Clinical/Behavioral Health sub-committee meeting
October 19, 2005
3:30 pm

In attendance: Bob George – SCPS; John Raasch – YAS; David Sliefert – SEARHC; Ariyeh Levinson – SEARHC; Matthew Turner and Kayla Boettcher – AOC

The group began discussion on the Division of Behavioral Health's 10 Components of Comprehensive Continuous Integrated System of Care – a 10-step community plan required of agencies that receive DBH grants. Bob and John determined how they could divide the 10 steps and each report on half of them – both YAS and SCPS have reports due this month. We tried to determine the extent to which SEARHC was also part of this plan – it was decided that their input on the report is not necessary.

The remainder of the meeting was spent discussing possible directions for this committee. Committee members agreed that there are some obstacles and impediments for community members to receiving the most efficient and effective care they need. They began to identify those obstacles, with a future goal of prioritizing this list and making efforts to eliminate some of them. The following topics were discussed:

- Duplication of services – how to collaborate and utilize services together better: training, expertise, etc. (need to include STA in these discussions)
    - Ideal to create an underlying attitude about making future decisions based on what is best for community to serve their needs – attitude that the services are larger than the agency, and providing care is more important than which agency provides it. (This is for new services needed in community – not those mandated by MOA between YAS and SCPS.)
    - Referrals back and forth are difficult – each agency has their own intake process/paperwork – is there a way to streamline paperwork if someone has been seen at another agency?
    - Some structural differences may make it difficult to streamline paperwork
- Non-beneficiaries can't afford some services at SEARHC without insurance
- Familial reluctancy – gets referrals, but family doesn't want to
    - Stigma associated with seeking care; changing the label of "mental help"
    - A network of parent advocates was suggested as an idea – currently the client's first contact is a visit to the clinic, which can be fearful – the advocates would not be connected clinically…if we had a representative from Native community who was an advocate to walk people through the process and help them get to appts., it may make a difference; needs to be someone from the community – could be a volunteer, if possible,– SEARHC currently has two people doing this
- Does every clinic have someone they could call up and get their questions answered? Like a help line? If a parent has a question that may or may not be an indicator of a problem – someone answers the phone who can ask more questions, help family decide who could provide the best services, help transfer the call to another agency and help them walk through the process; or a referral line/agency not affiliated with any one agency – that can help the family get to the right service and help them walk through the process; perhaps instead of creating a new agency, this built into our attitude about how we work together.

    - maybe each agency trains a few people for this service – the advocate who walks them through the system
- Time from seeking help to actual care
- Non-natives (for SEARHC) or the "Worried Well" – those who seek care but do not meet a clinical standard that can be billed.
- Adult non CMI (chronically mentally ill), non beneficiary, as a gap
- Non beneficiary kids who just need counseling
- Providing family support (non-clinical) while child is receiving care
- Parent mentors – modeling of appropriate parenting
- Mt. Edgecumbe students – when they are a behavior problem they are sent home – would rather see some kind of host family that could
- Foster Parents – need for more families
- Respite care for parents of kids with special needs
- Non-therapeutic therapeutic services for kids (wilderness-based experiences, etc)
    - though STA is doing some good stuff, how can we have more of this, more consistently throughout the year.
- Need to work more closely with Native service providers
- staff that work directly with clients are often unskilled and underpaid; they learn on the job and then either learn new skills and move on from the job, or they don't learn or grow in the position…
- Need combined training opportunities (this needs to be defined well)
    - Only goes so far – need ongoing mentorship and application to daily work life

Next steps:
Define the gaps more clearly
Prioritize the list
Choose goals that can be met in the near future; also identify which will take a year or 2 years

Next meeting November 2, 4:00 to 5:00 pm

Also need to invite STA representative – Louise or Bill