2878

November 22, 2010

Stanley Mrozowski, Ph.D.
OMHSAS
223 Beechmont Building
DGS Annex Complex
P.O. Box 2675
Harrisburg, PA 17105-2675

smrozowski@state.pa.us

Comments on proposed regulations: Chapter 23. Residential Treatment Facilities IRRC# 2878

Dear Dr. Mrozowski:

We appreciate the opportunity to comment on the proposed regulations for Residential Treatment Facilities.

Regulations	
Page 15	Are accreditation, size of facility, and family advocate waiver eligible provisions? Due to the 24 month transition period we would be opposed to any waivers since the regulations are "minimum health and safety standards" and do not include anything but the minimal clinical requirements.
Page 20 (c)	Why send copies of all reports to Disability Rights Network? Treatment team members, including MH case management, JPO, CYS, if involved, should also receive a copy. What's the expectation around notifying the family? Family/guardians must be first notified of reportable incidents and advised of advocacy group that may assist them. In addition to the OMHSAS Regional or field office, contracting agency (BH-MCO), Department of Health and RTF Family Advocate, the assigned MH case manager or lead case manager can notify interagency team and work with the family to address the needs of the child/youth.
Page 20 (d)	Also notify family and treatment team members (covered on next page). All oral reports under (d) will also be made immediately to the family/guardian and the assigned MH case manager or lead case manager.
Page 20 (e)	This should be clarified further in regard to reporting incidents of abuse to Childline. RTF should be required to have trained investigators on staff to investigate reportable incidents (but not those reportable to Childline) and make a final report to the above mentioned parties.
Page 29 (f)	Re: family – Clarify that there isn't a "blackout" period; visits should occur upon admission.
Page 31 (c)	+ agreed; visits shouldn't be earned or taken away as a consequence.

Page 31 23.34	Notification of RTF Restraint Policy. Recommend that safety is a right of all children in an RTF and Safety Planning is a requirement. And add in Restraint policy, planning with family and treatment team, documentation, etc.
Page 32 (1)	Two weeks notice is good for routine meetings but may be less when there is an urgent need. Add – Families can request a meeting at any time and should be made aware of that.
Page 32 (3)	+ weekly visit RTF or at family home – Are these therapy sessions? Not clear. Regulations should differentiate family participation in administrative process of planning, admission, review and discharge versus family involvement in treatment.
Page 33 (9)	Family on-site visit – Families should be present on day of admission, then an on-site visit within seven days. (iv) Family-focused therapy should be a core component in a residential "treatment" facility.
Page 35 (c)	RTF director should be Master's level position.
Page 35 (1)	Define more frequent contact for children on medication as 1:1 contact and communication with the family/legal guardian.
Page 36 (3, 4, 5, 7)	Define frequency and duration. Establish minimum standards of regular and on-going contact between Medical Director and treatment staff for health and safety of children in care
Page 36 & 37 & 38	Clinical director (1) oversees staff training and clinical supervision of all staff MHP, MHW and MH Aides. Medical Director also may have clinical supervision duties. Neither are required to have clinical supervisory experience. MHP is not required to have clinical supervisory experience. These are intensive services and treatment programs.
Page 37	Add under MHP staff duties "provide individual, family and group therapy", lead clinician on developing and implementing individualized treatment plan. Clarify who supervises mental health workers? – Clinical director or MHP .
Page 39 (b) (iii)	Change to mental health case manager.
Page 40 (3)	Promoting resiliency . . . this goes beyond the responsibilities of one person. Should be part of culture of program.
Page 40	Aftercare plan . . . need expectation around time frame of having aftercare services in place (i.e. 60 days prior to discharge). RTF provider is lead on referrals for appropriate MH services. Discharge summary should be made available to all team members at time of discharge. Family works with a local community based interagency team.
Page 41	+ family advocate is a welcome addition. (9) instead of meeting with children regularly, how about meeting with families regularly 1:1 and through groups.
Staff Training	
Page 42	Completed comparable training, and documentation can be provided. Who decides if it is "comparable"? This is a waiver request presented prior to initial licensing for approval or determined at the initial licensing by OMHSAS.

