

***Nebraska's Children's Mental Health and  
Substance Abuse State Infrastructure Grant (SIG)***  
**STEERING COMMITTEE MEETING**

**Thursday, April 19, 2007—10:00-2:00 (Working Lunch Provided)**  
**Garrat Rooms I & II**  
**The Cornhusker Hotel—333 S. 13<sup>th</sup> Street, Lincoln (474-7474)**

Start time: 10:15 AM

**Roll Call – Members Present:**

Kathy Anderson	Brandon Fletcher	Michelle Marsh
Beth Baxter	Brenda Fletcher	Todd Reckling
John Clark	Nichole Goaley	Mary Steiner
Elizabeth Dugger	Gary Henrie	Joann Schaefer
Jerry Easterday	Scot Adams	

*Quorum Reached*

LB-216 was passed into law

- Called the department/division of Health and Human Services (6 division heads, 1 CEO)
- Game plan into place – stationary, contracts, reporting, etc.
- Three appointments to the directors of the divisions.
  - o Dr. Joann Schaefer to head up Division of Public Health
  - o Scot Adams to head up Division of Behavioral Health
  - o John Hilgert to serve as the Director of Veterans' Homes
- Everyone is optimistic about the new system
- Public health handles physicians, licensure, etc. and water

**Introductions of Steering Committee Support Personnel**

Mark DeKraai	David Cygan	Sue Adams
Pat Lopez	Ken Gallagher	Janell Walther
Roxie Cillessen	Denise Bulling	

**Opening Remarks**

**NMA Provider Survey and Focus Group Results**

- Dale Mahlman, Mary McNulty, Dr. Katherine Keiser, and Teresa Barry
- Subcontract with College of Nursing
- Grant supported by HHS and PPC
- Focused on family physicians and pediatricians in NE
- Objectives
  1. Determine confidence and competence which exists currently
  2. Determine the competence and confidence in their desired practice
- Youth age 10-19 were included in with the written survey
- Survey written on Survey Monkey to all physicians and pediatricians in NE

- Surveyed 12/8 – 12/22/06
  - Used focus groups, 3 one-hour sessions only discussing 0-5 year olds
    - First in Omaha – 1 psychiatrist, 5 pediatricians, 1 family physician
    - Lincoln – psychiatrist, pediatrician, 5 family physicians,
    - Conference call – 4 pediatricians
  - Response rate of 5% in surveys (partly due to holiday season)
- Current Practice Findings
- Focus Group Results
    - Had standardized questions and audio taped focus groups
    - Pediatricians were more comfortable with the screenings
  - Current Practice – competence level
  - Focus Group results
    - Difficult to separate a psychiatric vs. development issue, especially in 0-5
    - There is continuity of care, though
    - Parenting issues caused deviation in behavior
- Desired Practice – Confidence and competence.
- Barriers to effective screening – all similar among age groups except peer pressure and family support issues, which was unique to 10-19 year olds
  - Physicians would validate screening/input if a school, nurse or someone else backed it up
  - Barriers – several complained that they don't have a quick turn-around on mental health providers like they do with other specialists
  - Supplemental data of interest
  - Summary of Findings
    - Looking for indications of possible issues – a screening would lead to supplemental follow up
    - Screening would be useful in this case
  - Curriculum recommendations [to HHS and PPC]
    - Perinatal Depression Grant – Family Health, add this curriculum to perinatal curriculum
    - Meeting with Chris Wright, Deb Schorr, and others in the areas of EPSDT
    - This grant is related to our infrastructures and state, regional and local level.
    - Prevention and early intervention are part of our goals, and this allows us to do so; looking at children who need more community-based supports
  - Q&A
    - There was not a mechanism to contact those who took surveys
    - These findings are similar to the national trends and in other areas, despite the small number
    - Is this statistically representative since the response is so small?
      - Since they are consistent with other state information and national levels, we felt the focus group validated the written responses
      - This all depends on the provider as far as a social-emotional-behavioral concerns when the physical stuff comes first
    - Could be published in NMA magazine with the opportunity for feedback to collect more feedback – in April 2007 publication
    - Full report and presentation and executive summary in NMA publication

- Not an emphasis on children's mental health screenings at health fairs, etc. Low-cost option for advertising
  - Perhaps should be part of kindergarten registration process

### **Overview of Pilot projects:**

- A lot of work has been done with DOE (J. Walker and E. Brockofsky) and together within the HHS
- SIG Priority outcomes established by the steering committee
  - Support family and youth partnerships
  - Ensure appropriate services and supports
  - Ensure accountability
  - Support realignment / integration

### **Mobile Crisis Treatment Pilot Project**

- Looked at successful, sustainable programs that matched our setting (rural AND urban)
- Invited Youth Villages to present – Caroline Hannah, Tennessee
- Brett Stockton began with Youth Villages to assist in various depts. – clinical, education, etc. Business Development Mgr.

### **MCT Pilot Project Presentation by Youth Villages, Tennessee (*youthvillages.org*)**

- Continuum Philosophy and Values
  - Children raised by their families, limited out of home placements, all children served in their home components...etc.
- Serves 7,000 children and families annually (youth under 18 years of age)
- Locations – mainly in the southeast, looking to launch in Massachusetts in a year
- SCS – basics of the crisis program
  - 86 staff, 71 counselors, 24/7, including holidays
  - 8 regions, 8 toll-free lines statewide
  - 92% of calls occur 8a.m.-12a.m., not in early a.m. as anticipated (busiest after school to about 9 p.m.)
  - Funding – complicated process.
    - 90% of funding goes to staffing (24/7, need a minimum staff)
    - Original data wasn't the best – sorely underestimated necessary staff (started with 51, and ended with 96 during the first year)
    - Learning was to learn if they were as efficient as they needed to be
    - Streamlined, dropped to 64 staff, increased with additional funding
- Developing Competent Staff
  - Requires MA + 1 yr C&A (in a clinical setting)
  - Requires 4 weeks orientation and training before they can respond
  - Supervision includes weekly elements such as developmental plans, individual supervision, group staffing, licensure consultation....
  - Ongoing monthly training and yearly boosters
  - 24/7 availability of supervisors and psychiatrist
- Elements of a crisis call
- Triage Call
  - Usually calls from community members or parents / guardians (police officers, schools, etc...)

