Parent Initiated Treatment
Age of Consent and School Based Conversation
8/2/2018 2:30pm-4:30pm

Attendees:

Blake Ellison, Diana Cockrell, Karen Edlebrock, Marcus Chaffee, Mandy Paradise, Camille Goldy, Mary Clogston., Kevin Black, Mandy Huber, Amanda Lewis, Paul Davis, Peggy Dolane, On the phone: Kathy Brewer, Erin Wick, Sara Ellsworth, Katie Cutshaw, Kathy Walker, Melanie Smith, Lynn Anderson, Donna Christensen, Laurie Lippold

Success measures for the meeting shared:

Educational Service District (ESD):

- ESD overview of current state of how access works for school based services
- ESD perspective of impact on access for school based services if age of consent shifted to 18
- ESD perspective of impact on access for school based services in a model similar to Illinois where youth under 18 may access 8 sessions without parent consent.

ESD Overview and presentation:

There are 9 ESD's in the State. ESD 113 serves a 5 county region with Substance Use Disorder (SUD) and Mental Health and Co-Occurring services K-12.

Age of consent currently 13

For children under 13, it takes longer to get access to services. Referrals come from school not the parent(s) – so ESD is bringing idea of services to families before they have thought about getting services. It can take weeks to connect with family, discuss the need/concern and get permission to provide services versus a 15 year old seeking services who generally receives them the same day.

Age of consent at 18

Concern with change to Age of Consent is significant lag in time to access services extends to all youth, and there are youth that are amenable to parents involvement, but parents have limited ability or willingness to participate – would be unable to engage these youth in services.

Illinois model – Summary: youth over the age of 12 can initiate services but after 8 sessions, they would have to receive parent consent. There are several avenues for exceptions. There may be potential middle ground – generally enough time to engage the family with the youth's permission, would be several potential challenges.

Q&A

Q: 8 weeks (Illinois model) is enough time, and you would do this anyway?

A: Yes, agency philosophy is to involve the family in care, so it would happen either way. Generally 8 weeks would be enough time.

Q: Services provided during the school day? How do you pay for it?

A: Yes, during or after school – pay for it through braided funding (bill Medicaid or utilize district co-pay)

Q: How do you manage a need for higher level services?

A: Referral and interim care while facilitating the process

Q: How do they bill insurance without parental notification?

A: School provides co-pay – District covers services

Q: Have you desired a difference in age of consent at some point in time?

A: For a small subsection of youth who are acute and need help. It would be helpful to have ability for parents to require youth attend services. Looking at big picture – feel more youth would lose access than the gain for the few youth.

Q: Have students been informed about Parent Initiated Treatment (PIT) in those cases?

A: Generally those parents are not healthy enough to pursue this option.

Q: Intersection of services with Individualized Education Plan (IEP) or other behavioral functional need, i.e. 504 plan and how they interact with ESD 113 services?

A: Students aren't limited to having an IEP to access services – but there are youth that are on an IEP and sometimes services are written into the IEP. The clinician will attend the IEP meetings when invited, and there are times when their services are connected.

Q: Functional behavioral?

A: It is the schools function to enforce the IEP and 504 – their services are separate from ESD 113's services.

Q: When would you request or consider breaking confidentiality? How does that work?

A: If there is concern of harm to self or others – notification and confidentiality will be broken. Substance Use Disorder (SUD) emergency, Child abuse/neglect or court order. Self-harm is generally the situation where the family is notified without consent.

Q: This is the standard that informs state and federal law, policy, and is this the overall perspective.

A: State and federal law – 42 CFR Part 2

Q: Considering recommendation of some limited information to parents without consent – education, general information, etc. - would you be comfortable with sharing it with parents before the child is comfortable if determined in the best interest of the child?

A: Situational – challenging, sometimes difficult/ hard to see/know the impact on the child without the relationship with the parent in place or started.

Follow up Q – recommendation would plan to include room for professional judgement through the lens of best interest of the child.

A: That would be better, more supportive – the safeguard of professional discretion would be important

Q: Do you prescribe medication, and would you want parental consent then?

A: We don't prescribe.

Q: If youth is receiving services in multiple service venues (school/outpatient) how do you address that information?

A: We wouldn't provide services to a youth receiving the same services elsewhere – although some do SUD through school based services and MH somewhere else in the community – Would get Release Of Information (ROIs) and coordinate care.

Q: What if it is Inpatient (IP) to Outpatient (OP) treatment?

