Parent Initiated Treatment/Advisory Stakeholder Workgroup

October 15, 2018 Meeting

Hood Room – Blake East 1 PM – 6 PM

PIT WORKGROUP HB2779	
(1) The Department of Social and Health Services must convene an advisory group of stakeholders to review the parent-initiated treatment process authorized by chapter 71.34 RCW.25. The advisory group must develop recommendations regarding: (a) The age of consent for the behavioral health treatment of a minor (b) Options for parental involvement in youth treatment decisions (c) Information communicated to families and providers about the parent-initiated treatment process (d) The definition of medical necessity for emergency mental health services and options for parental involvement in those determinations. (2) The advisory group established in this section must review the effectiveness of serving commercially sexually exploited children using parent initiated treatment, involuntary treatment, or other treatment services delivered pursuant to chapter 71.344 RCW. (3) By December 1, 2018, the department of social and health services must report the findings and recommendations of the advisory group to the children's mental health work group established in section 2 of this act.	
(1) Welcome/Introductions	**Lead: Blake Ellison, Diana Cockrell**
• Welcome and Introductions • Overview of participation ground rules	**Attendees:** Laurie Lippold, Kathy Brewer, Lonnie Johns-Brown, Natalia Koss Vallejo, Jim Theofelis, Peggy Dolane, Brad Forbes, Melanie Smith, Liz Trautman **On the Phone:** Avreayl Jacobson, Jaclyn Greenberg, Kevin Black, Bob Hilt, Josh Henderson, Marsha Chenoweth, Mary Clogston, Shannon Simmons **HCA Staff:** Blake Ellison, Mandy Huber, Paul Davis, Diana Cockrell, LaRessa Fourre, Lois Williams, Patty King (by phone) The meeting started at 1:05. Blake asked everyone in the room and on the phone to introduce themselves. Blake reminded the participants about the ground rules, which are particularly

	important to include for those on the phone. Blake reminded the group that the purpose of the meeting was for the workgroups to report back to the main group. **Participation Ground Rules** -Take turns talking one at a time. -Refrain from side conversations. -Ensure opportunity for people on phone to ask questions and give input. -If we get stuck on a particular topic, we will move ahead and come back to it later today or next meeting. -Focus is on what we are doing now – not what has happened in the past. -Goal is to find common ground – which will mean compromise for everyone. -If you can't agree – please offer a solution!
(2) Overview of Family Youth System Partner Roundtables (FYSPRTs) reach out	**Lead: Diana Cockrell**
• Review of FYSPRT feedback RE: recommendations with consensus from PIT/AOC breakout group	Diana discussed this being the final Parent Initiated Treatment (PIT) workgroup. She said the group has come a long way and thanked everyone for their participation. She said here were ten meetings and tri-lead outreach to system partners. To gain further community feedback on recommendations, there was reach out to all of the regional Family Youth System Partner Roundtables (FYSPRTs) for their response. One region reported back that they had no concerns. A parent stakeholder said she felt that the FYSPTS have a lot of requests for feedback and don't always get a response out. She commented that the FYSPRT feedback system still needs work. She is hearing that the FYSPRTS were pleased with the results. A question came from a stakeholder if there was enough reach out to youth. The group was informed of the multiple reach outs to the FYSPRTs by HCA/DBHR and tri-leads. It was commented that youth voice through King County was comfortable with recommendations. A youth advocate stakeholder said that it was good to get the parent and student leader comments. And it would be nice to make sure that the youth feedback was gathered. It was commented that parents feel good about recommendations, although recommendations have not gone as far as they would have liked. No one on the phone had comments.

