CHILDREN AND FAMILY SERVICES ADVISORY COMMITTEE
MINUTES
JULY 21, 2016

PRESENT: Kristin Agenten, Sara Barron, Missy Kueht-Becker, Carrie Knight, Maura McMahon, John Schiraj, Mary Wittwer, Karen Villarreal

STAFF PRESENT: Esther Jensen, Kathy Mullooly, Ron Pupp

APPROVAL OF MINUTES OF THE JULY 21, 2016 MEETING

A motion was made by John Schiraj, seconded by Kristin Agenten to approve the minutes of the June 16, 2016 meeting.

SPECIAL SERVICES ADVISORY COMMITTEE

There are no updates at this time.

COLLABORATIVE CRISIS SERVICES (Update on year 2)

Laurie Kohler, from the Outpatient Mental Health Clinic began her update discussing the Collaborative Crisis Intervention Services to Youth grant known State-wide as the CCISY grant. There are five counties that have been given the 5-year grant and will receive approximately $83,000 annually for 5-years (July 2014-July 2019). Laurie manages the grant and our county was allocated $90,936 last year. The overall goal is to improve crisis services and outcomes for youth from birth to age 20 who have apparent Severe Emotional Disturbances (SED). The State would like the counties to focus on the transition age group moving past age 18 and into young adulthood. The focus on this age group and youth with SED's is because they are the most underserved group of youth. And when these youth do come into our system of care they are the ones that are requiring the highest level of care whether that it is through residential treatment or other services from counties.

The State institutes have done a large redesign and there is only one operating unit which is at Winnebago Mental Health Institute. Often times that unit alone is at capacity so the State is asking counties to look at options that each county can do besides emergency detention. We are aware from getting involved with a lot of the potential cases coming into the clinic and are presenting as an emergency detention case, where a youth feels they are in a bad spot and are saying some things that may appear as an emergency mental health crisis situation. However after the clinician assesses the youth they are discovering that it is not an actual emergency situation so they feel that putting the youth in handcuffs, taking them out of the community and hospitalizing them is not the right way to treat that type of situation. Our intention is not to say no to emergency detention but there are times when a youth is presenting risk behaviors, and may need to be emergency detained. When we are proceeding we want to make sure that it is correct and appropriate for that situation. We also want to look at how we can build up the community to provide some other alternatives to reaching this goal.

The big reaching goals of the grant are to extend service and outreach by increasing youth seen by crisis services to 15%, decrease inpatient hospitalizations/emergency detentions by 10%, and develop a crisis stabilization or diversion resource and increase access to community based mental health services. And to also increase collaboration with youth serving agencies such as law enforcement, hospitals who are first responder's, and the county's Coordinated Service Team Initiative (CST), to improve suicide prevention, utilizing the Universal Suicide screening of crisis contacts and follow-up outreach.

Laurie reported that in 2010 our County began looking at lowering juvenile emergency detentions and expanded crisis services. NAMI and the County began Crisis Intervention Team (CIT), which is a 48-hour training program provided to law enforcement to allow them to better respond to emergency detentions. In the past five years from 2011 to 2015 we have brought the numbers down for emergency detentions from 214 to 105 detentions, with 75 of those cases being detained during hours when there were no clinicians available. These were cases where law enforcement came to a crisis scene and the youth met the standard by law, and was taken into custody. The commitment cases that we have oversight and that we oversee care of has stayed the same despite the decrease in emergency detentions, and the amount of youth being placed on orders is the same. We are working very hard at eliminating the unnecessary emergency detentions versus not doing them at all. At this time we are at 57 emergency detentions which are 12 down from this time last year.

We began taking a baseline in 2014 on how many cases were being referred to crisis services. We managed 223 juvenile cases and of those cases 60% we worked out a safety plan, and an additional 17% were helped with voluntary admissions to the hospital. That shows that 77% of the cases that came to our attention were able to avoid emergency detention.

Laurie explained that the Mobile Crisis Services are available where the public can reach out and ask for mental health services and is available to all ages. We have 2-1-1 that operates a number specific to Waukesha County, the hotline number is 262-547-3388. And anyone looking for services can come directly to Health & Human Services and/or call our Mental Health Center. Laurie did state that the Mental Health Center is a 28-bed facility and that it is for adults only, so they are trying to increase access to mental health services for youth in the community before it becomes a concern for us. She did mentioned that as of July 1, 2016 they are now able to provide 24-hour clinical services providing overnight and weekend coverage. The Mental Health Center is providing backup. This was a change from last year as they were only available from 8:00 a.m. to 9:00 p.m. which is a significant increase in the amount of hours that they can provide clinical support to the community.

