



ESC of CUYAHOGA COUNTY
Transitioning Youth Subgroup
Meeting Minutes
January 5, 2018 1:00-2:30 pm



Mission: Cuyahoga Community Team works across systems to improve physical, mental, and educational needs and increase access to appropriate resources and services for youth in Cuyahoga County.

Vision: Cuyahoga County children and families will be socially, emotionally, behaviorally and academically resilient and productive citizens.

Attendees: Mary Wise, Denise Pietrzak, Caitlin Metheny, David Hussey, Ben Kearney, Lisa Breuning, Bridget Gibbons, Molly Wimbiscus (phone)

- Districts generally not notified or made aware of placements & treatment (only know if/when receiving a bill).
- Family doesn't always give permission to hospital to share information with districts.
- Urging hospitals to write out the concerns and needs of a youth who is returning to school after treatment & how the district can support & address those needs.
- Families should sign a release for information for schools when students are admitted – should be standard best practices.
- Admitting psych could also be following the youth and may continue to follow and communicate with schools.
- On the west side, child psych's are hard to access
- Cleveland Clinic MH Team: since starting the pilot in Berea, looking to track the students' hospitalization (could be 5-20 students) and increase communication between hospitals and districts; trying to model after the SAMHSA Gund HS suicide program (Palo Alto). Increase transparency for communication. Using a free toolkit online.
 - No fee for service – school has received funding for a clinical counselor
 - In Berea, looking at the students with highest MH needs to assist with transition back to school and coordinating with MH providers.
 - Working with hospital system for release of information at the beginning of treatment, rather than at the end of treatment or placements.
 - Greatest barrier is "us" – meaning hospitals. If hospital isn't communicating clear enough, families may be unaware of district supports and may form biases that restrict moving forward.
- Breakdown of communication between hospitals and schools – may benefit from assigning a role as a transition coordinator so there is one point of contact
- Hospital staff being encouraged to write a clear, concise letter notifying schools of hospitalization and requesting to discuss in more detail
- **Can consultation funding be used to assist with transition support?

- Cleveland Clinic working successfully with Bellefaire to rework the consultation terminology – has cleared up some confusion with families and increased consultation services.
- CPST has taken a hit with the funding changes and will likely be gone within next 6-18 months.
 - Advocacy: Needs a system linkage/bridge process for transition support that goes beyond the capabilities of the family.
 - What data can hospitals collect to assist with advocacy?
- Hospital can give the parents discharge summary and letter and suggest families share with schools
- Model for positive communication involves a re-entry meeting (with a request for medical/clinical attendance) – two way communication is so important for success
- Lakewood sending out a letter telling families what services are available in the community and within the school buildings; providing point of contact for each service so parents can inquire about services
- Lakewood has had success working with Marianna and transitioning from Foster Care. There is one point of contact who schedules meetings and is available to answer questions & provide guidance.
- ODYS Transition subgroup (older youth)
- Detention centers having the same transition issues as hospitals
 - No linkage to services
 - Do not have a probation officer if not on probation, so students are released and on their own without guidance
- Applewood. Funding through ADAAMHS Board with 1 therapist for each location
- Need to develop exit plans for detention centers
- Parents refuse to attend arraignment hearings

1. Current Transition Processes in Place

a. Successful Practices

b. Challenges with Current Practices

- i. Some parents refuse and/or are very difficult about signing the release for information

2. Identified Gaps & Needs for Transitioning Youth

a. Psychiatric Treatment, Residential Care, Foster Care, & Juvenile Court

3. Prioritize Next Steps

- a. Re-entry strategies & coordination of care for severe MH
- b. Identify the information that schools desire to receive after a hospital stay?
 - i. Different levels of care, information, and severity of treatment (2-day stay vs. 30 days with medication changes, etc.)
- c. Molly can share survey data from Berea, Lakewood, and Brunswick staff
 - i. May rework into a template to share with more staff
- d. Communication: Continuation between a school point of contact and the provider
- e. Bridget/Juvenile Court: track numbers of students per month and per year and what schools/districts they're transitioning to/from
 - i. Get transition/discharge data from residential
- f. Need transition plans for students who go out for other concerns, such as New Directions (alcohol/drug, eating disorders, etc.)
- g. Inquire if districts are willing to work as a transition coordinator consortium to work together to strengthen and coordinate plans and resources (regional coordinators for specific areas, rather than districts remaining isolated)
- h. Linda: Numbers for Front Line call data
- i. Eventually consider students through online schools