Children's Emergency Detention & Crisis Stabilization (CEDCS) Services
March 24, 2015 / 1:30 – 3:00 pm
DHS – 1 West Wilson Street, Madison, WI
Secretary's Conference Room, #650

Meeting Attendees:

Elizabeth Hudson, OCMH
Linda Hall, WAFCA
Joyce Allen, DMHSAS/BPTR
Jonelle Brom, DCF
Caroline Ellerkamp, DHS
William Hannah, DHS
Ron Hermes, DCF
Bill Orth, Sauk County
Kate McCoy, OCMH
Joann Stephens, OCMH
Sarah Coyle, DMHSAS
Kay Cram, DMHSAS
Brad Munger, DMHSAS
Sola Millard, DMHSAS
Ryan Hutter, DOA
Erin Sarauer, DHS
Tina Buhrow, Parent
John Tuohy, DCF
Cindy Lindgren, DHS
Andrew Forsaith, DHS
Mark Hale, DHS
Iris Ostenson, CSCN

PHONE:
Mary Kay Wills, Dane County
Bill Topel, Winnebago County

Meeting Summary:

The meeting began with welcome and introductions and Sarah Coyle recapped the goals of the group.

Kate briefly reviewed an Emergency Detention Flow Chart that she prepared for the group. Members were asked to review for accuracy and inform Kate if any changes should be made.

Kate provided a data update. Erin S. verified that more than 50% of Winnebago admissions are Emergency Detentions. When Erin was asked what percentage of ED's are Medicaid, she stated that Chris O'Connell will be looking into that. [Kate subsequently verified that 60% of EDs admitted to WMHI in 2014 were Medicaid funded.] We discussed the statement in the overview that most kids who were ED'd did not use crisis services. Members identified that this was most likely not the case, that there were many reasons why we may not see a crisis intervention prior to hospitalization. Counties and providers indicated that counties often do not bill for Crisis Intervention services, and that they instead assume those costs. Bill Orth noted that some counties are not very far along in billing or are under billing Medicaid for crisis services, so it wouldn't show up in MA.

Also, in the child welfare system, kids may be getting crisis services, but it wouldn't be billed through normal Medicaid channels. Some Counties contract for a variety of services and crisis is part of those services. Elizabeth said that OCMH is trying to develop a comprehensive understanding of how crisis services are utilized so that we can gauge their effectiveness. She

asked the group for their assistance in developing such an understanding. Kate referred participants to the electronic version of her powerpoint so they could review the data points in the notes section to see how she pulled the information together.

Kate noted that only 50% of youth Medicaid enrollees who were ED'd received any post-ED therapy. She asked the group whether mental health treatment data is also under-reported and under-billed, and the counties said that it is not. Thus, it appears that EDs are not a consistent pathway to mental health services.

We then discussed the trouble with involuntary hospitalization versus ED. Many hospitals are refusing to admit patients on a voluntary basis and requiring an ED for admission. Some thoughts were that if it is an ED hospitals will receive payment from insurance versus voluntary, insurance may deny claim. Private hospitals don't want to admit voluntary, and physicians don't want to take on the liability of a voluntary patient and assume the risks if the person decides to leave on their own or discontinue treatment. Elizabeth asked why this has changed so noticeably in recent years and no one offered any ideas.

When asked where the majority of referrals are coming from it was noted that the referral source for all ED's must be the county. However, the data show that most EDs from WMHI are initiated in the home, and a substantial minority start in schools. Providers Iris and Tina noted that many ED's of youth do start in the schools.

Brad spoke about the Collaborative Crisis Intervention Services to Youth (CCISY) Grants. He mentioned that there are CIP (Crisis Intervention Partners) and CIT (Crisis Intervention Team) training s through NAMI. He said the trainings are geared toward crisis for adults, but can be modified to be pertinent for people who work with children. Waukesha has done this with good outcomes. Jonelle Brom suggested CIP be provided for juvenile detention staff. (Handouts were forwarded to group members).

Some of the components of the grant are that each DHS 34 certified crisis program has to revise their plans to reflect greater connectivity to community and natural supports. It was identified that these services are primarily billed to MA (when billed at all) because it is a hassle to bill private insurers. CCISY recipients also have to have a plan for stabilization for youth in crisis. There are only 25 to 30 beds available in the state for youth stabilization. If a child is served in CST they have to have a plan for crisis before a crisis occurs. The grant includes a number of outcomes which need to be achieved.

Iris presented information on the Crisis Services for Children Network (CSCN). It began in the northwest part of the state in 2004. They have a set system of assessment and determination of need. Jill Chaffee started the network and incorporated services in the child welfare world.

The network was primarily created as a hospital diversion initiative between WAFCA and WCHSA. There are currently tencounties who contract with the network, which served 23 children last year. They had initially expected to serve 20 children per day in crisis stabilization beds, so this was a lot less than anticipated. CSCN helps counties access crisis stabilization resources for three primary

purposes – as a diversion to hospitalization, as a step down coming out of hospital back into community and as a planned response to address a need prior to crisis. CSCN also provides training and TA for counties dealing with youth in crisis.

CSCN uses a face-to-face assessment procedure, which they also use to de-escalate the situation in real time.. If they feel a hospitalization is not necessary but services are needed they can place the child in a stabilization site, which could be a foster home, group home, or treatment foster home, all of which must have specialized DHS 34 training to deal specifically with youth in crisis. These sites are all licensed by DCF, and after 5 days of placement at one of these sites, DCF gets involved with the case.

Iris emphasized the importance of on-site, least restrictive approaches and said that they should take precedence over "brick and mortar solutions," even though there might sometimes be a need for such approaches. She recommends the focus be on the assessment process, and who is doing the determination of need. She also emphasized the need for child welfare and mental health workers to collaborate on cases. Iris and Erin Sarauer both said that 50% of EDs were discharged in under 72 hours, indicating that better assessment, de-escalation and family-based interventions should be used to address and divert these cases.

(Iris will forward her powerpoint to be sent out to the group).

There was discussion about the disconnection between child-serving systems on the ground as a contributing factor to youth crises. In particular, the mental health system and the child welfare system may each claim that a child is the responsibility of the other entity. Oftentimes a youth crisis is indicative of a family crisis or family conflict, rather than a strict mental health problem. In such cases, a more holistic approach involving other systems beyond mental health may be appropriate. Elizabeth asked whether CSTs could help in this process. Joyce said that child welfare workers are supposed to be involved in CST teams, but that participation has to be meaningful and that the state cannot mandate meaningful participation. Jonelle shared that she had seen the disconnect between child-serving services on the ground when she was working as a child welfare worker. She emphasized that child welfare workers should be working with mental health workers and vice versa to effectively address a family's needs.

Joann spoke to the group about developing a set day and time for future meetings as it is difficult to find a meeting room large enough for the group. She will send a doodle poll to obtain information from group members to identify days of the week and times that will work the best for most folks.

Elizabeth discussed next steps. One thing that was identified was to look at successful models, (e.g., New Jersey's approach or the NIATx model) guidelines, and curricula. At the next meeting we will take a look at several counties which have been successful in reducing youth EDs, as well as get an update about the new crisis stabilization resources which are being developed by CCISY grantees. Based on our data, problem analysis, and knowledge of systems in WI which are working, from there the group can begin to discuss what direction to go to make recommendations, and other next steps.