

FAMILIES WORK GROUP – 3/15/16

1. Introductions

2. Icebreaker – First best friend.

3. OYS Updates –

CBA – quarterly meetings (budget review). POTENTIAL – funds MAY come available in April which would be made available to working groups. Proposals in the “hopper”.

If we think about action items which may need funding and discuss this as we move through planning processes; more thought and collaboration can be applied toward proposals when money becomes available.

May 6th – OYS Steering Committee Strategic Planning session –

- Question: Written feedback – way to react via email.

- Document will be on the OYS website.

Timeline for spending money – Current fiscal year.

How much funding - unknown

4. JJ101

i. Mary Jo Thompson – Nursing Director at CHI Immanuel

Manages day-to-day operations of inpatient unit. 36 beds for youth crisis stabilization

Risk of harm to self or others. Acute MH status change. Substance use warranting medical care. Stringent criteria. Shortened length of stay for crisis stabilization (driven by insurance coverage). Barrier to families re: coverage – most plans max out at 30 days.

Hospitalization - active plan and means to carry it out in order to authorize hospitalization.

Full continuum of services, 9 outpatient clinics

School liaison program w/integrative health communities.

Interventionists, not only case managers. Meet with teachers, families, work in the neighborhood and in the school. Training with school personnel. Good outcomes in high risk areas.

Day treatment – prevent hospitalization and provide transition support. Sub-acute phase.

Therapist in primary care clinics (NW 168th & Maple), Ralston – lack of licensed professionals = families going to primary care physician for meds, this helps provide support to the PCP.

Emergency department – families looking for assistance in crisis. 45 – 50% of youth who enter need urgent care and do not know where else to turn for care. Obtaining care quickly in urgent situations is difficult.

Court ordered care. Placement youth sometimes take 30-60 days to place and hold spots in acute care beds which reduces bed availability. Frustrating because it is a placement issue and impacts ability to serve youth who do need acute care.

PRTF – psychiatric residential treatment facility – serve more than just DC

CHI Residential will care for youth ages 6-18

Question – are children who are ordered to group home being held at PRTF – occupying beds which would otherwise be available? Yes.

Cannot court order to a place – can only court order to a level of care.

Full demographic service – female 12-16 is largest demographic served in acute care.

Question – are Sudanese and Hispanic youth served – is it as much cultural as MH. Yes. Serve a mix of youth. Have some language barriers which have been addressed.

Foster care transition – 1 hour of time with family at hospital, much different from how it used to be with multiple home visits prior to placement. Transition has proved more difficult and youth ends up coming back.

Youth transition to shelter – plan is a transition to shelter care because foster care is unavailable. Not an ideal plan. High readmission rate of those youth. Tracking these as high risk, offering case management.

Suicide rates on the rise. Suicide in Ralston recently. Suicide in Elkhorn over this weekend. Youth ages 14-15 in DC seem to be most prevalent.

Question – are you seeing cutters? Yes

Family engagement – communicate on every point of contact. School, family members involved. Transportation for care conference to meet with treatment team, outpatient appointments – contact CPS to align transportation, offer support – follow-up care.

Stigma of MH still big in the community. Fearful – sometimes do not want child to return home. Intensive case management in the home to preserve family unit. Fair amount of families who do not want child to return home.

Criticism – needs to be more communication to reach out to community. Do you have outreach or communication?

Region 6 MH campaign around awareness.

Funding streams in NE sometimes creates silos – Child Welfare, Schools – we miss out on a federal level. NE does not always take advantage of federal dollars.

Support and education group for families – had for about 15 years, low attendance (3-4) families might attend. Family support and communication (free) very low attendance.

We are trying to establish a child/family mental health center – community philanthropists. Assessment center – get youth and families out of the ER. Children’s hospital for mental health.

ii. Robinson Family Support – not present

5. Review Draft Youth and Family Material

I like it, it is simple. Is there a reason for not listing any physical locations?

Is it possible to list a physical address?

Is it possible to list additional terms?

- Suggestion was to make it tri-fold. Could it be 4 – fold

Did a youth help – Yes, formerly system-involved was involved

How do people get this – available at points of contact which were discussed at this working group. Hope to dispense as broadly as possible

7. New member – Kim Nichols – Learning Community Center of North Omaha

Guest - Marcus Ricks - OFD