NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

May 30, 2011

1. Please join my meeting.
https://www3.gotomeeting.com/join/365107910

2. Use your microphone and speakers (VoIP) - a headset is recommended.
Or, call in using your telephone.

Dial +1 (805) 309-0011
Access Code: 365-107-910
Audio PIN: Shown after joining the meeting

Meeting ID: 365-107-910

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSRSN region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10/27/99
Revised: 1/17/01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: May 30, 2012 **Time: 1:00-3:00 PM**

Location: NSMHA Conference Room

For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	• On-line crisis plans available after August 1st. • LR Contacts at providers	Inform /discuss	All				*10 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.	Inform /discuss	Chair/ Greg				*5 min*
		Quality Topics					
Focused Clinical Improvement Meeting Process (Clinical Forums)	Follow-up on Ombuds recommendation that there be discussions on key clinical issues	Inform/ discuss	Greg	Committee Discussion Form		**3**	*15 min*
Routine UR Revision Requests	Follow up on outstanding UR revision requests	Inform/ Discuss	Charissa	Committee Discussion Form		**4**	*5 min*
North Sound System providing Healthy Options Services	A Health Plan wants NSMHA to manage their Healthy Options Mental Health Benefit and use our network and system.	Inform/ discuss	Greg	Committee Discussion Form		**5**	*30 min*
Proposed Contract Amendments	Likely contract change requiring outreach services to nursing homes and other facilities.	Inform/ Discuss	Greg	Outline of proposed changes		**6**	*10 min*
Provision of Specialized Services	Discussion regarding provision of specialized services.	Inform/ discuss	Greg	Committee Discussion Form		**7**	*10 min*
Housing Complaints	Discussion regarding NSMHA's jurisdiction regarding complaints about housing.	Inform/ discuss	Diana	Committee Discussion Form		**8**	*10 min*
Parent Initiated Treatment	New RCW regarding treatment for children ages 13-18.	Inform/ discuss	Charissa	Committee Discussion Form		**9**	*10 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: June 27, 2012 - 1:00-3:00 PM **Potential Future Agenda Items:**

Draft not yet approved

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
April 25, 2012
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: **Mark McDonald, Candy Trautman** and **Susan Ramaglia**, NSMHA Advisory Board; **Dan Bilson**, NAMI Whatcom; **Stacey Alles**, Compass Health; **Marie Jubie**, Snohomish County Council on Aging; **Larry Van Dyke,** Pioneer Services; **Anne Deacon**, Whatcom County; **Mike Manley,** Sunrise Services; **Cindy Ferraro,** Bridgeways; **Kathy McNaughton,** Catholic; **Chuck Davis,** Ombuds; **Nancy Jones**, Snohomish County and **Joan Lubbe,** NSMHA Advisory Board.

BY PHONE: Fred Plappert, NSMHA Advisory Board; **Pam Benjamin**, WCPC; **David Small,** Sea Mar and **Cindy Paffumi**, Interfaith.

STAFF: Greg Long, Kurt Aemmer, Charissa Westergard, Tom Yost, Sandy Whitcutt and **Barbara Jacobson**.

OTHERS PRESENT: **Carol Van Buren**, Sunrise and **Heather Fennell**, Compass Health.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	Anne called the meeting to order at 1:00 pm and introductions were made. The agenda was reviewed for additions; the Allen Marr Report is moved up in the agenda to the top of quality topics.	
2. **Previous Meeting Summary – Chair**	The meeting summary is reviewed and is approved as amended.	Approved
3. **Announcements and Updates – All**	• The State budget was passed with minimal cuts to mental health over what was thought may occur; though B3 services loss funding which for this region is for supported employment ($253,000). Greg noted that NSMHA recommended using the fund balance to retain this program. They did not end up closing the decertified wards at WSH. • The new Executive Director Joe Valentine started Monday and has hit the ground running. • Greg noted that the State has given some information on contract amendments that will be upcoming. There will be greater expectations to provide services to older adults to keep them from being institutionalized. There will also be expectations around increasing services to special populations; Greg believes we may be required to do a PIP around asking about sexual identity; we are behind on this in this region. • Stacey noted that Compass Health has some management positions open; an outpatient director for the three north counties and a PACT manager. Pass the word onto any you know who may be interested.	Informational
4. **Evaluation Forms from**	Anne reviewed the feedback received on the forms for the last meeting. Greg suggested doing this verbally at the end of the	Informational

