Overview

Advocating for Access and Appropriate Treatment

This section of the Practice Kit provides information related to mental health consumer rights, information privacy, and miscellaneous tips and fact sheets to assist the consumer in accessing appropriate mental health treatment in the District of Columbia.

CLC Resource Guide

Mental Health Consumer Rights

Resources

- **D.C. Code § 7-1231.01, *et seq.***
  - This Chapter of the D.C. Code is entitled the Mental Health Consumers' Rights Protection Act of 2001. There are also several specifically enumerated rights pertaining to the autonomy and privacy of consumers "in residential, day, or inpatient treatment programs," *see* D.C. Code § 7-1231.04 (e). The Act further outlines consent requirements, limitations on the administration of psychotropic medication, *see* D.C. Code §§ 7-1231.07, -1231.14, information privacy limits, *see* D.C. Code § 7-1231.10, and limitations on the use of seclusion and restraint, *see* D.C. Code § 7-1231.09.
  - Perhaps significantly for representing child clients, the Act also requires development of an "individualized service plan for the care of a child or youth with or at risk of mental health problems, including processes for the appropriate transition of youth receiving mental health services and mental health supports from the system of care for children, youth, and their families into the system of care for adults." D.C. Code § 7-1231.02 (14); *see also* D.C. Code § 7-1231. "Consumers shall have the right to meaningful participation in the development of their service plans, as well as the opportunity to participate in planning for their transition from one provider to another," D.C. Code § 7-1231.05 (a), and the plan shall include provisions addressing the transition from the child to adult systems of care beginning at least one year prior to the anticipated transition. *See id*.
  - In addition to listing these substantive rights, the Act also sets up a means of enforcing its provisions by requiring the Department of Behavioral Health (DBH) and its providers to establish grievance procedures. *See* D.C. Code § 7-1231.12. A grievance is simply "a description by any individual of his or her dissatisfaction with [DBH] or other provider, including the denial or abuse of any consumer right or protection provided in [the Act} or in other law." D.C. Code § 7-1231.02 (12). The applicable regulations require DBH to establish a procedure for handling grievances. *See* 22-A DCMR § 304.1 (2003). Pursuant to this requirement, DBH has created a grievance procedure within its Office of Consumer and Family Affairs, known as FAIR (Finding Answers, Improving Relationships).

- **Department of Behavioral Health Consumer Rights Statement**
  - This form highlights the rights of mental health consumers in the District of Columbia in simple, easy to understand language. It also includes a fillable box at the bottom that should be completed when the form is originally provided to the consumer by the Department of Behavioral Health or community-based provider.

- **Department of Behavioral Health Grievance Procedures**
  - 22-A DCMR §§ 300, *et seq.* is the section of the District of Columbia Municipal Regulations that lay out the steps a consumer or you, as their advocate, should follow to file a grievance related to mental health service delivery in the District. Additionally, the regulations outline the procedures to be followed by the Department of Behavioral Health once a grievance has been filed.

- **Regulations Governing Consent to Mental Health Treatment**
  - 22-A DCMR §§ 100, *et seq.* is the section of the Municipal Regulations that describes and governs the various procedures to be followed for obtaining consent from a mental health consumer. The regulations also provide rules for when consent is required, how and when the power to consent can be transferred, and defines informed consent.

CLC Resource Guide

Mental Health Information Privacy

Resources

- **D.C. Code §§ 7-1201.01, *et seq.***
  - This Chapter of the D.C. Code is entitled the D.C. Mental Health Information Act of 1978. The sections contained in this chapter dictate how and when mental health treatment information may be disclosed to the court or other entities. This Chapter also dictates how disclosures may be made when allowable and what restrictions are placed on such disclosures.

- **Department of Behavioral Health Authorization to Use or Disclose Protected Information**
  - This form, included immediately after this Resource Guide, is intended to be used to allow the sharing of information across government departments and other organizations who participate in coordinated care planning for children and youth involved in the foster care or juvenile justice systems.

