Indiana Behavioral Health Commission

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Indiana Behavioral Health Commission

Children & Families Subgroup

Thursday, August 26, 2021, 3:00 pm – 4:30 pm

Join Virtual Meeting: https://us02web.zoom.us/j/86008473440?pwd=R2FvNFJKdkdPeXZqRW5RSThjR2xtQT09

Agenda

Welcome and Introductions

- Brooke Lawson (BL) – co-chair, Mental Health and School Counseling Coordinator, Hamilton Southeastern Schools
- Elaine Trepanier (ET) – DMHA Support
- Bethany Ecklor (BE) – DMHA Support, School & Community Based Programs Director
- Rachel Johnson-Yates (RJY) – Deputy Director, Chief of Staff, DMHA
- Jess Yoder (JY) – Project AWARE Specialist, IDOE
- Donna Culley (DC) – Clinical Psychologist, Director of Child and Family Services, Southwestern Behavioral Health Care
- Leah McGrath (LM) – Vice President of Public Affairs, Knowledge Services

- Review of Minutes from April 28, 2021
  - DC – motion to approve
  - LM – 2nd
  - All in favor, minutes approved

Purpose of today's meeting

- Chase Lyday unable to attend today (other co-chair), worked with Brooke to arrange recommendations into 3 buckets below
- BL – review of buckets, open for group discussion

- 3 buckets discussion
  - Access to behavioral health services for all Hoosier children and families
    - Outpatient services
    - Gap in services from outpatient to inpatient services (IOP, Partial, etc)
    - Number of inpatient beds in the state
      - RJY – is school-based included in outpatient?
      - BL – good question, need to be specific about that
      - LM – whole child education, linking that to the "why", linking to academic outcomes
      - BL – save that thought for the 3rd bucket discussion, lots of research to

support whole child education leading to better academic outcomes
- LM – think it could be incorporated into the bullet points here
- DC – major areas are covered, also sit on suicide mobile crisis options for kids and families group, those issues not reflected here (crisis and suicide); bullet under education for "funding/positions" – barriers to access right now, it's every provider/CMHC/service entity struggles to get positions filled, so many vacancies, relates to under-funding of mental health services in general, not just for children, but the de-valuation of mental health – all of that does speak to access – not advocating for additional bullets but just up for discussion
- BL – when student discharged from hospital, transition back to services and back to school, wouldn't always have a lot of information about the student's time on the unit, school can be stressful environment to return to – do we need to add something to this bullet around crisis services and transitions
- RJY – utilizing people with lived experience in the realm of youth – area for growth – when youth are transitioning between levels of care, something to mobilize
- BL – anyone using youth in that way?
- RJY – no, but Amy Brinkley at DMHA would be point of contact
- BL – "funding/positions" below was really about schools being able to hire mental health positions
- JY – thinking about access, conversation circulating around workforce, physical beds/space, but the referral process needs to be talked about – how are we routing children and families to these services – existing relationships/MOUs between organizations, existing meeting spaces to talk about referrals
- BL – lag time between referral and intake, can be difficult for families
- LM – other gap is with those who qualify for Medicaid and those who don't
- BL – level of services for children with private insurance versus children with Medicaid
- DC – some staff working with clients in school setting in ¾ counties, but only the students who have Medicaid/MRO; tried to put staff (LCSW – able to take private insurance) in schools to serve students with commercial insurance, but couldn't sustain those positions because we did not get enough referrals, have to define program eligibility by students with MRO because that's the only funding mechanism that we have if no financial arrangement with schools to pay for services out of different bucket, this is huge barrier to access, if we could figure out something to support all students across the spectrum regardless of insurance type
- BL – HSE only has licensed providers, with such large number of students with private insurance, programs like that can be difficult to sustain
    - Shifts and edits to bucket 1 – will be incorporated

- Appropriate models to restorative discipline approaches
    - Moving away from zero tolerance policies,
        - BL – not just schools, JDAI, other alternatives to juvenile detention
    - Including behavioral health supports
        - BL – Youth Assistance Program example, including some case management supports
    - Training necessary for all organizations

        - BL – Using more restorative approaches when youth are struggling
    - RJY – anything we can do to link it to any concrete outcomes for students who are experiencing disparities, terms like restorative justice can feel nebulous if not area of expertise, need to help define it clearly and make it accessible, to help develop buy-in and support
    - LM – any way to link it to preventative or proactive models for developing youth in need, linking to proactive language, collaborative
    - JY – training bullet point, more specific to what kinds of organizations have ability to effect change in this area, schools, but who else?
    - BL – law enforcement, youth-serving organizations, didn't want to be prescriptive but to encourage a conversation about what this looks like in each community
    - BE – PLC restorative practices trainings, schools receiving training, but community organizations reached out to receive the trainings as well, YMCAs, after-school programs, wanting to align with school partners – could look at the types of organizations that reached out to get those trainings as examples of types of organizations
    - JY – would love to hear youth voice/perspective, those who have experience in discipline policies and practices, what is the effect of zero tolerance policies, what does restorative discipline approach look and feel like from youth perspective
    - DC – "trauma-informed", not sure where it fits, but does speak to the philosophy of the zero tolerance policies

