Parent Initiated Treatment/Commercially Sexually Exploited Children (CSEC) Stakeholder Breakout Group

July 19, 2018 Meeting

1:00PM-3:00PM

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	**Lead: Laurie Lippold**
• Introduction of attendees and review of legislative directive from BH2779	Attendees: Laurie Lippold, Melanie Smith, Melina Rozzisi, Paul Davis, Patty King, Nicholas Oakley, Jim Theofelis, Kathy Brewer, Brad Forbes, Lynne Marie Randall, On the Phone: Kalen Roy, Amy F., LaRessa Fourre, Peggy Dolane, Lois Williams, Amanda Lewis
(2) Introduction	**Lead: Laurie Lippold**
• Introductions	Discussion of Safe Harbor group's two pilot sights. The group has not met in a couple of months and plans to follow up soon. Beyond King County, they have developed a statewide taskforce to respond, which is comprised of 12 Commercially Sexually Exploited Children (CSEC) taskforces. King county has the largest taskforce and Mental Health Professionals (MHPs) participate. The statewide coordinating committee from the Office of the Attorney General meets twice a year and provides a report to the legislature.

	Have any of these groups talked about something like Parent Initiated Treatment (PIT) for CSEC? Yes, it comes up constantly, however no in-depth discussion or formal meeting has taken place. There are no options for treatment outside the Juvenile Justice (JJ) system. It was shared that some parents feel there aren't options. Committee for our Children participates on taskforce. Currently work is being done on website that has resources for those who want out of exploitation and need support and services. Melina offered to share this information with the group.
(3) Review survey questions	**Lead: Laurie Lippold**
• Discuss survey questions and identify population groups to send to	Survey development is underway for PIT. At the last full meeting we discussed who to send the survey to. Questions considered are: • Is PIT an effective mechanism? • Would we need to broaden the definition for the filing of PIT? • What does it mean to be CSEC? • Options for learning warning signs? • Who determines if a youth is CSEC? • If youth does not have parent or guardian, who may be able to file a PIT and what services would they receive? Question of language for involuntary Treatment Act (ITA) as well? Or do our boundaries stop at PIT? It is suggested that there should be language to talk about both. Could some kind of voluntary filing take place outside of JJ and what would the criteria be? Would anyone want to advocate for PIT as we know it? Some would advocate strongly against it. Starting at what we envision; perhaps subsection at Safe Harbor where youth who are not interested in accessing treatment could still access resources. If willing, would a youth get what they need? Youth with this particular client profile may feel overwhelmed. The vehicle we're thinking about is residential, and probably not appropriate for the majority of this population. Idea of outpatient only diagnosis. Suggestion of adding length of stay or types of services, and recommend that youth ITAs could be sealed. Do we need a legal vehicle to get someone into treatment, and what would this be? It would be important for it to be a simpler process for PIT vs. ITA. No legal involvement. We need to find something for this population. Discussed process of ITA and who files. Discussed Joel's law – MHPs can refer.

	There was disagreement with creating a legal avenue for this population of youth. There is importance of giving them autonomy and the possibility of doing more harm than good. It's not about what anyone thinks they need and offering something, but letting them decide if it is what they need. Research shows that it is better to approach this population with options. Example; instead of saying "here is food for you," say, "do you need anything to eat, can I get you anything?" Instead of saying "I want to talk to you," say "do you want to talk?" It was recommended to bring in experts, in fear that our intentions could backfire. Background onerous process for ITA. Suggest a guarantee that no youth would be decompensating and need to be in treatment. Safe Harbor – small subsection, small number of ITAs and using JJ as the last resort and continuing to use this as an avenue. Suggestion again could we figure out how to seal a record and not have an ITA be on the record? A question of how unstable would a youth have to be for them to be admitted? The concern is the youth will stop showing up because they know they may be hospitalized and will no longer seek resources. The definition is danger to self or others and parents feel that if youth are on the street being victimized that they are, in fact, a danger to self or others, but it may not be considered in the current definition of danger to self and others.
(4) Criteria for filing a PIT and possible program	**Lead: Laurie Lippold**
• Discussion about potential receiving center model and criteria	Receiving center model – pilot two receiving centers for those who are willing to engage in treatment. Model composed of three tiers: immediate, acute, and long-term residential. Law Enforcement (LE) would potentially pick up a young person, could arrest but not charge, wanting the right to take them to a safe place. LE officer could get information during this time. A concern is not putting the youth back out on the street, with the risk of others knowing they just gave their information to the police. Outside of LE, should someone else be able to refer? Should/would a facility be locked? These youth are hyper-dependent on their exploiter, which can induce psychotic breaks because they are no longer in control and a seven-day hospitalization can make it worse. The response is individualized depending on the youth, the involvement with LE, and where they are taken. There doesn't appear to be a law for this, but receiving centers sound good. It can be beneficial if the receiving center is locked, but the research doesn't support locked facilities for this population. The idea that the facility is not a hospital is good. But some youth would need a hospital and then would be medically cleared to go to the receiving center, or that could happen at the receiving center. A stakeholder commented if it's not locked for the first 72 hours they are going to leave. Parents are concerned

