and early childhood mental health systems for better accessibility and continuity of care for families, as well as cross training for providers

3. Build from the Washington Infant and Early Childhood Mental Health Landscape Analysis project (in progress)

4. Integrate perinatal/IECMH services into maternal child health systems, behavioral health, public health, and early childhood systems of care.

If formed, this Prenatal to Five Advisory Group, would be prepared to report our findings and recommendations to the Children's Mental Health Workgroup by December 2019.

Questions can be directed to Jamie Elzea, jamie@wa-aimh.org

Student Behavioral Health Policy Proposals – 2019 Session
Draft – 1.7.2019

Policy Proposal	Broad Topic	Tier	Legislator If already identified	Specifics of policy or draft bill language	Identified lead advocate(s)	Relevant DP	Budget Proviso / Bill
Provide resources for schools to implement evidence-based SEL, suicide prevention, and anti-bullying, etc.	Student skills development	Tier 1		OPSI shall offer competitive grants for schools to be used for - Evidence based Social Emotional Learning that conforms to the standards adopted by the superintendent of public instruction. - Anti-bullying education - Suicide prevention	Melanie – CFC Carey Morris – LEV Jenn Stuber - Forefront		Proviso
Require mental health literacy and healthy relationships be taught in schools	Student skills development	Tier 1		New Section **Health education in grades K through eight.** Every pupil attending grades one through eight of the public schools shall receive instruction in health that includes all the social emotional health, substance use and abuse, and healthy relationship standards as prescribed by rule of the superintendent of public instruction. **New Section High School Graduation requirement** As part of the 2 health and physical education credits required to graduate, every student must complete a curriculum that includes all the social emotional health, substance use and abuse, and healthy relationship standards as prescribed by rule of the superintendent of public instruction.	Brad Forbes – NAMI Todd Crooks- Chad's Legacy Project Melanie – CFC Carey Morris - WSCADV		Bill
Annual Training for all school personnel on the signs of abuse and the process for mandatory	School personnel training and professional	Tier 1	Orwall	**RCW 28A.400.317 - Physical abuse or sexual misconduct by school employees—Duty to report—Training.**	Melanie – CFC		Bill

Student Behavioral Health Policy Proposals – 2019 Session
Draft – 1.7.2019

Policy Proposal	Broad Topic	Tier	Legislator If already identified	Specifics of policy or draft bill language	Identified lead advocate(s)	Relevant DP	Budget Proviso / Bill
reporting of the suspected abuse of students.	Developmen t			(2) Certificated and classified school employees shall receive training regarding their reporting obligations under state law in their orientation training when hired and then every year~~s~~ thereafter. The training required under this subsection may be incorporated within existing training programs and related resources. OSPI shall develop either a standalone on-line training or as part of other trainings that may be used to fulfill this requirement.			
Improved BH systems for schools				Improve School based services - Expand pilots and - Fund navigators for every ESD's - Create workgroup to develop MTSS protocols for schools consistent with the integrated student supports protocols and recommend appropriate trainings for teachers and administrators - Resources for districts to expand school based BH programs	Laurie Melanie Carey		Proviso
Provide resources for schools to operationalize their mental and emotional distress crisis plans including technical assistance from OSPI	System Capacity and Investments – Direct to schools / ESD's	Tier 2 and 3		RCW 28A.320.127 – Add a requirement that every school district send a current crisis plan to OSPI prior to each school year. OSPI shall review crisis plans upon request and provide technical assistance.	Jenn – Forefront Melanie - CFC		Bill

Handout 3

Student Behavioral Health Policy Proposals – 2019 Session
Draft – 1.7.2019

Policy Proposal	Broad Topic	Tier	Legislator If already identified	Specifics of policy or draft bill language	Identified lead advocate(s)	Relevant DP	Budget Proviso / Bill
and require they be on file.				OSPI shall randomly audit at least X% of crisis plans every year. Can be part of the duties of the navigator			
Add Navigator, Technical Support and Threat Assessment Coordinators to each ESD's	System Capacity and Investments – Direct to schools / ESD's		Dolan	Each ESD will get 3 positions to support student mental health and safety ** Add SEL technical assistance to the work of these positions?		Governo r's budget funds ½ $7.5 M	Bill
Require schools report bullying	System Capacity and investments - State capacity and policy			**RCW 28A.600.480 Reporting of harassment, intimidation, or bullying—Retaliation prohibited—Immunity.** (1) No school employee, student, or volunteer may engage in reprisal, retaliation, or false accusation against a victim, witness, or one with reliable information about an act of harassment, intimidation, or bullying. (2) A school employee, student, or volunteer who has witnessed, or has reliable information that a student has been subjected to, harassment, intimidation, or bullying, whether verbal or physical, is **required** to report such incident to an appropriate school official. (3) A school employee, student, or volunteer who promptly reports an incident of harassment, intimidation, or bullying to an appropriate school official, and who makes this report in compliance with the procedures in the	Melanie- CFC .		Bill