Laurie shared a recap of year one stating that we had a lot of funding money paying for the CIT training. The County has dedicated funding to all of the law enforcement agencies that send an officer and that we provide a stipend back to agencies that send officers for training. This assures that officers are not taken off the streets and agencies can dedicate staff to train for 48 hours and are not going to be short of protection in their communities. Also, there is an increase in mental health services through pursuing a young adult certified peer specialist. This person is trained and employed to pursue young adult outreach programming. An upgrade in our current Mobile Crisis Services program occurred through Lean Government Program analysis using

data, baseline and assess efficiency, and the inclusion of a standardized suicide prevention assessment screening tool, Columbia Suicide Rating Assessment and Screen. And the implementation of universal follow-up to youth, with crisis contact within 48-hours.

Laurie then shared a recap of year two, stating they had another youth based CIT officer training in February. There were 40 officers that participated in the training and out of this training they began to have a CIT collaborative in the community. What we do know is that having the training for officers one time and not having the follow up will not get the conversation going and the collaboration that we need. Also, since that time we have had two different meetings with the CIT Collaborative which include law enforcement, crisis services, and some hospital services within the county. Laurie explained that they are having a more active conversation about what type of crisis they are seeing, what is working, and what do we need to do to improve.

They now have two peer specialists who are both under the age of 30. She felt that as younger people they see things in a different perspective along with their life experiences of living with mental health issues. The peer specialists suggested that we needed more of a culture of wellness where youth feel more accepted. They partnered with LSS and NAMI and began a social group for young adults called Recreation and Recovery (R&R). It includes social networking outlets with positive media messages through Facebook and Twitter. There was a pilot of 26 youth who participated and had an active and strong peer group of 12 for the peer specialists to work with. They wanted to try a Wellness and Recovery Action Plan (WRAP), both peer specialists have been certified to provide this kind of group.

Laurie explained that they discovered that youth who just turned 18 and were ready to launch were not interested. But they also ran the program here at Health and Human Services in the Clinic as a pilot and it worked out very well with the younger adolescents. It was different from what they had previously heard about, was strength based, and they were creative with art and really taking charge of things. There was a small group of four youth that participated and it was noted that they had a better retention rate. The four youth are now going to be presenting at the State's Children Come First Conference about their experiences alongside with the adult peer specialists. She stated that they are trying to do what they can with crisis intervention and do it better but they also want to create a culture of wellness in the community.

Laurie stated that they have also rolled out Youth Mental Health First Aid which was a one-day, 8 hour long training held by the National Council for Behavioral Health. There were two specialists that had been trained on this program through NAMI. They then trained administration at the Elmbrook School District with that information. This was to help their district have some background on how to deal with someone presenting with mental health issues such as what is it, what does it mean, and how to engage someone who is coming to them in need.

Laurie also mentioned that they began a new pilot program called, Ending the Silence at Oconomowoc School District that the young adult peer specialists participated in. They did this through the health classes and had seen 310 students through the program, and completed 12 presentations. They had such an outstanding result that the district put the peer specialists into

their other programming and did a follow up series that was educational, along with a small WRAP group with some of the youth. It was extremely well received by the students and the administration. Next year it will be expanded into three districts. There is also a workshop that the youth put on from their perspective of how it is to be like them. They discussed the stigma of mental health and what keeps youth from reaching out for help, why it's a problem if you don't reach out, how to support someone, what are some red flags, and how to help a friend. This was so successful that it will be expanded next year.

We are still looking for the possibility of Crisis Bed/Crisis Respite which would be a stabilization or diversion for youth who are struggling and need to be removed from their home for a while to, just get away. We have had several discussions with other agencies but are still unable to find a fit for us.

The question was asked of Laurie, what are some of the barriers that they face with Crisis Bed/Crisis Respite? She replied that liability can be a big concern especially with foster homes/treatment foster homes, and some of the regulations of removing a child from their home. It has to be done in conjunction with Court Orders and the possibility of Conditions of Return that can also make this difficult. As a county we do not look at placing someone right away, we are looking for ways to keep people in their homes. So as a county we do not have a developed crisis/respite program. There are a lot of issues with it such as, which placement would be appropriate (treatment foster home/group home), are they taking up a bed for someone else? Do we buy a bed somewhere and then keep paying for it and then it doesn't get staffed? We don't know what our utilization would be if we had such a resource. When we do move forward we may need to take a look at an intensive program to look at stabilizing families/youth that are at risk of out of home placement and at risk of having multiple inpatient admissions. We may need to also take a look towards stabilization versus respite at this point.

