Scott Walker
Governor

Shel Gross
Chairperson

Donna Wrenn
Vice-Chairperson

State of Wisconsin

Wisconsin Council on Mental Health
1 West Wilson Street, P.O. Box 7851
Madison, Wisconsin 53707-7851

DRAFT MEETING MINUTES OF THE CHILDREN YOUTH COMMITTEE
June 4, 2015 at 8:30 am to 3:30 pm
Madison Police South Precinct, 825 Hughes Place, Madison, Wisconsin

Members of the Children Youth Committee (CYC) in Attendance: Bonnie MacRitchie, Carrie Finkbiner, Kim Eithun, Dan Naylor, Paula Buege, Rick Immler, Phyllis Greenberger, Joanne Juhnke, Teresa Steinmetz, Snezana Matic

Members of CYC in attendance by phone: Kathryn Bush

Department of Health Services Staff/Other state staff in Attendance: Joanette Robertson, Kenya Bright, Ryan Stachoviak, Tim Connor, Karen Bittner

Members of the Public in Attendance: Therese Ahlers

Item 1: Call to Order

- Members were welcomed and introductions were made.
- Phyllis motioned to approve the May 13th minutes and Kim seconded. The minutes were reviewed with the following corrections:
    - Item 8, 1st bullet point, the first 2 sentences should now read: Interest in school-based mental health has increased significantly. Different representatives of different types of school-based mental health services could present, preferably people who are actually doing it.
    - Item 8, 2nd bullet point, the following will be added at the end of the 2nd sentence: in suspected imminent risk situations.

  Minutes were approved as amended with Dan abstaining.
- The next meeting is scheduled for Thursday July 9th, 2015, 12:30pm-3:30pm at DHS, conference room 850A.
- No announcements
- No public comment

Item 2: Needs Assessment Update

Ryan Stachoviak began by describing the Mental Health Block Grant (MHBG) process, which happens every 2 years. The State has to decide how to spend the money. The Substance Abuse and Mental Health Services Administration (SAMHSA) requires doing a Needs Assessment, which is one of the tools that the State uses to guide the MHBG process. Two years ago DMHSAS, along with an advisory group from the Council did a thorough assessment that was completed in January of 2014 and just recently have updated it.

Tim Conner distributed a one page summary of the Needs Assessment Update and began to highlight different areas in the report. Tim noted that the child's portion of the document uses the Needs Assessment from January of 2014 as the prior resource. The one page summary is an update based on 4 domains:

1. Prevalence of Mental Health Needs
2. Access to the County Mental Health Service System
3. Workforce Capacity of the County Mental Health Service System
4. Consumer Mental Health Outcomes (which includes some quality info)

Prevalence

Tim noted that because Wisconsin mental health prevalence rates are not available for all demographic groups, national rates are used. The most recent estimates indicate an overall national prevalence of Any Mental Illness (AMI) at 18.5% and of Serious Mental Illness (SMI) at 4.1% for adults 18 and over.

In order to get prevalence rates, all youth in the state would need to be surveyed. At this time, that does not happen and Tim stated that he is not aware of any state that is able to do this because in order to do so, it is necessary to go through parents, which may result in additional challenges.

The national rates show that 21% of youth have AMI and 11% have SMI.

Access to the County Mental Health Service System

The Needs Assessment Update includes data that the State received from counties and does not include all Medicaid recipients or individuals served through others sectors as did the original Needs Assessment. The original report revealed that 42% of youth with any mental illness accessed services using any type of public funding compared to just 28% of adults. The Needs Assessment Update shows the opposite as 8.9% of adults accessed services from the county mental health system as compared to 4.7% of youth.

The Needs Assessment Update focuses on acute care to illustrate the role of the county. It is noted that 75% of consumers who began their county episode of care with a crisis intervention service had 3 or fewer total services. It is also noted that 43% of all episodes of care included only a single crisis intervention, including an emergency room visit, or an admission to an inpatient hospital, with no further interventions.

For those individuals with an unmet mental health need for treatment, cost is the biggest barrier to services, according to 46.8% of respondents. The other barriers were related to the individuals' readiness for treatment. These numbers have not changed much in the last 2 years and are similar to national numbers. The full report shows adults and youth separately.

Workforce Capacity of the County Mental Health Service System

This area focuses on whether county systems have the necessary capacities as well as what services are already being provided. This section does not separate youth from adults. Certified Adult Peer Specialists is included in this section. There was an increase in certification and use of peer specialists, which supplements the current services used. There are now currently 333 certified peer specialists in the

state as compared to 193 in 2012, with many working as a certified peer specialist. The question was asked, can they make a living off those wages.