Last Meeting – Chair/Greg	meeting to help with low responses.	
5. Allen/Marr Settlement Reviews	Tom noted that Allen Marr Settlement came from a lawsuit against the state with DD clients at State hospitals not being able to get out and settle in the community from lack of services. We review one case on a quarterly basis in a case review to look at coordination of services of DD and mental health. Tom had done this in the past and Terry is taking it over. He reviewed the report and noted the things that are working well and gave recommendations on things that need to be improved. This is the general report; we will do a summary report and go to providers with specific recommendations and after we hear from them how they will address these we finalize the report. In this region there are 40 clients that we serve in this Allen Marr Class; though we serve many more DD clients overall.	Informational
6. Ombuds Quarterly Report	Chuck gave his report as included in the packet and noted that complaints are down and noted the good work of providers around this. One of the recommendations made is for DID training for providers. Greg noted the low number of cases in the region for such specialized training; also it is a long course of treatment. Greg asked for suggestions on how to treat these infrequent severe diagnoses such as this and eating disorders. There is a suggestion to use consultants in some of these cases. Kathy noted that they have many clinicians trained in trauma work and that they would prefer to consult with experts as needed; then they would still maintain control over the case they are responsible for.	Informational
7. Second Opinion Report	Kurt reviewed the report that is included in the packet. He noted that were 14 requests in this timeframe and all were completed within the 30 day timeline.	Informational
8. Semi Annual CIRC Report	Kurt reviewed the report that is included in the packet and noted that there were 22 incidents reported with one screened out. He noted that new contract language may be coming where they may add categories or loosen up on some categories; an update will be made if this changes.	Informational
9. Online CA/LOCUS IRR Assurance	Charissa noted these assessment decision tools were adopted in 2007 and last year we started regional inter-rater reliability (IRR) scoring; the attachment reviews provider concerns and the RSN response to help address some of this. One of the large changes is that an online scoring tool will be starting up soon and Charissa gave a brief overview of the online system. Another change is that clinicians that pass will test every other year instead of every year. Discussion on the timeline for training and when to test is discussed and Charissa will review to see what decisions were made on when to test the first time. Charissa will let everyone know when the online tool is ready to go.	Informational
10. Status of Online	Greg noted that this issue came about as the databases were split	Informational

Crisis Plans	up and the online crisis plans became unavailable for all providers to utilize. The workgroup of provider and IT people met and finished the work that had been started. The data elements that needed to be added per this meeting went to the CIS group to take on the recommendations and it seems to be workable. A notice will go out on this soon with the 90 day timeline to update your system. Stacey noted that Bobbie Belushi has worked with the providers to assist in working with Raintree around this. Mike M noted the cost concerns that providers have that will come from working with Raintree. Greg will check with Michael on what the timeline is once the provider enters the data; how soon will it be available to view.	
11. Less Restrictive (LR) Process	Sandy noted that a consumer may be released from involuntary hold on a less restrictive order where they can be discharged but still need some conditions placed on them. This is for 90 days; providers provide more intensive services during this time. The policy was updated in September 2011 and she has heard from some providers and wants to check in; the policy is attached for review. David S. noted they were not contacted ahead of time for release of some clients and he noted the issue of discharge without two weeks of medication. Charissa noted this is discussed occasionally at the inpatient meetings. David also noted that the police would not get involved in a case where an LR needed to be revoked. Sandy noted that these are called pick up orders and only a DMHP can request a pick up order with the police. Pam B noted that Peace Health has been calling every time recently. No advance notice can be given when they are released by the court at times. NSMHA would like a list of a contact and a back up contact for each agency that can be distributed to hospitals to call when a discharge is emergent. Send feedback to Sandy with specific names for her to review and send your contacts to Sandy to put together the agency contact. Sandy will send an email to all to request this.	Informational
12. Policy Approval 1723	Sandy noted that this is a new policy; it is for coordinating with licensed care facilities to prevent risk of losing their placement or hospitalization. It also addresses the resident being able to discharge back to their facility. There is a motion to approve policy 1723 as presented; there is a motion and a second. Motion carried.	Motion carried
13. Open Forum	None mentioned.	
14. Date and Agenda for Next Meeting	The meeting was adjourned at 3:03 pm. The next meeting is May 23, 2012.	