	A lead stakeholder stated that she hopes that everyone can accept the compromise and encouraged the emphasis to be on what we have agreed on instead of the negatives, which will only lead everyone backward. Blake said there were recommendations to do appraisals of the process as we go forward. It was commented that parents are really excited with the recommendations and do not want to move backwards.
(3) Overview of PIT/AOC Breakout Group	**Lead: Kathy Brewer**
• Review list of recommendations with consensus	Kathy reviewed the recommendations with the group. Overall, the recommendations that were agreed upon reflect that the treatment providers for minor-initiated, parent initiated, and involuntary treatment can share without the consent of the minor, a limited amount of basic information. Specific information is included in the Age of Consent (AOC) recommendations that were shared. However, the provider can chose not to share and will document why they are not sharing. They may also work with the youth about sharing at some point. Parents may authorize the limited release to stepparents. Parents and youth can release information to a new provider to provide treatment. Efforts should be made to try to get parent and youth to agree. Limited information cannot be shared about Substance Use Disorder (SUD), due to 42 CFR. A stakeholder said at the last meeting, that 42 CFR was discussed and may allow for some changes in our state law, where information regarding SUD could be shared. Could we add something additional in the recommendations? Kathy will look at this. Number 5, a stakeholder requested that we add other types of abusive therapies to the list, other than just conversion therapy that cannot be used. A parent stakeholder commented that other types of abusive therapy are covered in the licensing requirement recommendations. Number 2, a stakeholder asked if a youth doesn't consent, but the provider wants to release information, can the youth appeal the provider's recommendation to release information? Who would they appeal to? It was suggested that it could be fleshed out by adding in a way to show that the youth was informed, allowed to discuss it, and the decision documented, etc. A lead stakeholder asked if it could be added in the documentation that the youth was told the information would be shared and why the therapist is recommending it. Should "detriment" be defined? Is there an

	option of seeking a second opinion within the agency from another therapist? Is there an ombudsman option to appeal to? Does it need to be included that the young person needs to be informed before the information is released? Should there be documentation of the youth's concerns? It was suggested these concerns be added into Best Practices trainings for providers and an additional sentence about the engagement be added (that youth has been informed and objection noted). A stakeholder asked if we can spell out who the information is being shared with, i.e., parent/caregiver, and further stated that the Best Practice training should work well. Regarding number 2, the language will be clarified, adding in release of information is to parent/guardian, kinship caregiver, documentation of why information is being shared in the record, and added into the Best Practice training. Blake asked if there were additional comments from the phone. A stakeholder asked for clarification, if there is a definition of release of information? So it is clear, it was clarified in number 4 with the limited release of information, as illustrated in number 2. a-g. Kathy provided overview of numbers 6-11. Number 7, to include kinship caregivers in the definition of parent for PIT. Number 8, best practice to encourage involving both parents. May move to best practice training. Number 9, to protect the therapist, so they can't be sued. Number 10, defining who can provide treatment. Number 11, minor = agency has to notify a parent. A stakeholder flagged the need for mental health (MH) practitioners to seek out training and expertise for them to be able to handle difficult situations. A lead stakeholder shared that they would already have that kind of training, but maybe online resources could be offered. A stakeholder said there is a trend in requiring less education to provide treatment, so more resources within community treatment can be developed, such as by a youth/parent peer. Kathy suggested expanding training to include online training resources for further research. Further comments from page 2 were requested. There was a questions about the definition for the limited release of information and the need to further define the specific items? It was suggested to possibly connect

	5 and 2 together. Add to number 5 "as defined in number 2" and "limited release of information." On number 2, add the limited release of information, to include foster parents. A stakeholder commented on limited release of information, that the language should be consistent in regards to the DCYF social worker being able to authorize the Limited ROI to the FP. Was there thought as to how that fits in with Health Insurance Portability and Accountability Act (HIPPA). There is a suggestion to make sure that when the DCYF social worker is involved, they are the true legal guardian and have the right to authorize. A lead stakeholder commented that social workers are risk adverse and will not overstep boundaries. Another lead stakeholder suggested checking with an Assistant Attorney General (AAG) before sending recommendations to the Children's Mental Health Workgroup (CMHWG). Diana agreed to check with AAG. There were no additional comments from the phone attendees. Kathy summarized page 2. Number 8, moved to best practice, help with families involved in divorce. Page number 3- numbers 12-15. Kathy said that number 73 indicates access up to 12 sessions. A parent can authorize treatment, review occurs every 30 days. Clinical standards need to be developed. Number 14, agreed for parent to authorize for voluntary CLIP. Wraparound With Intensive Services (WISe) can be accessed by the parent if youth is authorized for service. Number 12 can be discontinued only by the parent or the provider. After the treatment period, the youth can discontinue. It was commented that the timeline on treatment review is every 30 days and by external provider every 45 days. Should the review timelines be the same? Group was informed there is currently only one external auditor in the state to do the reviews and there would be a need for additional resources, if review times were shorter. One youth advocate felt it was too long of a review period. A parent stakeholder felt it was too short. There is disagreement as to review time. No comments from participants on the phone. It was asked if we can specify that treatment be discontinued after three months. Paul clarified, that after three months, the youth could decline. Kathy clarified that