Student Behavioral Health Policy Proposals – 2019 Session
Draft – 1.7.2019

Policy Proposal	Broad Topic	Tier	Legislator If already identified	Specifics of policy or draft bill language	Identified lead advocate(s)	Relevant DP	Budget Proviso / Bill
				district's policy prohibiting bullying, harassment, or intimidation, is immune from a cause of action for damages arising from any failure to remedy the New reported incident. **New Section** – Beginning in 2021 the superintendent of public instruction shall add harassment, intimidation and bullying to their Washington State Report Card. The report card should reflect the demographics of the students involved, the type / severity of the HIB and what type of outcome. **New Section –** The Superintendent of Public Instruction shall issue guidance to schools on best practices for schools to collect data on harassment, intimidation and bullying that protects individual student's privacy and gathers the relevant data for the report card.			
Suicide prevention plan including building capacity at DOH, OSPI and ESD's	System Capacity and investments - State capacity and policy	Tier 1,2 and 3		Stand alone proposal	Jenn Stuber - Forefront	Included in DOH / OSPI DP's – Partially funded in Governo	Bill

Student Behavioral Health Policy Proposals – 2019 Session
Draft – 1.7.2019

Policy Proposal	Broad Topic	Tier	Legislator If already identified	Specifics of policy or draft bill language	Identified lead advocate(s)	Relevant DP	Budget Proviso / Bill
						rs Budget	
Increasing the numbers of school counselors and social workers in schools and revise their scope of work to require 80% of their time be spent with students focusing on counseling work.	System Capacity and investments - State capacity and policy	Tier 2 and 3	Ortiz-Self		Amy Brackenbury Bob Cooper	OPSI DP for Middle School $156 million in Gov budget for counselors, nurses and guidance counselors	Bill

Handout 3

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

Compilation of responses received as of 1/9/2019

	Does it require:			
Current Topics	**RCW Change? Y / N**	**Policy Change? Y/N**	**Budget Impact? Y/N**	**Estimated dollar amount if Budget required**
1. PAL: **Laurie Lippold** Recommendations: • *Ensure the community referral line can serve both Medicaid and non-Medicaid families.* Notes: **Please see handout 1*	Unsure		Unsure	
2. Trauma Informed Care: **Laurie Lippold:** Recommendations: • *Provide trauma-informed training for front-line workers engaging with children (childcare providers, child welfare workers, etc.)* • *Follow-up Trauma Informed Care report due December 31.* Notes: Sharon Shadwell will update the group on the recommendations from Trauma Informed Care group.	Likely	Likely	Likely	
3. Workforce development and training: ***Avanti Bergquist, MD** ****Laurie Lippold** Recommendations: • *Increase availability of loan repayment options for all mental health providers.* • *Increase residency positions for general psychiatry as well as child and adolescent psychiatry.*	N Likely	Y Y	Y Y	Depends on the number of residency positions and loan

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

• *Provide funding for pediatric residents and family medicine residents to learn from child and adolescent psychiatry fellows or attending's to improve their understanding of treatment minor to moderate mental health issues as a means to improve access to care.* • *Expand capacity for preceptorships, dual licensing/credentialing, and other mechanisms (e.g. UW Bothell)* Notes:		(some)	(most)	repayment options
4. Workforce development and training: **Dr. Eric Trupin** Recommendations: • *Create a certificate program for DBT* • *Develop a fee-based certificate program in Children's Behavioral Health Evidence-Based Practice (EBP)* <u>Notes from 12/07/2018:</u> The Department of Psychology and Psychiatry at the University of Washington are collaborating in developing a fee-based Certificate Program in Children's Behavioral Health Evidence Based Practice (EBP). The target audience of the EBP Certificate is intended for practicing mental health professionals who are seeking additional education in Evidence Based Practices. We have done significant surveying throughout the state and have received a great amount of interest from public children's behavioral health providers and stakeholders. It is our sense that enhancing the skill set of our children's workforce will go a long way in improving outcomes for the children and families we serve. The program will consist of 15 graduate credits consisting of four courses and an additional "Capstone" course which will entail a clinical application or implementation of an evidence based practice. The four courses are Parenting Interventions, Treatment of Anxiety and Mood Disorders/DBT, Extreme and Complex Cases, TF-CBT and Treating Trauma. We are looking to make this available both locally and well as accessible through an online application for enrollees around the state. Hopefully we will be able to initiate this in the fall of 2019. We are eager to discuss how this opportunity can be available to applicants whose personal resources or resources at their place of work will challenge capacity to	Y	Y	N	N/A