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Clinical Forums

PRESENTER: Greg Long

COMMITTEE ACTION: **Action Item (x) FYI & Discussion (x) FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Ombuds in their last report recommended setting up forums on reoccurring clinical issues. Ombuds stated:

We recommend NSMHA consider forming a regional team to discuss common, core issues of difficult-to-treat clients—problems of delusion, inappropriate behavior, paranoia, meds refusal and chemical dependency for example. The team would discuss these issues and eventually develop practices that prove most effective locally. We recommend NSMHA introduce this to the Quality Management Oversight Committee and tie in the concepts of using motivational interviewing and peer counselors.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA proposes that we try a 90 minute clinical forum on a quarterly basis for one year on a specific topic. NSMHA will arrange for our Medical Director to lead two of these forums and requests that providers have one of their clinical staff lead two of these forums. QMOC would select the topics. These forums might lead to clinical programming changes or guidelines which could be handled through our ongoing quality management and QMOC processes.

TIMELINES:

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Outstanding 2012 Routine UR Revision Requests

PRESENTER: Charissa Westergard

COMMITTEE ACTION: **Action Item () FYI & Discussion () FYI only (X)**

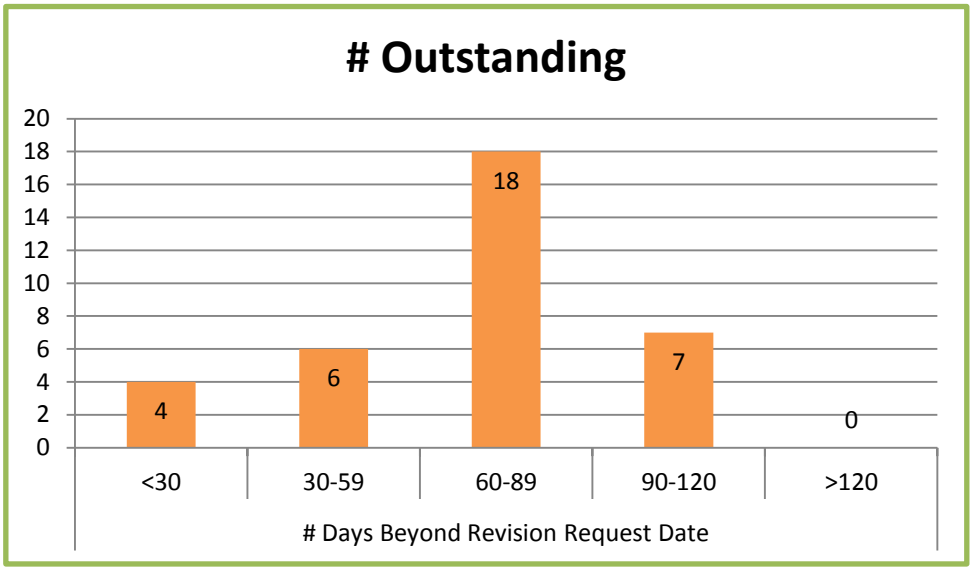
SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
NSMHA conducted the Routine Utilization Review February – April 2012. For those charts where a change was needed, a letter was sent requesting revision. The responses to these requests are due within 30 days, but we understand that some of the requests can take a bit longer to complete. We think that 60 days is a reasonable amount of time to complete requested changes. In the attachment, note that there are 25 outstanding revision requests regionally that are at or beyond the 60 day mark.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA will be notifying agencies of the specific requests at their agency that are at or beyond the 60 day mark. Please ensure a prompt and complete response.

TIMELINES:

ATTACHMENTS:
UR Requests

Current Outstanding 2012 Routine UR Revision Requests
as of 5/21/2012



NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Providers' Providing Healthy Options Services

PRESENTER: Greg Long

COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
One of the Healthy Options Health Plans has approached NSMHA about managing their Healthy Options Mental Health Benefit. The Healthy Options Benefit is 20 outpatient sessions per year for children and 12 outpatient sessions for adults per year. People on Healthy Options still are entitled to their RSN benefit if they meet the State-wide access to care standards. It is envisioned that our existing access, care coordination, grievance system, and provider network would be used as much as possible. Services would have to be provided by master's level staff and above. This system is contractually obligated to begin functioning on July 1, 2012.