	the parent could initiate treatment again. It was asked if is there a limit to the number of times a parent could initiate outpatient (OP) treatment. There would not be a limit if left open ended. A stakeholder offered that it could be left to the provider's discretion. How would providers know how many times a parent initiated OP for their youth? It was commented that there are records with the youth at intake, or the medical records would show the amount of treatment the youth has had. This could go into the Best Practice training. A lead stakeholder informed that insurance companies may not authorize multiple treatment episodes. A stakeholder said there is a need to highlight this specifically in follow up work as to how this is playing out in practice. Kathy suggested an annual survey to monitor. Number 15-16. A stakeholder commented that these are suggestions, and don't necessarily need to be in law. To be proactive, it is recommended a free online training be developed for Best Practices working with children, youth, and families. HCA/DBHR to create and send out a survey on an annual basis for the first three years, to be reviewed and then shared. Number 18, CMHWG to consider changing language- Title of PIT- something less stigmatizing for parents. It was suggested to combine all the training and best practice information into one paragraph to be clear, rather than added in throughout the pages of recommendations. A question was posed if all licensed providers should be required to take the Best Practices online training. A stakeholder said it should not be required for all providers because not all providers treat youth. The online training should be viewed as a resource but not required. It was pointed out that youth were not very responsive to the survey. A suggestion was made to look at other options to reach youth, consider focus groups or something else, rather than survey groups to reach youth in the future. If surveys are relied on to reach youth voice, there may not be a good response.

	It was commented that we should be clear about what best practice is. Are we talking about Evidence Based Practices (EBPs)? There is a need to be aware, it may come across as something else. It was expressed that providers want to know the laws so that they can connect with the youth. A lead stakeholder said that training is expensive and there are continuing education requirements for licensed providers. At the end of the year, providers are told what the new laws are, but expertise is not required. People pay attention to the laws that they think affect them. It was suggested to add the laws on a website for parents to use. A parent stakeholder feels that the parents won't follow-up; there is a culture issue that needs to shift. Paul commented that he does a lot of training, especially with WISe; offering training for how to work through different types of issues with youth and families. Kathy summarized that training takes time to develop and offer, and should not be required. Stakeholders agreed with optional training. Kathy said that time should be taken to really develop a training and offer it. It would be a free continuing education unit (CEU). To summarize, Kathy will pull out the Best Practice sections and put on a separate document. Blake asked for responses from participants on the phone. A stakeholder, who was not present for Friday's PIT/AOC meeting, wanted to know if the group is rebranding the title, so people can be informed. Kathy said it is number 18 and the group didn't come to a conclusion. Exact wording has not been finalized and ideas will be referred to the CMHWG.
(4) Overview of Admission Practices Breakout Group	**Lead: Lonnie Johns-Brewer**
• Stakeholder group is informed of final recommendations, where consensus was reached	Lonnie shared the Admission Practices workgroup recommendations and thanked the group for their work. The group compared private insurance with Medicaid. There were only four final recommendations. 1. Recommend funding access for additional services. Ex. Limited resources for residential and Children's Long Term Inpatient (CLIP). Funding for post hospitalization. Where do kids go when released from the hospital, and there are not a lot of CLIP beds. System needs include places for kids to go. 2. Recommend safeguards or other supports for hospitals and E&T's that encourage, rather than discourage, the provision of PIT. Further discussion is needed as to the reason why PIT