- FIRST, determine if the child is safe
- Once safety is established, determine what response is necessary
  - Emergent : a substantial likelihood of the child hurting self or others
  - Urgent: if you can't get there in 4 hours, then they may deteriorate
- Face to Face Assessment
  - Many non-crisis calls involve face to face assessment when the parents need support – it's an emergency to them
  - We often want to keep ALL the people involved present
  - Depend on resources available (already have supervision, service provider, etc.)
- Disposition / Diversion Options
  - If it starts in the ER, we stay with the family until things are settled
  - If the problem was respite, then there were other issues because no respite beds were available to anyone
    - Use Informal Respite, in their natural support system (friend or family member's house...)
    - Stingy, because it's a short term fix to a long-term problem – they will be able to access it after MST is gone
    - Also, more comfortable to the family
- Supervision during Assessment
  - Levels of supervision, need support – dealing with people with strong opinions, analyzing where other / more supervision / training is necessary
  - Must go through every layer of supervision
  - Therapist to consult on every disposition before we determine types of needs
- Outreach and Training – Staffing and intervention, referral surveys...
  - Specialized training for places like schools and detention centers, etc.
  - Track children that they see more than 3 times per month
    - Find what services they need, find what is setting them off.
- Lessons learned
  - Diversions are more likely from homes than from ERs
  - Respite is not a silver bullet as anticipated
  - Huge misunderstanding on inpatient care – most people think it's going to be 14-28 days, but in Tenn., the average stay is 3 days.
  - Interrupting cycles of crisis is critical
  - Critical to have controls on admission avenues.
  - Under Title 33, law enforcement is involved in involuntary hospital admissions
  - Bulk of work is done in client's home; also detention centers or hospitals
  - Visiting ERs was relatively easy, because they don't have a lot of time to help these issues in their ER, but some have difficult regulations to work around
  - Trend data - 69-70% of keeping kids in the home/diversion rate
    - Diversion rate was 74% this March
    - Started at 61%
    - Region can't fall below 50 or above 80%
  - Response time to emergent calls –
    - 70 min response time, so they increased funding and staffing
    - Now it's about a 50 minute response time (depending on area)
  - Detention Center: MCUs stay involved through juvenile justice

- Relationship with the court system?
  - Difficulty advocating for something the court feels differently about
  - Part of it is building relationships with individual judges
- Intercept program is more about building the skills that the parent has developed – like parents getting involved over probation officers, etc.
- Staff has lowest turnover in the org – often hiring people who have been in the field for a while
  - It's a lifestyle decision since they are on-call, etc.
  - Largely working out of their homes
  - Mid-south is sparsely populated, don't get a lot of calls, and have staff who they see once a week
- Do visit schools
- Why do we like THIS model?
  - Looked at other models, but other programs haven't grown beyond the boundaries into rural communities like we are looking for.
  - Don't do round the clock service

### **Pilot Component #2: Comprehensive Family Assessment – Lori & Roxie**

- Out of home care reasons (for a specific age group)
  - 62% due to neglect, 38.5% removed for parental substance abuse
- Safety Assessment (SA) process – notify law enforcement, decide whether to accept for an SA, if accepted, then law enforcement and HHS will respond and complete an SA
- When SA is complete, if a mental health or substance abuse issue in the family is suspected, they make a referral to our mental health contractor, Magellan, who has a preferred health provider to initiate a Comprehensive Family Assessment
  - Most of the time, there are adults in the process who suffer from mental health issues affecting the children, but not always
  - Share plan with P&S, and provided to the family, so if they wanted to engage in treatment, then they could follow up with the MH treatment needs and P&S needs
  - Want to keep the family in tact (people are willing and able to access treatment).
  - Through the Medicaid managed care waiver, we are able to do 5 CAP sessions per year – a crisis type service for a family
  - Funding – not all P&S clients are Medicaid Eligible, so assess families who are at risk; with BH partners, mingle funding to help both Medicaid and non-Medicaid
  - Weren't doing CFA in the first place, so there's a shift in thinking
  - People don't want to volunteer for this
  - Working with families, county attorneys, etc.
  - All of this comes from things we've shared, brought forward by the infrastructure piece, and through HHS (Todd & David)
  - Also affected is that there are kids with concurrent disorders
    - Some great DD and CMH services, but problems with treatment
    - Few people do both (often specialize in one way or the other)
  - Very important to get there fast. Need to get a more permanent safety plan and get people into treatment who need it.
  - It's important that we articulate the issues to the courts
  - Treatment will be done in the home

**Pilot #3: Program Evaluation (Ken)**

- Wants to get away from performance measures and process indicators,
- Emphasis in evaluation questions is to answer:
  - o 1. Who are the kids and families we are trying to serve?
  - o 2. How are we serving them?
  - o 3. What difference does it make?

Annual Grantee Meeting -- Putting together poster to present at the meeting in D.C.

**4<sup>th</sup> Pilot component: EBP** – at some point in the future we will present a software package to have you review

Next meeting – May 16<sup>th</sup>

Dismissal: 2:10 p.m.