NSMHA is currently investigating the payment rates. Specific rates may be available by the time of QMOC. They are likely to be lower than the current rates that NSMHA pays for RSN services. These will be for people with less severe problems. NSMHA will directly pass through the rates that the Health Plan pays NSMHA. It is proposed that NSMHA will be paid a separate administrative fee for managing this benefit.
Questions that arise:

1. Are providers currently providing Healthy Option funded mental health services?
2. Do providers have sufficient capacity to take on additional individuals?
3. How low can the fee go before providers cannot afford to provide this service?
4. Can SeaMar and Interfaith Clinic afford to provide these services at low rates and then get additional funding through the FQHC funding system?

CONCLUSIONS/RECOMMENDATIONS:
This is a new step for NSMHA and the public mental health system. It must be viewed as an initial step into Health Care Reform. This will take some innovation and adjustments on all of our parts.

TIMELINES:

ATTACHMENTS:

Proposed new contract Amendments

5/21/2012

DBHR is proposing new and more specific contractual requirements of our RSNs regarding services to be delivered at nursing homes, AFHs, etc.

7.6.2.1. Maintain the ability to provide an intake evaluation at adult family homes, assisted living facilities or skilled nursing facilities to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the Enrollee requires an on-site service due to Enrollee preference or medical needs or lack of transportation.

7.6.2.2. Maintain the ability to provide services to Enrollees in adult family homes, assisted living facilities and skilled nursing facilities when required due to Enrollee preference or medical needs or lack of transportation.

7.12.1. At a minimum the Contractor shall:

7.12.1.1. Provide an intake evaluation by a MHP within ten (10) working days of an Enrollee request. Maintain the ability to provide an intake evaluation at adult family homes, assisted living facilities or skilled nursing facilities to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the Enrollee requires an on-site service due to Enrollee preference or medical needs or lack of transportation.

7.12.1.5 Maintain the ability to provide services to Enrollees in adult family homes, assisted living facilities and skilled nursing facilities when required due to Enrollee preference or medical needs or lack of transportation.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Highly Specialized Services

PRESENTER: Greg Long

COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

Ombuds raised the following issue in their last six month report:

Sometimes clients with histories of complex trauma also have co-morbid diagnoses of Dissociative Identity Disorder, or DID. We see the need for select staff in the provider agencies to be trained to treat DID. It's very likely that the definition of DID will broaden considerably in the DSM V and an increasing number of clients may have medically necessary treatment needs for it. We recommend that NSMHA arrange training and create a cadre of therapists within the community mental health program. Within this cadre, mutual support and case consultation can occur for therapists treating clients with DID. The International Society for Study of Trauma & Dissociation offers basic and advanced training courses on-line and in the region. The Society also has studies in progress to determine best practices.

The drawback of doing extensive training with staff on treatment of fairly infrequent clinical disorders is that they do not see enough of these disorders to develop experience and expertise in the treatment of the disorders. NSMHA provided extensive training on eating disorder treatment at considerable costs. Now after several years, the staff involved in that training has either left the public mental health system or haven't seen enough individuals with severe eating disorders to feel confident in treating the disorder.

This issue was briefly discussed at our last meeting. One QMOC member suggested the hiring of consultants to oversee the service by their staff. This is certainly an option open to agencies.

The other option is for the service to be subcontracted to a specialist. NSMHA has had this occur previously. It can be costly and can continue for extended periods of time (years). A number of consumers with hearing disabilities have been treated by a specialized provider in King County.

Providers may be paid for these services by turning in service encounters through the CIS system like any other service.

CONCLUSIONS/RECOMMENDATIONS:

These situations arise infrequently, but provider agencies need to be prepared to arrange and manage these infrequent cases.

NSMHA proposes sending people with specialized and infrequent diagnoses which require long-term out of network services for independent out of network 2nd opinion on the diagnosis (At UW or specialized expert).

Adequate credentialing, contracts and oversight of these subcontracted services is essential.

TIMELINES:

ATTACHMENTS: Policy 1522

Effective Date: 4/25/2008; 7/29/2004
Revised Date:
Review Date: 5/30/2012

North Sound Mental Health Administration

Section 1500 – Clinical: Out-of-Network Referrals

Authorizing Source: 42 CFR 438.206
Cancels:
See Also:
All Provider contracting with NSMHA must comply with the following policy
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date:

POLICY #1522.00

SUBJECT: OUT-OF-NETWORK REFERRALS

PURPOSE

To permit a referral to a Mental Health Care Provider (MHCP) outside of the North Sound Mental Health Administration (NSMHA) Provider Network in order to meet the medically necessary mental health needs of a NSMHA consumer.