	is utilized primarily by only four hospitals. Encourage the use of PIT for hospitals and E&Ts to admit. A deeper discussion is needed for more safeguards, is it a legal issue, or just the demand for beds? 3. Request possible increase in Medicaid rate. Some hospitals don't accept the Medicaid rate, leaving BHOs and MCOs to fund the remaining cost of treatment. Also, there are co-pays for private insurances. 4. Education and communication developed as to what community resources are available between hospitals, BHOs, and MCOs and informing parents of the resources. Laurie mentioned conversations around partial hospitalization being expanded. CMHWG, hospitals, and others are discussing this. The hospitals are supportive of partial hospitalizations. Discussion needs to occur that there is a code to bill for it but it is unable to be activated. It was said that the BHOs may pay for the services, but don't always. There have been isolated cases when paid, but again, the codes need to be activated. Kathy clarified that the recommendation is to activate the code to use partial hospitalization. Kathy commented that question number one could be spelled out to include preventative pre-hospitalization. The CLIP Administrator informed that the legislature authorized a rate increase and more beds are being added in various programs. CLIP access is expanding through CSTC and Pearl Street Center. A lead stakeholder commented that it would be good to know the number of CLIP beds pre-expansion and currently. Also, it would be good to verify which hospitals are using PIT. There are four hospitals with PIT beds, but the bed is based on the type of admission. A stakeholder recently heard that Mary Bridge had started to use PIT and now they are no longer admitting. HCA/DBHR will follow up and let Laurie know. Kathy said the law requires that PIT be accepted, but the hospital might be refusing on medical necessity requirements. Inpatient treatment has to meet admission criteria. Also, if it was specifically for an eating disorder, currently only Children's Hospital provides eating disorder treatment.

	A stakeholder had questions for Admission Practices recommendations. Are we talking about OP or IP? Does the Medicaid rate affect both? Lonnie clarified the recommendations are not for services just at hospitals but services for children to get further intensive services pre- and post-hospitalization. The group started out talking about the few places available for youth to go whether pre- or post-treatment and options for youth to get more treatment and care. The second one was about Medicaid for hospitalization. Number 3 needs to be clear about reimbursement. A lead stakeholder commented that there will be a lot of discussion about Medicaid rates. A stakeholder asked if there have been any Designated Crisis Responders (DCRs) involved in these conversations. It was suggested to add that it is just for hospitalization. It is important to be clear about funding streams. Open the funding to compel outpatient. Lonnie asked for clarification and if this is a future recommendation. It was reiterated, there will be a lot of Medicaid rates discussion. It is a huge issue. It was said by some stakeholders that it would be good for DCRs to be involved in future discussions as they are often the first line responder when a youth is in a crisis situation. Because DCRs are often the first to respond to a youth in crisis, they need to be versed so they can give correct information to parents. A lead stakeholder suggested it be included in the training plan to add to the list of Best Practice trainings. A parent stakeholder said that she talked with a DBHR staff about standards for youth, and it was clarified that the system is based on adult needs. Lonnie said that we are looking at work moving forward, and we need to include the DRCs. A stakeholder on the phone said that the DCR has other resources that they are aware of and look at unfunded mandates. It was concluded that DCRs will be included in the trainings. Lonnie will clarify if hospitals are the only facilities for treatment, or are there other options, both pre- and post-hospitalization. Which are hospital based and which apply more broadly? It will be noted that the future work is identified as well as remaining questions. Future work will be

	reviewing all the original questions to make sure all are covered one way or the other. A stakeholder asked if this workgroup needs to be continued or should the remaining questions go to other groups? Maybe work with hospitals to identify the barriers, etc. A lead stakeholder commented that there would not be a need to recreate this workgroup to have a conversation with hospitals. Work will continue through CMHWG, and other possible breakout groups. The group was reminded of the expansion of the Partnership Access Line (PALs) line January 1, 2019. By January 1, 2019, the community referral line will be open and would benefit from hearing about the options. Training for DCRs will be added into the recommendations. A lead stakeholder said we need future opportunities to provide them with education, so they know how to use PIT. There need to be ways for them to become knowledgeable and close the gap in training.
(5) Overview of Commercially Sexually Exploited (CSEC)Breakout Group	**Lead: Laurie Lippold**
• Review recommendations with consensus	Laurie provided CSEC overview. Laurie asked if there is anyone on the phone involved in CSEC. One stakeholder stated that they are involved in the workgroup. Laurie advised that the group did not want to duplicate the work of any other CSEC groups or be contradictory. Laurie discussed that the group is charged to see if PIT makes sense for CSEC. One breakout workgroup meeting took place in July and potential recommendations were sent out for feedback. There was not a significant response through email for comments. Basically the answer is no, in terms of using PIT for this group of youth. Demonstrating signs of being exploited is not an automatic use of PIT. There may be other indicators that can be used, in terms of signs of significant behavioral health (BH) issues. The discussion was around hospitalization and that it can be harmful if used wrongly. These youth should not be locked up because that has been used unsuccessfully. A question was asked if whether or not, *not* using PIT for IP, also pertains to OP. The question about OP will be sent back out to the group and then clarify if it is only for IP. It must be