Laurie was asked what is the difference of Shelter Care versus Respite? Laurie replied, Shelter Care is the refusal of custody and anyone can access it. The intention of a crisis respite which is a diversion of hospitalization would be the level of supervision. The youth are high risk and likely line of site and/or 15 minute check type of supervision. We would need to bring in an intensive treatment model whether that it be to work with the crisis team to get them into medication assessment or some other therapeutic response as well as engage the family system. The supervision aspect and the treatment component make it a bit different than Lad Lake. It was brought up that they are using Lad Lake as a crisis placement by default and there are youth there that should not be there. Laurie agreed, and stated that the mental health staff has been spending a lot of clinical time at Lad Lake. When they have a client that is presenting at risk and got discharged from an inpatient facility and the family system is not ready for the youth to be back at home, our staff is out there doing crisis planning with the youth, daily check-ins, etc.

It was brought up that Lad Lake is being utilized in a situation where it is clear there is a problem in the home and the youth is in crisis, but does not meet the Chapter 51 criterion. There is nowhere else to go and the youth in crisis is placed at Lad Lake which can cause a crisis for other youth as well as exposing the youth with mental health issues to youth with negative issues. Laurie commented that Lad Lake has been having to deal with youth that are developmentally disabled and very low functioning and are sitting alongside youth who have a more criminal

mindset. Lad Lake has a huge challenge on their hands and that is a system-wide problem at this point. A comment was made that part of the reason why it is hard to get started is because people are not familiar with the difference in a youth who is mentally ill/developmentally delayed and the youth that Shelter Care is appropriate for. The reaction is, well we have Shelter Care and that's what it is there for, which is unfortunately inaccurate. It was also mentioned that there are youth in Shelter Care that have complicated family issues but do not have a lot of issues themselves and we are unable to find an appropriate foster care placement for whatever reason in a timely manner. Laurie mentioned that Shelter Care is providing a backup for everybody at this point. It was mentioned that when the youth does not succeed in Shelter Care they oftentimes are placed in Secure Detention which is not a good thing either.

Laurie explained that we need to create a culture change in the community. In the Mental Health Clinic they are investigating different ways to access same day psychiatric services, and creating a mental health/urgent care model. They have been working with a contractor from the National Council of Behavioral Health but have had issues regarding the lack of electronic records by the Department. They are unable to work with the fast paced system without electronic records which has limited them moving in the right direction however they do hope to go live August 1, 2016.

In year three our goals are to improve linkage to our community partners and focus again on law enforcement having two CIT trainings for the year. One with a youth focus, and one-adult training that the Clinic will be able to help fund. We have commitments from some jurisdictions that they will no longer be in need of the stipends so we are creating stipends on a scholarship basis. This will give us funds to utilize next year. We have engaged in a new active CIT committee and will be having increased collaboration and training with Waukesha County Foster Care parents. We may bring in a model similar to Youth Mental Health First Aid or start to do modules on how to work with youth in crisis, and how to identify mental health issues that youth placed in foster care may be exhibiting. We will continue to develop and/or identify an appropriate diversion/stabilization resource and are continuing with the Just in Time Scheduling for Health and Human Services. And we are expanding the inclusion of peer certified services for youth in our programming.

For many years this county has worked with mentoring through Lad Lake and we will continue to do that. But for those youth who are struggling with their recovery and could benefit from sitting along with a young adult with mental health issues to mentor them and help them engage in their treatment, we are going to begin a pilot working one on one with a peer specialist. We will be doing increased work with NAMI on expanding Ending the Silence and doing more outreach to school districts in the community looking at stigma and impact, and getting them engaged in other types of gatekeeper training like Question, Persuade, and Refer and other similar programs. Also in collaboration WCTC we will be working on a community suicide summit which begins on November 1, 2016 which is the beginning of National Suicide Awareness month, with extra funding from last year we will be bringing in a young adult speaker, Kevin Heinz, who had a suicide attempt and survived. He is a very passionate speaker who was in the foster care system and talks a lot about the effects of trauma and recovery. He is very energetic in trying to engage youth to talk about stigma and what else they can do

differently. We are hoping to engage the schools in this early on and have them be aware of this youth track that we will be providing for the suicide summit.

NOMINATING COMMITTEE

Karen Villarreal, Chair, commented on the Nominating Committee and will be sending out an email to the committee and remind them that they will need to meet before the September meeting, and will need to nominate for 2017.

2017 ISSUE SEGMENT

Ideas for the 2017 Issues Segments and Topics list were discussed. Karen Villarreal, Chair, will confirm speakers and the final list will be shared with CAFSAC members before the end of the year.

ADJOURNMENT

Missy Kueht-Becker moved to adjourn, seconded by Karen Agenten at 9:45 a.m.

NEXT MEETING

The next meeting is scheduled for September 15, 2016 at 8:30 a.m. in Room 271 at the Human Services Center Building, 514 Riverview Avenue.