- Whole Child Education
    - Framework for social emotional supports
    - Implementation supports for schools
    - Funding/positions to support this work
        - RJY – language around intentional collaboration with parents/guardians, misinformation exists, intentional outreach and education on what do these terms mean, what does it look like, how can they be involved, be sure parents are on board with implementing similar strategies in the home as are being done in the schools
        - LM – add that to 2nd bullet – implementation supports for schools and parents/caregivers, JY/BL endorsed
        - JY – funding/positions can mean different things, schools funding streams, what kinds of funding are we talking about? What positions do we think are most impactful to moving this work forward?
        - BL – would depend on the school and the community, not too prescriptive, being more specific around "student support positions"
        - JY – agree it will look different, "student support positions" are important, huge gap, need more professional development around social and emotional learning, initial push of "what is SEL?", but still ton of training needs to happen in the state, might be why there is misinformation
        - LM – endorse inclusion of parents in this, not understanding it; context of how it has been received, can we talk about the "why", helping students succeed in academics and life, communicate this, legislature is hearing a lot from various parents and community stakeholders, need to reinforce the "why"
        - JY – lacking data that supports the "why", have to use national data that supports whole child education, could include funding for data collection
        - LM – endorsed, piloting funding for data collection to help reinforce the "why"
        - BL – update to funding/positions and resources around data collection?

- JY – yes, having a point person is always helpful; correlation and causation are hard in this space, not as clear cut as academics, helpful to first define what data would be collected, can that actually point to outcomes and point to us needing to implement this and dedicate more resources to it
- BL – true for all data collection in mental health, hard to show outcomes, but agree having our own statewide data to support this would be helpful
- RJY – second the idea of coming up with phrase that might feel more clear, something like adulthood, preparing youth for transitioning to next stage of life, parents can get on board with teaching kids soft skills to be successful in their career, conflict between misinformation and the phrases that have gotten connected with that, be more specific with language
- BL – ACTION ITEM from today's meeting, committee members think of ideas, "preparing students for lifelong success" (or children); send BL and CL ideas
- LM – endorsed
- JY – have been discussing this, important that across agencies or individuals/professional in the space are using the same language, as IDOE leadership is developing ideas, will bring those to this group
- RJY – if this is already happening, very much about clarity, no need to reinvent the wheel
- JY – could use the group's help across sectors

- Prioritization of work for this committee
  - What is most important?
  - What will take the most time?
    - RJY – access (specifically to insurance parity), could get legislation support, where services aren't affordable; other two go so closely hand in hand, restorative discipline next, then whole child education
    - BL – proactive and collaborative approaches (restorative discipline rewording)
    - JY – public health – more upstream – but access right now in light of widespread trauma over the past year and a half, that could be a really impactful thing right now, while we dedicate time to more restorative discipline and social emotional supports upstream
    - LM – agree on the current order
    - DC – support the current order
    - RJY – legislative support would take some time, certainly not the low-hanging fruit, but opportunity with the commission to put some weight behind that (access)
    - LM – with covid relief funding, opportunity to leverage those dollars to help fill those gaps, recognize greater need
    - RJY – insurance billing rules get tricky, if person is being reimbursed at all through Medicaid for something, then you cannot through Medicaid offer a free service to someone else, DMHA block grant funding dedicated to serving youth in Indiana, getting stuck on youth with commercial insurance needing services
    - BL – notice the gap from outpatient to inpatient, students struggling to return back in in-person instruction, gap in services, sometimes CMHCs are prevented from providing that support, outside of CMHCs, individuals supporting mental health needs of communities (non-profits, private practitioners, etc.) – is there an opportunity for us to explore their ability to support their community in a different manner
    - BE – CMHCs are the public mental health safety net that state can oversee, other providers serving youth and families, but not existing way to know who they all are and what their billing practices are

        - BL – give communities opportunities to work together and identify how they could create programming and support for students
        - RJY – rule for anyone that bills Medicaid, cannot bill Medicaid for some youth and provide the same service for free to others, can utilize grant dollars to make it work, so example could be to dedicate X amount of dollars to certain services and no one is billing anything
        - BL – in communities who would have access to that grant funding? Only CMHC? Or could community consider other providers/organizations that have capacity to meet that need
        - DC – need to be careful that whoever received grant dollars would be held accountable to same standards as CMHCs, need to make sure funding doesn't go to providers that wouldn't be able to handle that level of service
        - BL – aware of standards and audits for CMHCs, but wouldn't want that to be a barrier to access for children and families
    - All members agree to current order of prioritization

Next Steps

- Prepare report out to Commission at large
    - DMHA support – captured everything from today's discussion, all additional pieces mentioned today, not everything necessarily needs to go into first presentation of recommendations to full commission,
        - Consolidation of main points for commission meeting in September, update current recommendations into final wording – share with subgroup and make any final edits before presentation to full commission
        - Will get a first draft of final recommendations to co-chairs for presentation in September

Future Subgroup Meetings

- Determine future subgroup work
    - RJY – Much of the honing in on final recommendations for commission report can be done via email
    - BL – final draft of buckets will be shared prior to meeting in September

- Full Commission meeting scheduled for September 29, 2021
    - Planned in-person, but potentially will be virtual