A: Very rare where a youth wouldn't agree to sign a ROI – more likely that information isn't followed through from the IP facility to share records.

Q: Who employs your therapists/counselors?

A: ESD – under the True North umbrella

Q: Improve or increase access due to your placement of services?

A: Yes, there is no access in many places where ESD 113 is the only provider - intentionally didn't try to place similar services in an established areas, but placed services in areas that don't have access.

Q: How many ESDs have equally substantial services?

A: ESD Pilot 1713 to try to leverage funding already there See attachment: OSPI-ESD Pilot Presentation.

Q: What is the vision with the Managed Care Organizations (MCOs)?

A: Children's Mental Health Workgroup pilot project: Lighthouse – ESD 113 and 101. Digging into Medicaid reimbursement. Exploring different versions of this model, and what works. Office of Superintendent of Public Instruction (OSPI) is beginning to have conversations with

MCOs. ESD 113 contracting with the MCOs in the future. ESD 101 not currently certified but exploring this. The ESDs would have to contract with all MCOs in their region, so that all kids are covered.

Q: In Illinois model, any further challenges with it such as safety, inability to contact parents?

A: Reasonable efforts have to be made and documented (3 with no response) then students could continue access. That allows continued service. Conditions – 4 different things – if damage to youth to share –don't have to. Those would have to stay in place in order for this to not impact negatively. Also, cannot speak to how this would impact other providers.

Q: Leave age of consent where it is now – make reasonable efforts after "x"-number of sessions – unless therapeutic reason not to. Wouldn't have to change age of consent?

A: In Illinois model where parent says no- services would have to stop.

Q: Most of the time youth are willing to consent. Do you have any idea how many say at the outset children do not want their parents knowledge of their accessing services– would it impact youth coming into the door and saying no. Would it have a chilling effect?

A: Depends on how the message is delivered – we approach it with involve your parent, it will be the best – but cannot speak to how age of consent is delivered across the system.

Q: Attorney view – let's say a youth with an identified drug/alcohol problem and have a car wreck or overdose – have there been parents who sued because they weren't informed/brought into services?

A: Possible somewhere, we manage that by always looking at risk and working to determine safety, example: know they drive regularly and drink/use heavily – they would look at that and have chosen to inform parents for safety of harm to self or others.

Q: Do they look at when a student is supposed to be receiving special educational services?

A: Most of their students don't have IEPs, the ones struggling academically, clinicians ensure rotation of times and work to schedule during noncredit hours. If struggling in all areas, make arrangements to see them at the end of the day after classes.

Q: How do you work with youth with severe emotional de-regulation?

A: We don't see a lot of behavioral health issues written into IEPs – not on IEPs for social emotional services – coach and support school staff for trauma informed – serve those youth in another "box". Interesting outcome is students in services with them, they have a decrease in school behaviors – not sure why, but thinking because there are supports and staff see behaviors with a map for someone to talk and refer the student to, alongside skill building for the youth.

Q: Comment: what about Oregon's model – might be something to look at. And are there any decreased expulsions?

A: Most young people participate in services without wanting to, and come back feeling they have benefited from those services.

Q: With Parent Initiated Treatment (PIT) for SUD - will we experience the same kind of results?

Comment: Discipline laws have changed – Joshua Lynch is the contact person at OSPI for this – and did a great presentation on Discipline Data at Why Coalition on June 15, 2018 – changed laws, data, looking at the practice of making behavioral health (BH) discipline or health issue.

Q: How does funding authorization happen?

A: Notifications of services do go to families now for Medicaid that have not been in place prior. They now have to speak to the Behavioral Health Organizations (BHOs) to have it sent to ESD to give to the youth. Insurance doesn't allow for alternate address due to parent funded insurance – which is where they use the district co pay to fund services.

Also high deductible plan = youth cannot access care because family cannot fund or pay for the co-pay, so use of the district co pay is used to fund services for those youth.

Note: Onset of symptoms and duration between onset and access to services is about 10 years. The ability to wrap around youth sooner benefits greatly.

Potential challenges identified for something like the Illinois model:

Follow up –in Illinois model after 8 sessions, if parent cannot pay copay after 8 sessions – will that mean there isn't ability? No funding?

Who pays for the initial 8 sessions – insurance requires pre-authorization –insurance may deny after sessions completed.

Challenge if Custodial parent isn't insurance funder – means must have both parent's consent - no contact orders = more challenge to getting parental consent.