Authorization
to Use or Disclose Protected Information
Department of Behavioral Mental Health (DBH)
Child and Youth Services Division (CYSD)

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to District of Columbia children or youth with mental health issues. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations.

I hereby give permission to use and disclose health, mental health, alcohol and drug, education, child welfare, and juvenile justice records as described below.

The person whose information may be used or disclosed is:

Name of child or youth (type or print) _____ eCura # (if applicable) _____

Address _____ Date of Birth _____

City/State/Zip Code _____ Other name(s) used _____

The information that may be used or disclosed includes: (check all that apply)

___ Health Records
___ Mental Health Records
___ Alcohol/Drug Records
___ School or Education Records
___ Child Welfare Records
___ Juvenile Justice Records
___ Other records (list) _____
___ All of the records listed above

This information may be disclosed by:

___ Any person or organization that possesses the information to be disclosed as a result of providing health, education, child welfare, juvenile justice, or other related services.
___ The organizations listed on Page 4
___ The following persons or organizations that provide services to me:

This information may be disclosed to:

___ Any person or organization that needs the information to provide services to the child/youth who is the subject of the record; pay for those services; or engage in quality assurance or other health care operations related to the child/youth as a result of providing health, education, child welfare, juvenile justice, or other related services.
___ The organizations listed on Page 4
___ The following persons or organizations:

The purposes for which this information may be used and disclosed include:

Evaluation of eligibility to participate in a child and family teaming process or review for medical necessity for Psychiatric Residential Treatment Facility (PRTF;
Delivery of services as a result of providing health, education, child welfare, juvenile justice, or other related services, including care coordination and case management;
Payment for such services; and
Health care operations, such as quality assurance.
Other, List: _____

EXPIRATION: This authorization will expire on the earlier of the following (complete one or both):

☐ On ____/____/_____ (cannot be more than 365 days from the date of this form)

☐ When the following happens (which must relate to the consumer or to the purpose of this request):

_____

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization will *not* affect any action by the organization that was authorized to release this information before it received my written notice of revocation. I understand that my right to revoke this authorization may be limited if the purpose of this authorization involves applying for health or life insurance.

I revoke this authorization effective ____/___/_____

_____

Signature of child/youth if age of 14, or parent or legal guardian and relationship to the child/youth

UNAUTHORIZED DISCLOSURE:

The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization, or as provided in Titles III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

I understand that this information cannot legally be redisclosed by the person or organization that received it without my authorization.

OTHER RIGHTS:

I understand that I have the right to inspect my record of protected health information. I also understand that I cannot be denied enrollment or services if I decide not to sign this form. However, I may not be able to apply for benefits or renewal of benefits that would help pay for these services.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

I, _____, understand that, by signing this form, I am authorizing the use and/or disclosure of the protected health information identified above.

_____ Date: _____
Signature

_____
Print or type full name

IDENTITY VERIFIED BY: _____
Examples: Known to provider agency representative; Government issued ID (e.g., driver's license, photo ID); or Court order.

AUTHORITY TO ACT ON BEHALF OF CHILD OR YOUTH (check one):

Parent _____ *Legal guardian _____ *** for legal guardian, must provide the guardianship order**

Address: _____

Phone Number: _____

SIGNATURE OF MINOR:
If the consumer is at least 14 years of age, but under 18 years of age, this authorization is not valid unless the child/youth signs in addition to the parent/legal guardian. A minor of any age may authorize disclosure based on his or her signature alone, if (1) he or she is an emancipated minor, or (2) he or she is receiving treatment or services without a parent or legal guardian giving consent.

_____ Date: _____
Signature of Minor

_____ Date of Birth: _____
Print or type full name

Address: _____

Phone Number: _____

TO THE RECORDS CUSTODIAN:

1. Provide a copy of this authorization to the child if age 14 or parent or legal guardian.
2. Put signed original in the child/youth's clinical record
3. Send a copy of this form with the information to be disclosed

This permission to use or disclose protected information applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to District of Columbia children and youth.

