ABHI Children's Mental Health Initiative Meeting Summary (draft)

ICS Branch: **Resource Development**
Meeting Date: **April 6, 2022 1:00 p.m.**

Participants:

Ric Schaefer, Arrowhead Health Alliance and Arrowhead Behavioral Health Initiative
Dave Lee – Carlton County Public Health and Human Services, Chair, State Advisory Council on Mental Health
Matt Johnson – Supervise Children's Mental Health Team in southern St. Louis County
Ryan Beamer – Community Wellness RN at Lakeview in Two Harbors
Kim Stokes – lived experience with seeking resources for a child, serve on State Advisory Committee on Children's Mental Health
Annmarie Florest – Clinical Director for Range Mental Health Center
Alexandria Adolphs – Systems of Care Coordinator in Family Initiative's Department with Carlton County Public Health and Human Services
Diane Holliday Welsh – consultant on Clarity Initiative with St. Louis County
Brittany Anderson – Grand Portage Reservation mental health services
Amy Brownell – Public Health Educator for suicide prevention and mental health for St. Louis County
Jenny Markwardt – mentor with Check and Connect in Mountain Iron

Participants introduced themselves and identified their reason for attending or areas of specific interest related to this working group. Comments included:

- Gaps in service are continually identified in discussions about what we have/do not have in our region. Interested in working together on solutions.
- Interested in working regionally to expand access to children's mental health services but also hoping that what we do regionally can be applied in other parts of the state.
- Mental health has been identified as the number one issue on our last two public health assessments, and it's anticipated it will continue to be number on this year's assessment. Interested in expanding access to resources for mental health, including children's mental health.
- Children's mental health crisis services, triage services and short-term residential options continue to be identified as critical needs. Working together we can develop a pilot project where we can help children and their families find short term crisis stabilization, develop a plan and provide a warm handoff and introduction to services that are available in the community.
- We can fill gaps by working together rather than working in silos
- The Clarity Project is looking at resources, availability and access to behavioral health services for all ages, but the needs of children and adolescents come up frequently. Interested in learning about what we can do in person and via telemedicine.

- Interested in learning about resources and identifying opportunities for partnerships.

Brief overview of ABHI Children's Mental Health Initiative.

- This is one of 8 work groups/ICS branches being convened. While each group will determine is own focus and work plan, there will likely be cross over between groups. We are not seeking to create additional silos but to promote communication between groups and integrate efforts
- Intent is to support core values of accountability, communication coordination, innovation and action in responding to mental health crisis.
- Initial meetings for each branch will be facilitated to help create action plan and reach consensus on initial goals, objectives and activities. Groups will transition to leadership from within (co-leaders preferred)

Action Plan Discussion

While Zoom format allows greater participation across distance, it can be clunky for developing collaborative work plans. A survey monkey survey will be distributed to work group members, with responses synthesized and shared for group discussion to help build the work plan and create a common understanding around goals, scope, actions, etc. Discussion today was intended as initial brainstorming about elements to consider in identifying the scope and intent of this group. Key thoughts shared included:

- As a parent of an adolescent who was struggling, there was no one place to go to seek resources and crisis stabilization, with many barriers encountered. These barriers were overcome once my child reached the age of 18 and could access lifesaving crisis residential services at Wellstone. This service needs to be available for children and adolescents in a single setting where you can bring your child in crisis and make a plan for the child/for the family in a calm, safe, unthreatening place (i.e. Birch Tree Center or Wellstone Center for kids)
- Current system has many barriers to reimbursement. Medicaid may cover some services, but private insurance may not. State had introduced legislation in 2015 to eliminate the requirement that a child be ward of the state to receive services that a family couldn't afford but uncertain of status.
- The Iron Range Task Force for Mental Health For Youth developed a plan with Range Mental Health Center on what children's crisis stabilization services could look like if development and ongoing operational funds were available. Perhaps we could use these plans as a starting point for discussion.
- There is legislation that has been introduced re: crisis stabilization for children that might provide an opportunity to move that model forward if it passes. The link will be sent to participants of this group for review. Does the proposed language match what the need is? https://www.revisor.mn.gov/bills/text.php?number=HF4021&version=0&session=ls92&session_year=2022&session_number=0
- Barriers identified by the Iron Range group included lack of DHS reimbursement, barriers to commercial payors covering services (bundling services was an issue – could not offer more

than one service per day, commercial pay wouldn't pay room and board if not in a hospital setting. Start up estimate at that time was $1.1 million if the service was not in a hospital.