POLICY

NSMHA has developed an integrated care system and strives to provide all medically necessary mental health care within the NSMHA Provider Network. NSHMA and its providers will have in place a process that permits a referral to an appropriate MHCP outside of the NSMHA Provider Network when there is not a MHCP with appropriate training and experience in the NSMHA Provider Network to meet the particular medically necessary mental health service needs of the NSMHA consumer. The CMHA contracting with this MHCP must assure this MHCP is credentialed appropriately by their agency so the person is qualified to provide and bill for the services they will be providing.

Consumers referred to subcontracted MHCPs or out-of-network providers will remain in open status with the referring agency. Clinicians serving consumers who receive subcontracted or out-of-network care will get updates at least every six months and keep the NSMHA Care Coordinator informed of the status of the consumer's ongoing care. Providers are responsible for submitting encounter data to the MIS system and maintaining appropriate documentation to maintain compliance with Medicaid rules.

Subcontracted services are not considered out-of-network services, and do not require approval by NSMHA, but NSMHA does require notification of consumers receiving these services. A subcontract is an ongoing contract between a CMHA and individual or organization to provide services not available within the network for a group of individuals. Copies of subcontracts will be submitted to NSMHA annually and new contracts within 30 days of the contract start date.

An out-of-network referral is considered to be a service that is not covered by a current contract or subcontract, therefore requiring a new agreement to be initiated by the provider agency. It is for a specific individual at a specific time for a specific service and service period. It is not an ongoing subcontract.

Referrals to providers outside the state of Washington must be approved by NSMHA. These referrals will only be approved if it is found that there is no appropriate provider available within the region and state.

PROCEDURES

For Subcontracted and Out-of-Network Services:

When a provider sends a consumer for treatment outside of the CMHA for either subcontracted services or out-of-network/in-state services, the provider will notify the NSMHA Care Coordinator by telephone, fax or letter including consumer name, consumer number, and the name/address/phone number of the non-CMHA provider, with a short justification for the use of the non-CMHA provider.

If the out-of-network provider recommends a particular treatment, diagnostic test, or service covered by NSMHA, and it is determined to be medically necessary and a NSMHA covered service utilizing NSMHA's criteria, then that treatment, diagnostic test or service will be provided at no cost to the consumer.

Subcontracted and out-of-network services are contracted and paid by the provider agency making the referral. NSMHA will reimburse the contracted provider at the standard hourly rate.

Out-of-state referrals: When a consumer requires a service that is not available within the state, a request may be submitted to the NSMHA Adult or Child Care Coordinator as appropriate.

The request can be submitted orally or in writing by:

1. The NSMHA consumer, custodial parents of children and adolescents, and/or others with legal custody;
2. NSMHA Provider, and/or the initial MHCP conducting the intake assessment.

The request for an out of state provider will be reviewed by a Care Coordinator or other decision making authority in conjunction with NSMHA's Medical Director based on medical necessity and the consumer's current symptoms. The Care Coordinator and Medical Director determine whether or not a qualified MHCP or an equivalent service is available within the NSMHA Provider Network or within the state before considering if an out of state referral is appropriate and the final determination is rendered. NSMHA may request a second opinion in this process.

Criteria for out-of-state service approval:

1. Consumer has a current coupon with a mental health benefit
2. Consumer has had an assessment by a contracted provider
3. Contracted CMHA provider certifies that the treatment requested for the consumer is medically necessary, is not available from that agency, and that they are not aware of its availability within the network or the state.
4. Contracted CMHA will continue to work with the consumer, monitor the out-of-state care the consumer is receiving, and report updates to the NSMHA Care Coordinator.

Notices of determination will be rendered within the following time limits:

1. Urgent/Emergent treatment within twenty-four (24) hours;
2. Routine treatment within fourteen (14) calendar days.

Medically necessary mental health care services can only be rendered by out of state MHCPs that are qualified to review and treat the particular mental health condition identified in the request.

Payment for out-of-state services is contracted directly by NSMHA with the out-of-state provider agency.

The Care Coordinator will keep a log of all subcontracted, out-of-network and out-of-state treatment provided.

Each Provider within NSMHA's Provider Network shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into their agency policy manual.

