**Central Wisconsin Health Partnership**

**CCS Service Facilitation Forum**

**Monday, June 20th**

**Green Lake County Government Center**

**Present:** Michelle Carpenter, Hans Brammer, Celia Wagner, Collin Williams, Clara Voightlander, and Kim Whitaker – Waushara County; Danielle Moore, Erika Cattle, Erica Baldwin, and Amanda Negaard – Juneau County; Lenna Hamilton, Julie Izzo, and Allison Else (presenter) – Adams County; Brian Fischer and Heather Hardwicke – Waupaca County; Tara Eichstedt, Kate Meyer, and Jason Jerome – Green Lake County; Dan Naylor and Lori Martin – White Pine Consulting

1. **Introductions and Issues Basket**
   * Several additional people joined our group including Brian and Heather with Waupaca County, Kate Meyer with Green Lake County, Danielle with Juneau, and Collin and Clara with Waushara.
   * Dan asked the group if there were items anyone would like to add to the “issues basket” for discussion by the group – there were none.
2. **Review notes from April 20th forum and follow-up discussion**
3. Dan proposed the topic of crisis response planning as a regional training. Dan has been in contact with Sharon Locklin, the NE regional Crisis Coordinator; they are looking at the possibility of using the August 10th training day for this purpose.
4. Complete discussion on Transitions
   * + Dan reviewed a draft transition and discharge planning workshop outline
     + Discussion – talking with consumers about transition/discharge can be stressful. Importance of clear expectations from the beginning including discussion of transition as a process. If a consumer isn’t actively engaged in CCS, there may be other supports and/or services that may better meet their needs. Important for consumers to have knowledge of the array of services and supports that are available to them so they can make an informed choice.
     + There was reference to a 6-year limit for enrollment in CCS. Lori has previously asked Langeston this question – there is no DHS 36 limit to length of involvement. Length of involvement should be based on the needs and preferences of each consumer.
5. **Definition and review of Evidence-Based Practices (EBPs) – Allison Else**

* Allison shared an overview of different types of practice:
  + Traditional practice – learning from others, passed down from others.
  + Intuitive practice – what makes sense, what is the right thing to do?
  + Evidence-based practice – has a scientific method. Observe problem, collect data, provide treatment, evaluate results.
* Service facilitators – consider different practices – what are the needs of the consumers you work with? Our regional CCS Quality Improvement Committee would like to focus on one or two EBP’s to develop across the 6 counties, and are looking for input.
* Review of DHS’s Definitions of EBPs for CST and CCS Program Surveys, including:

EBP’s for Adults:

* + *Assertive Community Treatment (ACT)* – a team-based approach to providing case management, treatment, rehabilitation and support services. Key elements include: a small caseload (staff/consumer ratio of 10:1 or fewer); multidisciplinary team approach; clinical services; services provide in community settings; and 24-hour responsibility for responding to psychiatric crises.
  + *Integrated Dual Disorders Treatment (IDDT)* –integrates treatment for Substance Abuse and Mental Health. Key elements: team approach; treatment is consistent with the consumer’s stage of recovery (engagement, motivation, action, relapse prevention).
  + *Family Psychoeducation* – part of an overall clinical treatment plan for consumers with mental illness. Includes active involvement of family members in treatment and management; offers support to aid in recovery. Key elements: structured curriculum; part of clinical treatment.

Green Lake currently provides this service, utilizing Steve Shekels with Progressive Parenting Solutions out of Westfield – he uses the Love and Logic curriculum/model. This may be an interest to other counties in the region.

* + *Illness self-management and recovery (IMR)* – aimed at teaching consumers strategies for collaborating actively in their treatment with providers, with goal of reducing their risk of relapses and improving social support. Specific EBPs that may be incorporated include relapse prevention planning, teaching coping strategies, social skills training, and Cognitive Behavioral Therapy. Key elements: service includes a specific curriculum that includes mental illness facts, recovery strategies, medication use, stress management, and coping skills.
  + *Medication Management (MedTEAM)* – toolkit available through SAMHSA; key elements: systematic plan for medication management; objective measures of outcome; clear documentation; consumer and practitioner share in decision-making.
  + *Supported Employment* – Uses a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Key elements: competitive employment options in the general population; integration with treatment (employment specialists are on the treatment team); rapid job search; eligibility based on consumer choice, not characteristics such as job readiness, lack of substance abuse, etc.; follow-along supports are provided to employer and client on a time-unlimited basis.

There was interest expressed by the group in pursing this option further.

* + *Tobacco Cessation Bucket Approach –* set of tobacco reduction interventions tailored to the user’s willingness to move toward quitting. The “bucket” characterizes their stage of change: quit, quit now, talk and prepare, just talk, not right now.

EBP’s for Children:

* *Multisystemic Therapy (MST)* – intensive family and community-based treatment that addresses multiple determinants of serious antisocial behavior across systems (home, school, community). Goal is to facilitate change in the natural environment to promote individual change. Key Elements: services take into account life situation and environment and involve peers, school staff, and parents; individualized services provided by MST therapists or masters-level professionals; time-limited; available 24/7.
* *Therapeutic Foster Care (TFC) and Multidimensional Treatment Foster Care (MTFC)* – children are placed with foster parents who are trained to work with children with special needs. Key elements: focus on treatment; explicit program to train and supervise treatment foster parents; placement is in the individual family home.
* *Functional Family Therapy* – for youth who have demonstrated the entire range of maladaptive, acting out behaviors. Treatment phases include engagement, motivation, assessment, behavior change, and generalization. Services are short-term (8 – 26 hours of direct service), and there is a flexible delivery of service by one and two-person teams to clients in the home, clinic, court, and at time of re-entry from institutional placement.
* *Parent-Child Interaction Therapy* – for young children (2 – 7 years) with disruptive behaviors, emphasizes improving the quality of the parent-child relationship.
* *Trauma-Focused Cognitive Behavior Therapy* (TF-CBT) – for children and adolescents; treats posttraumatic stress and related emotional/behavioral problems. Components of the treatment model (PRACTICE): Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation, Cognitive coping skills, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development.
* *Trauma-Informed Child-Parent Psychotherapy* (TI-CPP) – for children birth to 6 who have experienced trauma and as a result are experiencing emotional, behavioral, attachment, or mental health problems. Primary goal is to support and strengthen the child – parent relationship as a vehicle for restoring the child’s sense of safety, attachment, and appropriate affect.

1. **Other topics for Discussion**
   * ***Consider consumer involvement in these meetings*** – Dan referenced the importance and value of consumer involvement at all levels of our regional CCS initiative, and asked the group to consider involving a consumer in this forum. Concerns were expressed including the desire to keep these forums a safe and comfortable environment for discussing concerns and networking with peers.
   * ***Regional Assessment Form***– Lori shared the completed draft regional CCS assessment form and asked for feedback. She will be discussing next steps with the Service Directors later this week and will then share an update with this group.
   * ***Plans for future forums*** *–* Lori did a check-in with the group to see if the format of these meetings was meeting everyone’s needs. Discussed options including continuing with the same format, or using the time for training. Feedback included:
     + Don’t want these meetings to be too formal. Want to be able to bring up questions and issues to brainstorm with the group.
     + Could alternate meetings – open forum one meeting and topic-specific the next
     + A topic of interest – working with individuals with dual diagnoses
2. **Plan for next meeting – location, date, time topic(s)**

* Discussed possibility of developing a schedule for meetings. Days that don’t work: first Tues of month or Thursdays. Will continue discussion at next meeting.
* **Next meeting:** Friday, August 5th 10:00 – noon. Wautoma offered to host. They will look into Christiano’s as a possible location.