Consumer Mental Health Outcomes

The suicide rate has significantly risen in one year. In 2012 the WI suicide rate was 12.6 per 100,000 and national rate was 12.5. In 2013 WI's rate jumped to 14.4 and national rate increased to 12.6. Montana had the highest rate at 24, and the lowest is New Jersey at 8. In WI individuals in the 45-64 age range was the highest suicide rate which is more than twice the rate of youth suicides. The youth suicide rate is lower than the overall WI rate for 15-17yrs, at 8.4.

Mental health consumer satisfaction of youth and parents of youth are determined through mental health satisfaction surveys. Youth surveys show parents are happy with access, relationship with providers and less satisfied with outcomes of treatment. WI is significantly lower than neighboring states in this area.

Due to time restraints, the group developed a list of questions for future discussion:

- Why has there been a decline in access to county and public mental health?
- What is being done about overutilization of crisis respite, hospitals, and the overuse of state hospitals for youth?
- Regarding crisis services, 50% of all episodes of care began with a crisis intervention, an emergency room visit, or an admission to an inpatient hospital. What is being done to address early intervention?
- What is the response to an effective crisis plan?
- On page 30 of the Needs Assessment Update, the graph shows how many consumers per program accessed County Substance Abuse services. For Comprehensive Community Services, in 2012 the number was 171 and in 2013 the number is less than 25. Is this correct or is it a data issue in which something is being missed?
- Are we focusing attention on veterans and suicide? Veterans make up half of the suicides by age 55 and 20% of the suicides overall. The primary means is weapons. There is a veterans' academy and one of the top priorities is suicide prevention.
- Does the Needs Assessment truly reflect what is happening in the State if the data only comes from counties?
- In the future, will the State only focus on county data or pull together information from all available public data sets? Is it the trend of the division to do this?
- Firearms and youth in suicide. Is there a relationship due to the new laws?
- How will Peer Specialist work be included in the Needs Assessment in the future? Can Peer Specialists have gainful employment?
- Focus on the data is process. What are process indicators as opposed to outcome indicators?
- Look at the high level of youth having a first acute incident at the county level. Why is this? What is happening prior to county involvement? Any services? Compare numbers to other states. The 43% of all episodes of care included only a single crisis intervention

represented both adult and youth. What is the number for youth? Need to focus on prevention.

- 75% of consumers who began their county episode of care with a crisis intervention service had 3 or fewer total services. In order to understand whether this represents problems with access, it would be helpful to gather more information about this.
- Where is focus on 0-5 year old section of the Needs Assessment? Include data from child welfare and child care centers.

Break

Item 3: Strategic Planning Session

Kenya Bright began this section by noting that since this committee meets monthly for 3 hours each month, that leaves less than a full work week in a year to do work on goals and other items charged to the committee. Kenya then distributed the previous CYC strategic plan as well as listing the items from the Council's strategic plan that they have charged CYC with. The members then divided into 2 groups. In the first group each person was to describe the work of CYC using only one word. The 2nd group each person was to describe the committee as a whole using one word. Below are the words for each group:

Work of CYC
Important
Advocate
Influence
Change
Hope
Progress

CYC Committee
Developing
Passionate
Dedicated
Multi-disciplinary
Motivated
Representative
Diverse

After this exercise Kenya described the strategic planning process. The group would develop goals (broad), objectives (which she defined as mini-steps), resources (to help meet the goals) barriers, and an action plan.

Prior to developing the goals, the committee would present and listen to presentations on each of the 16 priority areas that were developed in previous meetings. After each presentation, each member would rank that priority area based on Importance, Feasibility, and Synergy/Collaboration. Below are the key points for each priority:

Presentations

14. **Seclusion and restraint**: day treatment, RCC, group homes, foster homes, CLTS respite; Paula, see sheet
Need more data
Birth to 18
Reduce S/R
Multi-disciplinary work groups looking in to S/R
Align standards across settings
OCMH looking in to s/r

7. **Respite** (including Crisis Respite)
Lack of respite
Increase of higher restriction placement
Lack of funding?
Who is doing it well?
How is it funded? (in Colorado Medicaid pays for respite)
How are those states with lower hospital rates using respite?

11. **School Mental Health Services** (the committee as a whole decided to change the title from School-Based Mental Health)
Access is the biggest issue
DPI – working on it, getting access to schools
Professional development
Medicaid reimbursement for collaboration
DHS resubmit Medicaid waiver
Use of block grant money to provide mental health services in schools (look at model in MN)
Transportation is huge barrier

3.5 **Increasing Skills – for Healthy Infant Development**
Systems and State focus on diagnosis
Manage behaviors
ACES – state focus
Need to increase skills for Infant Healthy Development, focus on prevention of the above 3
Feasible – UW/consultation/home visitors: there others are doing it
Opportunities for synergy
Clarify – infant mental health and caregiver dyad
Only $54,000 of MHBG is used for IMH
UW Dept. of child psychiatry will be doing Child Parent Psychotherapy in 2016

3 **Screening (Social Emotional, Depression in Adolescents, Trauma)**
Observations, monitoring, and screening are different approaches to identifying children at-risk.
Evidence-based screening is important for identifying at-risk children.
Referral for formal assessment occurs after screening positive
Healthy development occurs in the context of healthy relationships.
Why not screen?
Social/emotional issues not found in the monitoring process

Feasibility – HealthCheck (no valid tool required)
Synergy – many groups support it
Need to do screens as well as trauma screening

Lunch

Item 4: Strategic Planning Session Cont.