___ Department of Behavioral Health (DBH)

___ Child and Family Services (CFSA)

___ Department of Youth Rehabilitation Services (DYRS)

___ Court Social Services (CSS)

___ DC Public Schools (DCPS)

___ the Managed Care Organization (MCO) that provides services to the child or youth: _____
(Name)

___ the contracted mental health providers that provide services or supports to the child or youth (e.g., child's CSA, subproviders and specialty providers, DC choices)

___ Addiction Prevention and Recovery Administration (APRA)

___ Psychiatric Institute of Washington (PIW)

___ Childrens National Medical Center (CNMC)

___ Other, list below:

_____

_____

Questions to Ask a Therapist

Note: No need to ask all of these—pick and choose as needed!

Qualifications

- Are you licensed? What license do you have?
- How long have you been practicing as therapist?
- What treatment modalities are you trained in?
- What treatment modalities are you actively using?
- What are the presenting behaviors/concerns of the population you normally work with? My client?
- How often do you receive supervision?
    - What is your supervisor's licensure?
- What ongoing training do you receive?

Treatment Planning

- How do you develop treatment plans?
- Do you use any screening tools? (such as Child Behavior Checklist)
- Do you do any collateral contacts?
- Do you obtain assessments and evaluations done by other agencies?
- At what stage do you develop the treatment plan? (before first session, after one session, etc.)

Treatment Process

- What are your current treatment goals?
- How often do you review treatment plans/goals?
    - Do you ever revise diagnosis and treatment goals?
- Do you write monthly/quarterly/etc. reports?
- Where do you meet with my client (office, home, school, other)
    - How do you decide where to meet?
    - Do you ever change locations? If so, how do you decide?
- How often do you involve caregivers?
    - What does this look like?
    - Foster parent and/or biological parent?
    - Check-ins by phone?
- What agencies do you refer to for additional services/supports?
    - Does my client need any additional supports?
- Is your treatment time-limited?
- What is my client's prognosis?
- How do you work with psychiatrists, or other providers?
- Are you able to attend treatment team meetings?

- Have you ever testified?
- Are you open/able to testify?
- Will you write a letter for the court?

Termination

- Do you/your agency have a policy for terminating due to non-attendance?
- How do you decide when to terminate?
- What does your termination process look like?
    - How long does the process of terminating take? How do you decide?
    - How do you decide which referrals to make?

TF-CBT Specific

- Can you briefly explain the TF-CBT process?
- What do you do to ensure client is ready to begin TF-CBT?
- If already in treatment:
    - What phase are you currently working in? (Psychoeducation, Parenting skills, Relaxation, Affect modulation, Cognitive coping, Trauma narrative, In vivo mastery / exposure, Conjoint child-parent sessions, Enhancing future safety)
    - What is the topic of my client's trauma narrative?
- What is your expectation for caregiver participation? What do you do if they're not participating?
- *If therapist cannot answer these questions, that may indicate an issue!*

PCIT Specific

- Can you briefly explain the PCIT process?
- What is your expectation for caregiver participation? (correct answer: it is required)
- How are your sessions set-up? (needs to have a one-way mirror or live video feed, and 'bug-in-ear' device to allow therapist to provide parent live coaching)
- If already in progress:
    - Which phase are you in? (Child-Directed or Parent-Directed)
    - What is the most commonly coded interaction? (examples: acknowledgement, unlabeled praise, labeled praise, reflection, behavior direction, questions, indirect commands, direct command, negative talk)
- *If therapist cannot answer these questions, says s/he does not require caregiver participation, or does not have the described set-up, that may indicate an issue!*

Psychiatric Medication: Questions to Ask

(updated December 2014)

1. What mental health treatment has been tried prior to medication being prescribed?

2. What (non-medical) mental health treatment will accompany my client's use of medication?

3. What is the name of the medication? Is it known by other names?

4. Is this medication being prescribed in accordance with the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the child's condition?