ATTACHMENTS
None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Complaints about Housing Programs

PRESENTER: Diana Striplin / Greg Long

COMMITTEE ACTION: **Action Item () FYI & Discussion (x) FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY

Some of our providers have separate housing programs. The North Sound Mental Health Administration does not contract for these programs.

Occasionally consumers raise concerns about these programs that are outside the scope of the NSMHA grievance process.

CONCLUSIONS/RECOMMENDATIONS:

The NSMHA Complaint, Grievance and Fair Hearing Process are for services funded by NSMHA. If a problem comes up about services provided by other systems and by non-NSMHA funding, complaint process provided by those systems should be utilized.

NSMHA requests that providers with separate housing programs identify their complaint contact for these types of complaints so we can refer these complaints to the correct staff at each agency.

TIMELINES: None

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Parent Initiated treatment RCW sections 71.34 600-660 and 71.34.700-795

PRESENTER: Sandy Whitcutt or Charissa Westergard

COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This new RCW offers direction for parents who are seeking mental health treatment for their child ages 13-18. It gives guidance regarding the evaluation as well as inpatient care. This is a change from previous inpatient laws for 13-18 year old children, and offers parents more control to initiate care.

CONCLUSIONS/RECOMMENDATIONS: na

TIMELINES: na

ATTACHMENTS: RCW and parent initiated information form

Inside the Legislature

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- OFM Fiscal Note Website

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RCWs > Title 71 > Chapter 71.34 > Section 71.34.600

71.34.530 << 71.34.600 >> 71.34.610

RCW 71.34.600

Parent may request determination whether minor has mental disorder requiring inpatient treatment — Minor consent not required — Duties and obligations of professional person and facility.

(1) A parent may bring, or authorize the bringing of, his or her minor child to an evaluation and treatment facility or an inpatient facility licensed under chapter 70.41, 71.12, or 72.23 RCW and request that the professional person examine the minor to determine whether the minor has a mental disorder and is in need of inpatient treatment.

(2) The consent of the minor is not required for admission, evaluation, and treatment if the parent brings the minor to the facility.

(3) An appropriately trained professional person may evaluate whether the minor has a mental disorder. The evaluation shall be completed within twenty-four hours of the time the minor was brought to the facility, unless the professional person determines that the condition of the minor necessitates additional time for evaluation. In no event shall a minor be held longer than seventy-two hours for evaluation. If, in the judgment of the professional person, it is determined it is a medical necessity for the minor to receive inpatient treatment, the minor may be held for treatment. The facility shall limit treatment to that which the professional person determines is medically necessary to stabilize the minor's condition until the evaluation has been completed. Within twenty-four hours of completion of the evaluation, the professional person shall notify the department if the child is held for treatment and of the date of admission.

(4) No provider is obligated to provide treatment to a minor under the provisions of this section except that no provider may refuse to treat a minor under the provisions of this section solely on the basis that the minor has not consented to the treatment. No provider may admit a minor to treatment under this section unless it is medically necessary.

(5) No minor receiving inpatient treatment under this section may be discharged from the facility based solely on his or her request.

(6) Prior to the review conducted under RCW 71.34.610, the professional person shall notify the minor of his or her right to petition superior court for release from the facility.

(7) For the purposes of this section "professional person" means "professional person" as defined in RCW 71.05.020.

[2007 c 375 § 11; 2005 c 371 § 4; 1998 c 296 § 17. Formerly RCW 71.34.052.]

Notes:

Findings -- Purpose -- Construction -- Severability -- 2007 c 375: See notes following RCW 10.31.110.

Finding -- Intent--2005 c 371: "The legislature finds that, despite explicit statements in statute that the consent of a minor child is not required for a parent -initiated admission to inpatient or outpatient mental health treatment, treatment providers consistently refuse to accept a minor aged thirteen or over if the minor

does not also consent to treatment. The legislature intends that the parent-initiated treatment provisions, with their accompanying due process provisions for the minor, be made fully available to parents." [2005 c 371 § 1.]

Severability -- 2005 c 371: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [2005 c 371 § 7.]

Findings -- Intent -- Part headings not law -- Short title -- 1998 c 296: See notes following RCW 74.13.025.

Washington State Department of Social & Health Services

Mental Health Treatment Options for Minor Children

Parents or guardians seeking a mental health evaluation or treatment for a child must be notified of all legally available treatment options. These include minor-initiated treatment, parent-initiated treatment, and involuntary commitment.