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

participate. In addition, it would be of interest to look into whether an individual holding a certificate or an agency employing staff with these credentials could be incentivized for these enhanced skills. *For discussion: Concern those with limited resources would not be able to attend.* *Follow-up: Dollar amounts if any, needed for support*				
5. Child Care Services: ***Janet Frantz** ****Laurie Lippold** Recommendations: Notes: Janet Frantz from DCYF will have an update for the group on recommendations related to the development of a statewide plan for child care mental health services.	Likely	Y	Y	Not sure
6. Patient Initiated Treatment (from PIT sub-work group): Recommendations: • *Treatment providers for minor-initiated, parent initiated, and voluntary 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 for 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&T) centers to encourage the provision 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 to CSEC youth including secure detox, psychiatric facilities, receiving centers, outpatient treatment, and any Least Restrictive Alternatives (LRA).*	Y	Y	Y	TBD

• *Training to be developed and offered for treatment providers regarding Washington State Law and best practices when working with children, youth, and families.* Notes from 12/07/2018: This recommendation was voted approved by the CMHWG 12.7.18 WITH THE EXCEPTION of #6 which will be discussed on 1.11.19 language is: 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. *Please see handout "Parent Initiated Treatment"*				
7. Other: Create Echo Glen Children's Center Psychologist candidate position: **Representative Tana Senn** Recommendations: • *Create Echo Glen Children's Center Psychologist candidate position.* Notes: The ideal candidate will have a PhD or PsyD from an APA accredited clinical or counseling psychology program and fully licensed to practice as a Psychologist in the State of Washington. He/she will directly report to the Echo Glen lead Psychologist, be able to work collaboratively with providers from varied disciplinary and educational backgrounds; be conversant in evidence-based mental health interventions; be skilled in their ability to conceptualize cases from a trauma-informed lens; and have demonstrated ability to work effectively with multi-problem children/adolescents and families. The candidate will have expertise in one or more of the following areas: Assessment and treatment with youth affected by disorders commonly associated with exposure to Complex Trauma, ADHD, assessment and treatment planning for youth affected by Autism Spectrum Disorders, and Substance Abuse Disorders in Adolescence Candidates are trained to competency in:				

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

• Dialectical Behavior Therapy
• Adolescent Development including brain development
• Screening and assessment of mental health
• Neuropsychological Assessment
• Trauma informed assessment and evidenced based interventions used in Juvenile Justice residential settings (including but not limited to TF-CBT, ITCT, SPARCS, Think Trauma and TARGET)
• Knowledge and support related to secondary traumatic stress among direct care staff. Responsibilities include:
  o Assessment of general mental health including Anxiety, Depression and PTSD.
  o Evidence based exposure treatment.
  o Co-facilitating DBT and Trauma related skills groups.
• Therapy/Milieu Program – Collaborate with unit clinical leaders and direct care staff to implement the Integrated Treatment Model that primarily consists of Dialectical Behavioral Therapy and continuously assess fidelity of overall program (patient schedules, reinforcement systems, therapeutic groups and evidence-based principles associated with CBT and/or DBT).
• Clinical staff competency/deployment – Provide continuous training and consultation to direct care staff.				

8. Other: Partial Hospitalization or Day Treatment Program: ***Kristin Houser** ****Laurie Lippold** ** Recommendations: • *Properly resource partial hospitalization.* <u>Notes from 12/07/2018:</u> Partial hospitalization is allowed but doesn't seem to be getting used because of a lack of funding. *Added to ongoing topics per Diana.*	Don't think so	Don't think so	Y Y	Not sure
9. Other: Prenatal to Five Relational Health Advisory Group: **Jamie Elzea**				

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

Recommendations: • *Please see handout 2: Establishment of a Prenatal to Five Relational Health Advisory Group*				
10. Other: Residential Treatment Facilities: **Annette Klinefelter** Recommendations: • *It is recommended that WAC 246-337-110 be specific to seclusion, chemical restraints and restraint chairs or tables, and that physical holds necessary to prevent harm to self be held to the same criteria as schools.* Notes: WAC 246-337-110 In regards to use of restraint and seclusion in an RTF. Restraint and seclusion is not defined specifically in the RCW, but is interpreted by the Department of Health to be any physical hold for more than 30 seconds. The requirements, as laid out in this administrative code appear to be related to a chemical restraint (administering a sedative medication against one's will), and a physical restraint such as a restraint table or chair, and are excessive for a physical hold to prevent a child from injuring themselves or others. The requirements, in fact, make it impossible to do brief holds over 30 seconds but less than 60, which on occasion is necessary to prevent harm. Recommendations: • *Define abuse to limit reporting to acts of abuse that do not include physical altercations between children that do not result in injury resulting in an inpatient hospital stay. Abuse reporting requirements should mirror requirements of schools.* Notes: WAC 246-337-065 (5) Safety and Security- Reporting to the department and other relevant agencies Serious or undesirable outcomes, including: • Allegations of abuse • Death • Suicide	Y			