	and it's difficult to hear that the child was held for eight hours and then was able to leave. Also, some have experienced an appearance of bias regarding a CSEC profile, and this population is looked at as choice based. A stakeholder recommends finding a balance among all recommendations and approaches, and using a harm reduction approach. Criteria – medical necessity from hospital for youth engaging in risky behaviors within this population to be treated. Without medical necessity rating, treatment might not meet medical necessity criteria from insurance payers. MHP could make recommendation. Maybe some funding recommendations could be state funded. With an ITA, if commercial insurance won't pay, then Medicaid has to pay. There could be a special class to make youth Medicaid eligible if commercial insurance won't pay. A suggestion is a pathway to Children's Long Term Inpatient (CLIP). Voluntary application can be submitted, and a youth is put on a 180-day order, preceded by 72-hour and 14-day reviews. They could be put on the CLIP waitlist. It can be voluntary or ITA route. Who understands how to access CLIP application and process? MHPs participate in CLIP committees and know process. For example, Excelsior has experience with CLIP referrals, that all LRAs must be exhausted first. There is some bias for inpatient programs. CSEC is often seen as a behavior issue, and not psychological/psychiatric issue. There is limited understanding of the medical necessity component as a parent and/or provider. Stakeholder group does not want to create a system that isn't going to serve them appropriately. Who can initiate? Do we create receiving centers? Need someone to determine the best route of treatment. Maybe it is less about creating another path for PIT, but having enough options available. Co-location of receiving center to also be clinically licensed, they would have the ability to do a PIT or ITA. For CLIP, there are 84 beds, 4 contracted beds and are licensed as an E&T but it would be a separate program. Over half are ITA admits (65, 70%). Which has been a flip the last couple of years for CLIP. Other than a parent or the state, who should be able to initiate an ITA if they have a CSEC situation? Does there need to be a change in language for the parent? Would social workers get involved in this? Is there a role for them? If children are being abused, it's a mandatory reporter situation. Would Child Protective Service (CPS) social workers be involved? CPS may become involved if there is suspected family abuse/neglect. Expand definition of guardian to include Kinship care giver. Medical care form gives someone

	besides the parent ability to initiate care. The medical care form is online. During last meeting, adding kinship caregivers was recommended. Concern expressed for LE, that every time they come into contact with a CSEC youth, the officer would need to take the youth for evaluation. No, this is not what is meant. Youth who are mentally ill have avenues to get help, with the exception of this population. This is a gap and maybe youth is not mentally ill enough to be hospitalized. Decomposition – receiving center - psychosis or something for hospitalization? Disagreement was expressed by a stakeholder. ITA is a long process. In some counties, youth can be strapped to a gurney to participate in court proceedings for the legal process. This can be very traumatizing. PIT is also used as another option for ITA. For some youth who don't have a parent, ITA is an arduous process. Do we need another person to initiate this process? Some say yes, some say no. Talking about creating multiple options, and who else should initiate PIT? If we don't want to broaden eligibility, then we just need to determine who else, if anyone. Instead of arresting them, where would youth go? Could have problems with misuse. A stakeholder expressed concern that even taking someone to a hospital to be evaluated, will be harmful. Is exchanging sex for money a symptom? No
(5) Summary of Conversation and Next Steps	**Lead: Laurie Lippold**
• Review possible recommendations and next steps	Laurie summarized conversation and next steps. Two possibilities: First, a receiving center may be a good place. There are available receiving services that they could be referred to. Second, Is there some type of least restrictive alternative (LRA) to create something for CSEC requiring outpatient. Cautious of center and dual role, and potential of ruining this relationship. If center files PIT, contamination of role.

	There is a lot of talk from the mental health perspective, and taking youth to hospitals, we also need to keep in mind that this impacts substance use disorder as well and when in place, youth can be taken to residential treatment if provider is willing to participate in PIT, as well as secure withdrawal management facility for ITA. Need to include survivors and law enforcement Maybe a place for open ended questions to ask about how youth receive services who are being sexually exploited. Other comments: How are you using Child In Need of Services (CHINs) petitions and other mechanisms, and the answer is that it is not being used. If not for survey, some information we gather may be helpful. CSEC term is not a very well-known acronym. Need for a quick turnaround for minutes and questions to Laurie
End Meeting.	Meeting adjourned