	clear that PIT can be an option if the youth is of harm to self or others. Also, need to clarify the payment options. Questions 1-4 Number 1, clarified that this is limited to hospitalization. There was not discussion as to OP. Laurie will query the group if they agree for OP treatment. Number 2, yes, we need a variety of options for CSEC. Need capacity to address options - not just PIT. Number 3, receiving centers be co-located or in close proximity to hospitals and E&Ts. Clarification was asked about why there was push back to not co-locate with hospitals, E&Ts, etc. Reasons were provided such as youth not feeling comfortable in hospital settings. Some youth will tell others that if they go to a receiving center, they may end up getting hospitalized. Receiving center programs to be closely connected to IP options, as long as it would not inhibit the process or make it a requirement. A question was asked as to why an institution setting would not be safe. A lead stakeholder commented that the hospital's strict guidelines are not welcoming and would like to avoid imposing all the restrictions put in place when youth are hospitalized. A stakeholder on the phone supported not having mandatory admissions and also commented that a red flag has come up about capacity. The stakeholder supports the beneficial, although not mandatory, co-location to hospitals, etc. Number 4, added parent/kinship caregiver. More discussion needed to look at who else might help a youth file a PIT, but it needs more exploration, such as in the case of a youth needing PIT, but no parent/guardian able to file. It was clarified that ITA could be used by a DCR in a case like this. A parent stakeholder asked why would CSEC not be considered a danger to self? A lead stakeholder commented that this is a clinical discussion that should be tabled. A lead stakeholder followed up with a reminder that the PIT process includes a mental health diagnosis. There may be a lot of risky behaviors that do not classify a young person as mentally ill. The group was reminded that in the survey, parents disagreed with CSEC alone not being a reason to file PIT.

	A stakeholder shared that there is a lot of work being done around guardianships. Group is looking at more, least restrictive options for guardianships - something that doesn't take away all rights. It was suggested that Laurie connect with Rep. Kilduff? Remote comments were requested. None for number 4, which is the most energized conversation of who can file a PIT. Kinship care givers and also look at appointment of a guardian. Maybe a lack of capacity for the purpose of planning a PIT, but there has not been time to explore it. It is not suggested that law enforcement or receiving units file PIT. Waiting for additional input. It was reiterated that ITA would be the option if there is a concern of harm. Making uniform coverage is suggested. We should add any of our needs to the legislative contact. Would need to move quickly. Mostly geared at adults. It was asked about a youth without a parent or other to initiate treatment, should the state be called to consent for treatment. Kathy said most hospitals will because they need someone to release from treatment to. How does the CESC get to the hospital? Have they been arrested, showed up at clinic? If one shows up at an agency, can they be taken to hospital as a danger to self, but who can consent? Youth can be detained at the hospital. Laurie expressed appreciation for the information on guardianship that was provided. No additional comments were received. Paul said there was one third of the parents said there should be a referral to PIT for CSEC. PIT is for a MH diagnosis, but not necessarily a MH issue. Jim says as a clinician, what can a hospital do; medication, interruption of a pattern, but one hospital stay won't change behavior. It is a lot of work to get people out of that lifestyle. Laurie commented that recommendation number 2 covers young people needing more options, this should be one part of the services available.
(5) Discussion of report timeline	**Lead: Mandy Huber**
• Review timeframe of draft review to leads	**Report Timeline:** Leads will update recommendations and have back to Mandy by Monday-10/22. Mandy to send report to leads for review by 10/25 and leads can return back to Monday, 10/29.

	Mandy asked the leads how much time they need to review the report draft. Lonnie will get back on Wednesday and Laurie will return after she hears about OP PIT. Mandy will write up for review. Lonnie and Laurie agreed with a 24-hour turnaround time. Mandy will get the turnaround by the 29th. Mandy thanked everyone for their participation in this stakeholder group. Diana dismissed the meeting.
• End Meeting	The meeting ended at 3 PM