Children's Emergency Detention & Crisis Stabilization (CEDCS) Services
Facilitated by the Office of Children's Mental Health
May 12, 2015 / 10:30 – 12:00 pm
DHS – 1 West Wilson Street, Madison, WI
Room #630

Meeting Attendees:

Linda Hall, WAFCA
Jonelle Brom, DCF
Caroline Ellerkamp, DHS
William Hanna, 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
Erin Sarauer, DHS
Cindy Lindgren, DHS
Mark Hale, DHS
Mary Kay Wills, Dane County
Emily Tofte, DCF
Sola Millard, DMHSAS
Teresa Steinmetz, DMHSAS
Katrina Major, DOA
Bill Murray, DHS

PHONE:
Bill Topel, Winnebago County
Elizabeth Hudson, OCMH
Diane Cable, Adams County

Meeting Summary:

The meeting began with welcome and introductions.

Bill Hanna gave a brief overview of a meeting that was held on Monday, May 11 with the counties regarding crisis stabilization services.

Kate McCoy had drafted a Youth Crisis Service Continuum based on services discussed in the Monday meeting and asked for feedback. The group suggested changes which Kate subsequently incorporated into the document. (Attached to the summary).

Discussion RE: Planned respite –

- Bill O and Diane C both stated that some counties provide planned respite for families out of their GPR or other county funds.
- Mary Kay stated that CCS will not fund planned respite as part of CCS, but others pointed out that children enrolled in CCS can receive respite outside of their CCS benefits. (Medicaid only covers "medically necessary" treatment, and respite is not defined as medically necessary.)
- Mary Kay also said that in Dane Co they cannot guarantee a planned respite because they don't have enough foster homes available. It is a workforce / resource issue for their county. She said that last year they licensed 73 homes and filled them all.
- Jonelle advised the group that the child welfare population has increased significantly over the last few years and there is a shortage of homes for the youth in out of home

placement. Kate pointed out that this lack of foster parents is a resource constraint for many of the options on the service continuum.

Discussion RE: In home Crisis Stabilization Services –

- Mary Kay discussed Dane's model for in-home crisis stabilization services. It is available only to children enrolled in CCF (Children Come First). This is a Medicaid-funded wraparound model serving SED youth, who can receive up to 15 to 20 hours of face to face services a week.
- Kay advised that in Rock County the in home treatment model was funded through the Crisis Service but provided longer term treatment (more than 90 days)

Discussion RE: Short-term stabilization site (up to 24 hours)

- NCHC (North Central Health Care) provides "non-residential" stabilization (up to 24 hours) at their crisis program headquarters, which they say is very successful, and that most kids are stabilized within the 24 hours but that they only have the capacity for 1 or 2 children at a time and that there isn't always a need for the service, so sometimes it sits empty.
- The Central WI CCS Region is considering a 'flexible use' model is utilizing a former school (now a community center) to provide a 'hotel model' stabilization based on DCF level 5 shift-staff licensing. As long as the parent is with the child it is not considered an out of home placement, and as long as the stay is less than 24 hours licensing is not an issue.
- Bill T asked what happens when a child comes for this short-term stabilization and they need more than the 24 hours but not quite meeting the need for an inpatient stay? Would the child have to be moved? They would run into licensing issues. Also, he states the five day limit creates difficulties.

Discussion RE: Crisis Stabilization bed options–

- The thought is to use a group home in a county or region that would have 1 or 2 beds available as crisis beds. Another option is to have a bed in a foster home with foster parents who are DHS 34 trained and supervised. However, a barrier discussed was the resource issue, with not enough homes for the youth in out of home care let alone homes for respite or crisis stabilization.

Discussion RE: Voluntary Hospitalization –

- Erin brought up the voluntary hospitalization piece, as a resource issue when people need voluntary hospitalization but there is not a bed available (ie: no hospital with psych beds available, hospital doesn't admit, doesn't have the space or desire to work with that family / child, won't take their insurance, etc) that those turn into crisis and ED issues. She also wondered what the correlation between school ED's is with schools that have liaison officers vs those without.
- Bill H pointed out that we will not be able to effectively address all aspects of the continuum, so we need to prioritize based on need and feasibility. He said we need to know what the numbers are that we're talking about – what exactly is the need in our state? How much is voluntary hospitalization, how many kids are / can be served in voluntary hospitalization and how much is crisis stabilization services?

Discussion RE: Outreach, early identification, and prevention

The topic of the 'unknown' children came up, these are kids that are not known to the county providers until they show up in crisis. The county has no history with them or their family and they are not actively engaged in current care. As a result, the county is unsure how best to serve these children at the point of crisis.

It was pointed out that such children/youth may be receiving mental health services, but through the private agencies, and that private agencies, schools and parents may not understand the continuum of services that the county offers. They may also not see the need to interface with county crisis workers to share or develop a crisis plan in the event of a crisis. The group agreed that here needs to be some education for folks in these areas. This was identified as an area of opportunity for outreach and training.

Sarah mentioned that there are many counties that are doing a good job of the early identification, prevention and planning piece to identify kids at risk of crisis and then targeting services to meet their needs so they're not being ED'd.

Discussion: Additional Barriers to Services

Mary Kay identified a barrier with screening involving families enrolled in Badger Care. She stated that Badgercare will allow the county to screen people but if the county recommends a voluntary hospital stay Badgercare will insist on rescreening the person themselves. Rather than screen kids twice the county tends to send youth back to their HMOs if it appears that voluntary hospital might be a possibility. This may be a barrier that DHS could address.

Bill H asked how we can make the business case to show that it is in the best interest of the insurer to spend those dollars proactively versus wait until the ED.

Mary Kay gave Dean as an example. A family goes to their primary care doctor and asks for a referral to a behavioral health provider or to authorize an ER visit. The county is never contacted in their process.

Private providers are not aware of the county services. Some families are served in the private system but need more supports than just weekly or biweekly talk therapy and medications, which is the scope of services that private providers have to offer. When that becomes not enough the family is referred to crisis or ED. If providers knew about the county's continuum of services, they might refer to the community based services earlier so a family can get help before they are in a crisis situation.

If we want to look at educating stakeholders we need to identify them and find out what information they need.

When we discussed the schools, Bill H asked the DCF folks about their training process for school staff as mandatory reporters around abuse and neglect cases. Can de-escalation / crisis services information be given at that time?

Discussion: Additional Items:

- Kate circulated an ED FAQ sheet that could be used as part of an educational campaign in communities. She requested feedback by 5/22.

* Bill H. reported that DMHSAS has requested that Area Administration staff will interview counties to find out how things work in each county in order to get a big picture view of the state services. They expect to find out how varied the systems are from county to county. Where are they different? How similar are the systems and where are the similarities? To date there is nothing laid out that shows a big picture of the mental health service systems in the state.

Summary:

- The group agreed on a preliminary crisis service continuum document
- Two provisional recommendations were established: (1) educating community stakeholders - including private providers- about crisis intervention and (2) investigating BadgerCare HMOs' policies around use of crisis-related services

Respectfully submitted by Joann Stephens