9/15/2016
APPROVED

Respectfully submitted,
Tammy Kokan,
Administrative Specialist

Waukesha County Collaborative Crisis Intervention Services to Youth Grant

Laurie Kohler, LCSW
Clinical Services Division

Overview

- Grant received from State of Wisconsin Department of Human Services – Division of Mental Health and Substance Abuse Services
- Competitive grant awarded to five counties
- $83, 000 annually/ five years: July 2014 – July 2019 (Year 2 grant $90, 936)
- Grant contract managed through DHHS Outpatient Mental Health Clinic
- Overall Goal: Improve crisis services and outcomes for youth (birth – age 20) who have apparent severe emotional disturbance (SED). Improved identification of youth at risk for mental health services.

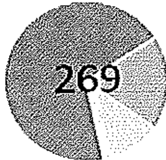
Goals of the Grant

- Extend Service Array and Outreach
  - Increase youth seen by crisis services by 15%
  - Decrease inpatient hospitalizations/ emergency detentions by 10%
  - Development of crisis stabilization resource
  - Increase access to community based mental health services
- Increase Collaborations with Youth Serving Agencies, Law Enforcement, and County Coordinated Service Team Initiative (CST)
- Improve Suicide Prevention
  - Universal Suicide screening of crisis contacts and follow-up outreach

Waukesha County Juvenile Emergency Detentions and the Case for Expanded Crisis Services

- 2011 - 214 EDs
- 2012 – 190 EDs
- 2013 – 171 EDs
- 2014 – 120 EDs
- 2015 – 105 EDs

Juvenile Crisis Contacts in 2014 - 2015



186 / 69% = Safety Plan / No Hospitalization

51 / 19% = Voluntary Admission to Hospital

32 / 12% = Emergency Detention

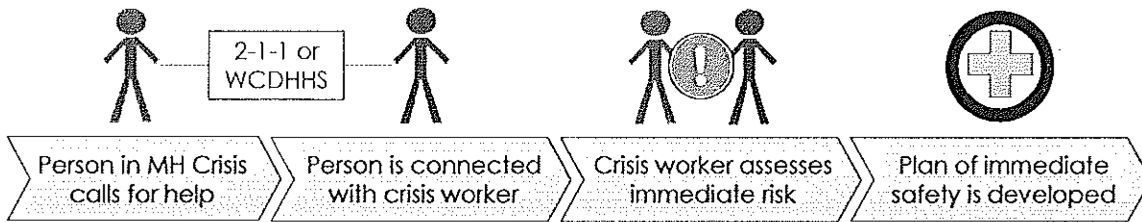
2014 Outcome of Crisis Intervention

134 (60%) - Safety Plan / No Hospital

38 (17%) - Voluntary Admission to Hospital

51 (23%) - Emergency Detention

Mobile Crisis Services Overview



Significance

- State-Mandated Program
- Promotes Safe County
- Uses Best Practice Model
- Cost-Effective Interventions

HOURS OF OPERATION:
*7/1/16 : 24/7 Mobile Crisis Capacity

Year 1:Youth Crisis Grant Activities

- Increased Partnership with Community Stakeholders through Educational Initiatives: CIT, CIP, QPR, Partnerships for Childrens' MH
- Increased MH Service Array through pursuing young adult certified peer specialists – 1 trained and employed to pursue young adult outreach programming
- Upgrade of current Mobile Crisis Services Program
  - Lean Government Program analysis – data, baseline, assess efficiency
  - Inclusion of standardized suicide assessment screening tool (Columbia Suicide Rating Assessment and Screen)
  - Implementation of universal follow-up to youth with crisis contact within 48-hours

Year 2: CCISY Grant Activities

- Continued Community Education and Outreach
  - Youth-based CIT Feb 2016
  - Peer Specialist –led support – Recreation and Recovery (R & R) and Youth WRAP
  - Youth Mental Health First Aid – training for community/ direct staff
  - Youth education and engagement initiatives - Education and Outreach to Schools
    - Ending the Silence Program – OHS
- Increase Access to Community MH and Community-based Crisis Resources
  - Exploration of Crisis Bed/crisis respite for continued diversion
  - Investigate same day psychiatric services – mh urgent care
  - Increase available hours/ numbers of staff available for MH Mobile Crisis Staff

Year 3: CCISY Grant Activities

- Improved Linkage to Community Partners
  - Active CIT Committee
  - 2 CIT trainings
  - Increased Collaboration and training with Waukesha County Foster Care
- Increase Access to crisis services for youth
  - Development of diversion/stabilization resource
  - Just In Time Scheduling at HHS
  - Expansion of inclusion of Peer Certified Services for youth and families
- Increased Community-wide Suicide Prevention Efforts
  - Ending the Silence Increased to 3 districts
  - Community Suicide Summit with youth track and youth focus set for November 1st.