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

• Injuries resulting in an inpatient hospital stay; and • Disruption of services through internal or emergency or disaster.				
11. Other: Medicaid Reimbursement: **Annette Klinefelter** Recommendation: • *RTF Medicaid rate should increase by 15% to reflect requirements for providing co-occurring services requiring on site medical and psychiatric care.*			Y	?
12. RTF Relationship with Law Enforcement: **Annette Klinefelter** Recommendations: • *RTF-Relationship with Law Enforcement.* • *Policy Recommendation: Law enforcement jurisdictions with RTF facilities collaboratively develop memoranda of understandings and identify potential law enforcement budget impacts for RTF's open or opening in jurisdictions.* Notes: MOU's between RTF's and law enforcement are based on national best practice standards for reducing trauma within behavioral health settings. Maine is an example of exemplary practice.			Y	
13. Other: Student Behavioral Health Policy Proposals: **Rep. Noel Frame** **Recommendations:** • *Please see handout 3: Student Behavioral Health Policy Proposals – 2019 Session*				
14. Other: Mental Health related Training: **Laurie Lippold** **Recommendations:** • *Ensure that subjects such as MH First Aid, Literacy SEL, and Trauma Informed Care are incorporated into training avenues for school professionals, as well as students.*	Possibly	Likely	Possibly	

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

	Does it require:			
Ongoing Topics	**RCW Change? Y / N**	**Policy Change? Y/N**	**Budget Impact? Y/N**	**Estimated dollar amount if Budget required**
1. School Based Services: **Avanti Bergquist, MD and Laurie Lippold:** Recommendations: • *Develop a workgroup to collaborate between OSPI and mental health groups/providers as a means to begin to improve school-based services and Social Emotional Learning curriculum development and implementation.* • *Support the establishment of a pool of funds, connected to ESD pilots, so that schools can build capacity and increase.* • *Provide resources to schools to ensure that staff and students receive appropriate mental health first aid, suicide prevention, and anti-bullying training.* • *Ensure collaboration with ongoing workgroups.* *For future consideration: Could PAL have school support feature for staff to use?* <u>Notes from 12/07/2018:</u> This recommendation was voted approved by the CMHWG 12.7.18	N Not sure Likely	Y Likely Likely	Y Y Y	Minimal In process of determining. ?

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

	Does it require:			
Decided Topics	**RCW Change? Y/N**	**Policy Change? Y/N**	**Budget Impact? Y/N**	**Estimated dollar amount if Budget required**
1. School Based Services (OSPI-Dr. Johnson): Recommendations: • *Expand the Children's Behavioral Health System Navigators to all nine Educational Service Districts.* Notes from 12/7 meeting: This recommendation is included in the OSPI decision and funding package 'Supports for School Safety and Mental Health'. This recommendation could also be categorized under workforce development and training. This recommendation was voted approved by the CMHWG 12.7.18	Y	N	Y	See Decision Package for full details.
2. Medicaid Reimbursement (Avant Berquist, MD and Laurie Lippold): Recommendations: • *Increase (behavioral health) rates to match Medicare rates.* Notes from 12/07/2018: Increase will improve access to care as more providers would be able to afford to provide care to patients with Medicaid. Ensure that Medicaid pays for/covers all levels of care, not just outpatient and inpatient, for all mental health issues, not just suicidality or substance use. Notes:	N	N	Y	Depends

Proposed 2019 Children's Mental Health Workgroup Legislative Recommendations

This recommendation was voted approved by the CMHWG 12.7.18				
3. Other (Ann Christian and Joan Miller): Recommendations: • *Coordinated specialty care: Early intervention for psychosis.* <u>Notes from 12/07/2018:</u> -Analyze and determine the cost of statewide implementation of Coordinated Specialty Care. -Fund additional Coordinated Specialty Care teams so that each BHO/ACH regional service area (RSA) of the state has one team. -Fund additional Coordinated Specialty Care teams so that capacity is available based on incidence and population across the state. This recommendation was voted approved by the CMHWG 12.7.18	N	Y	Y	$200,000 $2,200,000 $4,600,000

Washington State Health Care Authority

Parent Initiated Treatment Stakeholder Advisory Workgroup

Recommendation's to Children's Mental Health Workgroup

Full report can be found: https://www.hca.wa.gov/assets/PIT-progress-report-20181201.pdf

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 theyouth:
    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.

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.