Minor-Initiated Treatment (RCW 71.34.500-530)

A minor child, 13 to 18 years old, may request an evaluation for outpatient or inpatient mental health treatment without parental consent. If the facility agrees with the need for mental health treatment the child may be offered mental health services. For a child under the age of 13, either parental consent or consent from an approved guardian is required for inpatient treatment.

Parent-Initiated Treatment (RCW 71.34.600-660)

If the child is under the age of 18, the parent, guardian or authorized individual may bring the child to any mental health facility or hospital and request that a mental health evaluation be provided. This evaluation cannot take longer than 72 hours. Consent of the child is not required for either an outpatient or inpatient evaluation, or recommended inpatient treatment.

If it is determined the child has a mental disorder, and there is medical need for inpatient treatment, the parent or guardian may request that the child be held for treatment. If the inpatient program believes the child needs treatment for more than 7 days, the Department of Social and Health Services (DSHS) must then review the need for treatment. The child has the right to petition the Superior Court for release from the facility after the 7 days.

After the DSHS review, if DSHS determines that the child no longer needs inpatient treatment, the parent or guardian must be immediately notified, and the child will be released within 24 hours. In this case, if the parent or guardian and facility both believe it is medically necessary for the child to remain in inpatient treatment, the facility will hold the child until the 2nd judicial day following the DSHS review. This will allow the parent or guardian time to file an at-risk youth petition (RCW 13.32A.191) by calling the Division of Children and Family Services Intake Line or by going to their local Juvenile Court. If DSHS determines that the child needs outpatient treatment and the child declines such treatment, the refusal shall be grounds for the parent or guardian to file an at-risk youth petition.

For information about possible out-of-home placement of the child, call the Division of Children and Family Services and request a family assessment per RCW 13.32A.150. Family Reconciliation Services (RCW 13.32A.040) may also be provided through this Department.

Children admitted to inpatient facilities under minor initiated or parent initiated treatment procedures must be released from the facility immediately upon the written request of the parent.

Please note: ***No provider is obligated to provide treatment to a minor under the provisions of Parent-Initiated Treatment. However, a minor's refusal to consent to treatment shall not be the sole basis for a facility's decision to decline services.***

Involuntary Treatment (RCW 71.34.700-795)

If the facility believes the child is in need of immediate inpatient mental health treatment and the child refuses to consent to a voluntary admission, the child may be held for up to 12 hours to enable a Designated Mental Health Professional (DMHP) to evaluate the child for possible involuntary commitment. If no voluntary or less restrictive alternatives are available, and the DMHP determines that the child presents as a likelihood of serious harm or gravely disabled, as a result of a mental disorder, the child may be held at a facility. If the child is admitted to an inpatient mental health facility, he/she will be seen by a mental health specialist and medical staff within 24 hours. If it is determined that your child would be better served by a chemical dependency treatment facility he/she will be referred to an approved treatment program defined under RCW70.96A.020. The child can be held for treatment up to 72 hours, excluding weekends and holidays. During this time, the facility may petition the court to have the child committed for an additional fourteen days if they believe further treatment is necessary. At the end of the 14 days, the facility may file a petition for up to one hundred eighty days of additional treatment. If the facility does not file a petition for an additional 14 or 180 days, the parent or guardian may seek review of the decision by filing notice with the court and providing a copy of the facility's report. To obtain a copy of the report, a Release of Information form must be completed and submitted to the records department of the inpatient facility.

If the DMHP does not hold the child, the parent or guardian may seek review of that decision by filing notice with the court and providing a copy of the DMHP's report or notes. To obtain a copy of the report or notes, a Release of Information form must be completed and submitted to the records department of the DMHP office.

If the child is released from hospitalization on a conditional release or a court order for a less restrictive alternative and is not following the conditions of that release/order, or has substantially deteriorated in his/her functioning, the child may be taken into custody by a DMHP and transported to an inpatient evaluation and treatment facility. For further assistance or questions, call the local mental health crisis line.

☐ ***I have been provided with written and verbal notice of the available treatment options for the child.***

_____

Parent/Guardian Signature Date

_____

Facility Representative Signature Date

☐ ***Unable to obtain Parent/Guardian signature or acknowledgment because:***

_____

Reason for lack of signature

_____

Facility Representative Signature Date