- While staffing is an issue with all services, existing staff at RMHC have cited the gaps related to children/adolescent crisis stabilization and are passionate about addressing these issues. There are people who would be very excited about the opportunity to build these services.
- There are transitions between the different levels of care or returning back to community, to school, etc. There are not currently adequate resources or reimbursement for care navigation or coaching to bridge the connections back into the community and day to day activities.
- There is a need for inpatient and day treatment in rural areas. While telehealth has helped in some respects, it's also a different experience if participating via telehealth.
- Distance is also creating barriers in treatment of eating disorders
- We may not be able to move all services to rural areas, but if we could develop stronger systems for coordination and connection would improve.
- If we had a short-term crisis stabilization center, we would be able to identify what those gaps are and to address them in a more coordinate manner. We would have a single place to collect the stories and information and actual issues our children are dealing with. Right now, the issues are diverse and dispersed and it's difficult to quantify how many children are in crisis. There is no one place to gather this information to find out how many youth are in crisis. Minnesota Department of Education could be a place to gather information about why kids are leaving school and mental health issues they are facing when they leave school. Anecdotal information about children transported by ambulance to hospitals for mental health issues was significant. Lack of consistent information about what is going on in one place is a barrier. A potential crisis center could help to quantify and collate that information.
- From a Duluth perspective (not rural), crisis stabilization and subacute care is the number one issue seen by case managers. Crisis are dealt with in ERs and law enforcement, both of which are not specific to unique mental health needs of children and adolescents.
- On a smaller scale, one area that we could perhaps develop is peer support in school settings. Various schools have received grant funding to train students to be safe people and to go to in times of crisis. Students are more likely to approach peers rather than a mental health professional during certain times.
- There are various skills and training available only when kids end up seeking help (DBT skills through Amberwing as an example). Is there a way to get kids access to these skills before they end up in a place of crisis? Can we offer these through the schools for all kids or as voluntary resources that kids can access?
- One of our goals is that kids don't have to leave the region to access services. The closer they can access services to their homes/neighborhoods/communities, the better.
- There are a lot of resources and best practices in the region that we are all not well aware of. Having these regional conversations will highlight promising practices that can be expanded to other areas without reinventing the wheel.

- Question asked if there had already been a comprehensive gap analysis done. Gaps had been identified anecdotally and through abbreviated SWOT survey post-summit. Intent is that the work of the existing resources group to map and identify existing resource would help to identify gaps, promote existing resources and expand access, but a more comprehensive gaps analysis might be useful.
- The Prevention and Resiliency group is identifying "upstream" opportunities to support mental wellbeing and resiliency. There are gaps at this end of the continuum that can also inform our resource development work.

Next steps

Survey Monkey will be shared with all group participants. Responses will be summarized and shared with the group for discussion at the next meeting to help begin building an action plan.

Future meetings

The next meeting will be held via zoom on **Wednesday, May 4 at 3:00 p.m.**. Future meetings will ideally be held bi-weekly through early June, to support development of a work plan prior to the summer when it's more difficult to bring people together.

Communication

A written summary will be provided for all meetings. Meetings will be recorded to facilitate accurate discussion summaries and to capture participant feedback, but links will not be made public. They will be available for viewing upon request for 30 days following a meeting by a group participant unable to attend a meeting.

Participants consented to sharing of email addresses to support communication between group members. Email addressed of those present at today's meeting are included below.

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