1 **Pyramid Model**
Is an Evidenced Based Practice
Supports positive relationships
Provides concrete teaching strategies
If model is followed only 5% of kids will make it to the top of the pyramid
"we do all those things on the bottom" want help with the top
Practice hasn't kept up with research
3x expulsion rate for 0-5 yr olds as compared to school aged kids
Increase continuity of care workers
33 sites currently in WI

8 **Infant Mental Health Consultation**
Pre-K program 3x expulsion rate than k-12
Consultation in pre-K can change course of kid's life
Gives tools and understanding to pre-K teachers
Preventative: help kids/teachers/classroom/parents
Synergy: small moment opportunity to expand
Need to build consultant pool
Braiding funding could be available

2 **Trauma Informed Case Management Statewide (birth to 3)**
Waukesha County
ACE questionnaire used with birth to 5 for cases of substantiated abuse
Services to foster parents/parents/child
Good results
Aim to stop revolving door of foster care
Builds on the existing expertise of the Birth to 3 providers

10 **Transitional services when 18**
Project Yes! 2 pilot sites
Increase voice/access 16-25 yr transition age
Services need to be different
Youth voice to educate system and needs
5 yr grant
Promise Grant thru DWD – not mental health specific but SSI specific

5 **Evidence-Based Therapy (Trauma, JJ, Other**
Approaches to therapy that is supported by research

Fidelity measures
Right services at right time to improve outcomes
Other states using MHBG to fund training
SAMHSA promoting and tracking EBPs
Payers tracking EBPs
Opportunities support EBP in order to reduce child hospital rates

6 **Child Psychiatrist Shortage**
High rates of child hospitalizations due to lack of care
Develop team approach that integrates child psychiatrist
Synergy with current initiatives: loan forgiveness, training in rural areas
Some reasons for reduced interest in the field, reimbursement/inadequate time to see kids

12 **CPCP for Primary Care Statewide**
A significant portion of a Child's MH care can be performed by Primary Care Clinicians
Massachusetts Model (added Parent Peer Specialists)
Currently there are 2 pilot sites, hope will go statewide next legislative session
Efficacy has been shown
Needs additional funding to go statewide

15 **Data (Access, Outcomes, Medicaid, All Expenditures, CQI)**
Capacity to analyze and integrate data
DMHSAS uses and analyzes data from counties
Other states look at all public services
OCMH identified need to look at hospitalizations (not just re-admissions)
Need to bridge silos
Need quality data to evaluate cost effectiveness e.g. "Oklahoma"
Need adequate resources to look all of Public Mental Health
Need to look at uniformity of access and services

16 **Effective Reimbursement for Children's MH Services**
Good programs are shutting down due to inadequate reimbursement rates
Goal should be spend less on hospitalization and support good programs
3 states had lawsuits under EPSDT due to high MH hospital/out of home placements
Many clinicians report that it is difficult to get authorization for MA services
There is inadequate access in part due to MA low rates

9 **In-Home Treatment Infant and Toddler**
In home has to have prior authorization for ITX because work is also with parents
DC:O3R under age of 4 often not recognized in WI
Need to use HealthCheck to the fullest
Need to work with Medicaid

Break

Item 5: Strategic Planning Session Cont.

For the next activity members completed the Communications Style Inventory. Based on this, the committee needs more controllers/directors and analyzers/thinkers. Committee members may determine how to address this during member recruitment.

Next Steps:
The committee needs to determine how long the strategic plan is for. Kenya recommends that it be a 2 year plan but if there are more than 3 goals, then perhaps the plan should be longer as the committee does have less than a work week in a year to work on the goals. The committee also has to decide how many categories and how many goals per category. Kenya suggested developing a goal in each of the top 3 priorities that the group had in common and then develop objectives for those 3 goals. She also said that the group may make a broad enough goal that encompasses other categories. Once the goals and objectives are formed then a list of barriers and resources should be developed. This is what will make the strategic plan. As the group was not able to get to this point, this will need to be addressed at the next meeting.

Rick stated that he wants all members to rank all 16 priorities and email that information to him by Friday June 12th. There was discussion about emailing just the top 5 rankings. Rick recommended staying with the Committee's original plan. As some members left the meeting prior to this discussion, Karen will email the group with these instructions. Kenya stated that she would be able to help the group develop the goals and members stated they would like her to finish the process with them.

Item 6: Adjourn

Meeting adjourned