Page 42	Orientation training does not include anything about working with children with specific diagnoses that are common in RTF (bipolar, ADHD, ODD, PTSD, depressive disorder). Training does not cover anything about trauma or recovery and resiliency principles or family engagement/involvement. Some topics covered in annual training (after first year) but why would you wait?
Page 46	+details about restraint technique requirements are good, but add debriefing or Life Space Interview after an incident. We limit the use of restraints when we anticipate behavior and respond without setting up a negative reaction. Look how the regulations condone restraints and lack a promotion of safety planning and management.
Page 47-48 (e)	Serving children with ASD – Why would we think RTFs are an appropriate treatment for youth with ASD? Training is defined on an individual staff level but not on a unit or program level. RTFs should not include children/youth with ASD unless they have specific ASD clinical/EBP training completed by staff that will work with child/adolescent and perhaps an entirely different staff ratio. Include review by Office of Autism Affairs /joint licensing review.
Page 52-53	Bedrooms: Add option that children can bring approved personal items for bedroom (i.e. posters, family pictures). Every bedroom needs a door.
Page 78 -93	A general comment is that the draft regulations are inconsistent around the use of restraints and restrictive procedures, and appears to indicate that restraints are also not reportable incidents. For example, prohibits use of time out, but okay with chemical restraints? Page 79 describes appropriate use of time out, which contradicts page 78.
Page 79	This is a positive restraint-free environment – include developing plan to establishing a trauma-informed care and expectations around review and monitoring of plan.
Page 90	Regarding restraints, post-intervention debriefing described here but not included as needed for incident reporting. Safety planning is included under restrictive procedures and restraints are not cross-referenced with reportable incidents to family and other parties. Minimal attention to assessment for inpatient care in lieu of chemical and mechanical restraints.
Page 98	Releases have to be obtained for all treatment plan members, so "if written permission has been obtained" is not needed for school staff, schools need to be at the table more often, and we don't want to have this perceived as a barrier to their participation. Educational plans are often a barrier to discharge and reason why children are readmitted to RTF level of care.
Page 100 (5)	Beyond hi-fi-team family involvement, ISP should include family treatment goal, objectives, plus TL's, visits, and therapy sessions.
Page 101 (8)	Target discharge date should be set and listed on initial treatment plan and reviewed at each month's treatment team meeting.
Page 102	All treatment team members should be invited to monthly ISP meetings.
Page 103 (1)	Minimum frequency for treatment? EBI's suggested but not required? Treatment missing from RTF.

Page 105 (c)	Some services can start while child is in RTF, so discharge recommendations need to be made earlier than "within 14 days prior to discharge." Discharge recommendations should be made 60 days prior to discharge.
Page 105 (e)	Treatment team meeting, including all team members, needs to be held prior to RTF giving notice regarding unplanned discharge or transfer to another facility.
Page 115	Regarding RTF that treats children for D&A diagnosis. (3) D&A universal screening and assessments for co-occurring disorders; why not integrate D&A screening tool into all RTF admissions, not just for youth that already are identified?
Page 143	RTF not paid during TL. Currently RTFs are paid during TL. Why not pay RTF during TL, but increase expectations of RTF during TLs, such as contact and support during TL?
Page 146	Why 3? Why not rule out all appropriate in-state facilities prior to considering out-of-state? Depending on the circumstances, the numbers could vary.
Page 158 (ii)	Immediate child-safety or protection admission. The reference to "Department" reads as if all the requests for RTF go to MAFFS for approval, which is rarely the case. This doesn't address procedures when a BH-MCO is the funding and authorization source.

Thank you for the opportunity to share these comments and questions as a part of the review process.

Sincerely,

Daniel E. Eisenhauer
MH/MR Administrator

2878

Erhard, E. Shaye 14-522-21

From: Mrozowski, Stanley
Sent: Monday, November 22, 2010 11:58 AM
To: Erhard, E. Shaye; Talley, Scott G.; Coover, Courtney
Subject: FW: Draft RTF Regulation comments
Attachments: RTF draft regulations response 11-22-10.docx

fyi

From: Eisenhauer, Dan [mailto:DEisenhauer@dauphinc.org]
Sent: Monday, November 22, 2010 11:28 AM
To: Mrozowski, Stanley
Cc: Pascoa, Lynn; Schultz, Rose (MHMR)
Subject: Draft RTF Regulation comments

Hi Stan:

Attached are Dauphin County comments on Proposed regulations.

Thanks

Dan

Daniel E. Eisenhauer, Administrator
Dauphin County MH/MR Program
100 Chestnut Street 1st Floor
Harrisburg, PA 17101
ph - 717.780.7049
fx - 717.780.7061