

**Sitka Advancing Our Community  
Clinical/Behavioral Health Committee  
April 5, 2006 1:00 p.m.**

*Note: these notes are best read while also referring to the notes from the January 11 and 25 meetings of this committee. Those notes provide the complete list of items the committee is referring to.*

Originally present: John Raasch, Ariyeh Levinson, Michael Lande, David Sliefert

The purpose for this meeting was to get everybody on the same page, especially to let the Executive Directors know what work has been done in this committee over the past several months. With such a low turnout, there is some discussion about whether we should continue with today's meeting if Bob George, David Voluck, and Louise Brady aren't here. Committee members put in calls to those folks, and eventually all of them show up, but Michael has to leave.

While we wait for the others to arrive, John and Michael review the services grid and provide the following updates:

- Add YAS to child group therapy in all payment types
- Add YAS to substance abuse diagnosis – all child and adolescent categories
- Add SCPS to sub abuse residential inpatient – all adult (male only)

Once Bob and David have arrived, John reviews the work that has been done by this committee so far.

- First goal was to brainstorm gaps in services
- The committee then set out to group them by subject matter
- Prioritized what we could do in the short-term,
- Identified community concerns beyond what this committee could do (needs attention from broader AOC, general community)

John presents the charts according to subject area, and highlights the items that the committee has already worked on.

Regarding “behavioral staff trainings”, someone asks for clarification – if the “required trainings” are things like confidentiality, FASD, etc. Yes, there are certain requirements from state through the community mental health grant. Currently, the agencies do their trainings separately, although the grants probably require the same trainings. Each agency may also have some requested trainings. The goal is for YAS and SCPS to generate their training lists and cooperate on them, if possible. Someone mentions that Hanson House has more substantive trainings and should remain separate – they need to meet a higher level of training requirement.

Regarding “training and retention”: these are entry-level positions, and often the employees experience burnout from responsibilities, or they become experts and are promoted to new positions. The committee hasn't come up with any solutions yet, but there is a need to identify how to retain and keep those positions healthy and good.

- Someone comments that research is showing the closer the client is to staff, the better. There is a severe change in treatment if staff changes. There is so much focus

on what can we do with/for client, but sometimes it's more about what agencies should do.

- SCPS is working on a system for training and moving people up the system; also trying to penalize for staying less than 9 months (early withdrawal)
- It is suggested that agencies do exit interviews, if they don't already, to determine why people leave, if they feel safe, comfortable, sane, etc.

Re: Clinical issues – the committee has set a standard of care for maximum amount of time from when a client calls the agency to when they start treatment. There is still the question of how to retain/maintain that standard of care. SEARHC keeps a log; but you often can't track the reasons why it didn't happen in the desired amount of time.

- Clarification – non-urgent (emergent) care;
  - We don't have an urgent care timeline – Matthew adds to the chart:
  - SCPS has a master schedule – assessments have to be brought to their next team treatment meeting (Michael tracks all initial calls and the time of their assessment);
  - SCPS urgent care tries to be seen that day; non-urgent care within 3 days
- “Define agency service parameters” – the committee has met this goal
  - Next steps – there's a few minor adjustments to be made, need to present to larger body; include private clinicians to include their services, and make the grid community-wide
  - Could still be more clearly presented in the grid form, but best way we've found so far.

Re: Creation of new program/service

These are things we can't solve in this committee – need to present to other agencies

- An “advocate” would likely not be associated with any one agency, but rather serve as case manager to hook into appropriate services
- “Parent mentors” could provide hands-on training for parents; i.e. how to run household, discipline, etc.; this is not mental health crisis, but resources for families
- Need more foster parents
  - OCS has foster parents, but not for teens – babies/children only; OCS says they can't see the need...

*Louise joins the meeting 1:50*

- Host family for MEHS student with behavior issues – student gets in trouble there, danger of being kicked out and sent home, jeopardizes educational completion; been request from students/staff for more host families – asset to MEHS and student's education;
  - big change in MEHS this year – students have attained max. number of demerits but kids aren't being sent home.

Re: Other agencies/services – how can we collaborate better with the following?

- Work more closely with Native service providers
- Respite care for parents with special needs
  - Center for Community does this – staff does some babysitting; still a need, though – they don't do overnights, identify level of need

- Foster parents
  - Not a lot of kids being taken from the home, confusion within system?
  - How many are being sent out of town?

#### Education

- Public education campaign – National Mental Health Month, good opportunity for awareness
  - Letters to the editor, promoting agencies and what they do
  - A more coordinated effort among this group – we all work on promotion, but it might be helpful to try promoting services together
  - We should have an open training for community sometime
  - Native community – issues arises often, stigma creates barrier to care
  - Native resource person used to be at SEARHC 6 yrs ago; helped community access services to the appropriate agency

#### Other actions in progress

- Find easier ways to connect to these services

#### Questions/comments

SCPS had an issue with state: they were providing care to adult “worried well” but the state said they shouldn’t provide services outside of their grants. Bob’s argument was that they don’t get grant funding for 100% of anyone; they need other funds for everything.

There is some discussion about whether there should be “advertising” of the availability of non-ben services – that is, notifying referral agencies that these services exist. Bob will notify as soon as he gets word from the state.

Conversation shifts to inpatient services. It costs a lot to set up, says Ariyeh. Bob brought up that transportation costs to send someone off the island is costly, as well.

*Ex parte* was discussed. This is about holding someone against his/her will for mental health reasons. This is court-ordered. Louise mentioned that she had heard that SEARHC was not dealing with *ex parte* anymore. Ariyeh said that SEARHC is mandated to provide this service. Where it changes is if the mental health issue is related to alcohol. With alcohol cases, the state does not provide an attorney to the patient – so things get complicated on court orders.

- Louise says that this gap in service is something that AOC should be giving attention to. Ariyeh says that AOC isn’t the mechanism – the SEARHC board will not listen to AOC. But what needs to happen for change is that it moves through the SEARHC board. SEARHC does listen to the governing council, so that may be a way to do it – through the tribes.
- Louise will make a presentation to the Steering committee on this issue.
- Ariyeh says it will require the physician, the SEARCH attorney, and a program to accept the person w/in the Hospital (like Brady prog). SEARHC itself will not accept alcohol treatment.