5. How will the medication help my client?

6. How long does the medication take to take effect? When should I expect to see improvement?

7. What other medications have been considered and why was this one chosen?

8. What side effects commonly occur with this medication? Are any of them considered emergencies requiring a doctor to be called immediately? Is there anything in particular to look out for that would indicate that the medication is having a detrimental effect on my client?

9. What should be done if a problem develops (e.g. if my client becomes ill, doses are missed, or side effects develop)?

10. Is this medication addictive? Can it be abused?

11. What is the recommended dosage? What is the appropriate dosage range? How often will my client need to take this medication?

12. What is the impact on my client if my client takes the medication sporadically?

13. If my client temporarily discontinues the medication, what should the process be for re-starting medication?

14. How long will this mediation stay in my client's body?

15. Are there any laboratory tests (e.g. heart tests, blood tests, etc.) which need to be done before my client begins taking the medication in order to have a baseline to compare to post-

medication? Will any tests need to be done while my client is taking the medication? How often?

16. Who will be monitoring my client's response to medication (both psychiatrically and on a day to day basis)? Does this medication need to be monitored by a psychiatrist or could it be monitored by a pediatrician/physician?

17. How often does my client need to meet with you to get this medication prescribed?

18. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my client is taking?

19. Are there any other medications or foods which my client should avoid?

20. Are there any activities that my client should avoid while taking the medication? Are any precautions recommended for other activities?

21. How long will my client need to take this medication? How will the decision be made to stop this medication?

22. When it's time to discontinue the medication, what does that process look like? Is it safe to discontinue the medication immediately, or does my client need to gradually decrease the medication?

23. What is the cost of the medication (generic vs. brand name)? Does my client's insurance (or Medicaid) cover the preferred/prescribed medication? If yes, does it require annual prior authorization, and who will be responsible for obtaining that? If no, what are the alternatives (covered by insurance) and how are they different from the preferred/prescribed medication?

24. Have other providers been informed about the medication? (Eg, school nurse, mental health team, medical providers, etc.)

25. How will information from other providers impact your recommendation?

26. Who consented to my client taking this medication?

27. What is the best way to communicate with you?

Psychiatric Medication Monitoring Chart

Medication	General Indication	Usual Dose Range	Labs to Monitor
Lithium	Bipolar, mood stabilization	300mg-2400mg/day	Baseline & Every 6-12 months: CBC, electrolytes, Calcium, creatinine/BUN, thyroid studies, EKG (if indicated), preg test; Blood Level Monitoring: weekly until stable, then every 2mo until chronic steady dose, then every 6-12mo
Depakote (Valproic Acid)	Bipolar, mood stabilization, aggression, seizures	250mg - 60mg/kg/day	Baseline & Every 6-12 months: CBC, Liver Function Tests, clotting tests & ammonia (if indicated), preg test; Blood Level Monitoring: Within 1st 2 weeks and until steady state, then it's a clinical decision
Atypical Antipsychotics: Quetiapine, Olanzapine, Aripiprazole, Risperidone, Ziprasidone, Lurasidone, Clozapine	Bipolar, psychosis, mood stabilization, aggression	Depends on the med	Baseline & Every 6-12 months: Height, weight, fasting lipid panel, fasting glucose, CBC. No blood level monitoring is done.
SSRIs: Fluoxetine, Sertraline, Citalopram, Escitalopram, Fluvoxamine	Depression, Anxiety	Depends on the med	Weight and vitals only. No blood level monitoring is done.
Stimulants: methylphenidate derivatives and amphetamine-based	ADHD, narcolepsy	Depends on the med	Weight and vitals only. If there is a cardiac hx in patient, EKG at baseline. No blood level monitoring is done.
Alpha agents: Guanfacine, Conidine, Prazosin	ADHD, PTSD, sleep	Depends on the med	Weight and vitals only. No blood level monitoring is done.