Family Leadership Council
OF THE EL PASO BEHAVIORAL HEALTH CONSORTIUM

Specialty Care Work Group Meeting Notes
August 15, 2023
8:30 am - 9:30 am

Paso del Norte Health Foundation
Meeting Room C
221 N. Kansas, 19th Floor

Attendees:	**Representing:**
Sharon Butterworth	Paso del Norte Center at Meadows Institute
Sandra Day	Paso del Norte Health Foundation
Josue Lachica	Paso del Norte Center at Meadows Institute
Enrique Mata	Paso del Norte Center at Meadows Institute
Beatriz Marin-Olivarez	El Paso Center For Children
Oscar Millán	El Paso Center For Children
Claudia Munoz	Texas Department of Family & Protective Services
Celeste Nevarez	Emergence Health Network
Ivonne Tapia	Aliviane Inc./Chair Family Leadership Council

Welcome and Introductions
Enrique Mata convened the work group meeting at 8:35 a.m. and called for introductions.

Review Work Group Opportunities & Strategies
Enrique Mata and Josue Lachica provided an overview of the process leading to the work group's development and the related Opportunity for Change and strategies that the group will be addressing. They reinforced that the name of the Work Group, and the related strategies are all works in progress and can be amended with the approval of the work group and the FLC partners.

Open Discussion

The work group continued the meeting with an open discussion. Highlights from the conversation are as follows:

Opportunity For Change: Reframe the concept of mental health and substance use specialty care as secondary to Integrated Primary Care (**e.g., 25% of care**). **The group did not identify any needed amendments to the opportunity for change.**

- JPD Chief Medina or one of her staff should be invited to participate in this workgroup.
- Psychiatric hospitals should have a representative on this workgroup.
- The question was raised whether this workgroup needs to focus on the THC addiction problems.

- The group should invite Audrey Garcia from PdN Health Foundation to present of efforts under the Smoke Free Initiative at the next meeting.
- Indigent care does not cover treatment for smoking.
- Could we work on some type of pilot program that could assist with youth smoking/vaping?
- The group discussed how youth respond to positive reinforcement/incentive programs to quit and stay quit.
- Ivonne Tapia mentioned that over 90% of youth with a serious addiction started with marijuana and moved to heavier drugs.

Strategy I -As with primary care, clearly identify mental health and substance use care and support that is beyond the scope of practice and cannot be directly provided within the primary care setting. For example, serious mental health conditions that require an intensive coordinated approach with psychiatry, psychology, counseling, or substance use specialty care.

The following items under this strategy were discussed:

- Group therapy is one of the only readily available approaches in the region that helps youth battling addiction gain some benefits.
- TMS – for adults only and only after multiple failed therapeutic/medication approaches
- OSAR – screening refers.
- Medication management is mostly adult oriented uses modified/titrated by psychiatry for youth.
- Requirement of family involvement, which is challenging and, in many cases, unrealistic due to barriers like work, school, etc.
- The process is not consistent.
- For example, foster care, the child might be mandated to take medication.
- We need to define youth up to 24 years of age. Are we talking about minors? 17 and under have policies and practices, 18 and older have a different set of requirements/ barriers.

Strategy II – Expand and enhance availability of well-established evidence-based interventions for youth with more severe behavioral problems related to willful misconduct and delinquency (e.g., increase availability of child psychiatrists and child psychologists, increase availability and effective use of collaborative care model options (psychiatry, counseling, and primary care services).

The following items under this strategy were discussed:

- Training for parents and foster parents in situations that they might encounter when youth are involved with addiction.
- PdNHF vape campaign includes presentations for awareness of smoking/vaping concerns.
- Educational public service announcements for understanding what felonies result.
    - Consider tic Tok, etc. type social media.
    - Focus groups from a mixture of youth to identify other ways to attack the problems of drugs and access to drugs. Develop a focus group data gathering approach.

Strategy lll - Utilize the Multisystemic Therapy Rider to promote timely wraparound support for children with complex needs to prevent entry into the Foster Care or Justice.

- Celeste Nevarez shared EHN history and status on the partnership with JPD:
    - The current program team will include a supervisor and 3 therapists – Sarah Polk at EHN is the MST Supervisor and has been recognized for her good work. Each therapist can carry a caseload of no more than 5. The program is designed to be no more than 90 days. There can be some flexibility in the time frame. This is a 24/7 program so the goal would not be to

go into IOP or PHP, rather to matriculate into their daily routines in the community with periodic mental health follow ups.
    - The hardest problem is filling vacancies for trained staff.
    - The program is tough to implement. Family involvement is a required component. However, once the program is well integrated with the family there are positive results.
    - Currently youth who have not been adjudicated are a primary population. There can now be other groups that can refer to MST care.
    - The program is expensive and proprietary.

Strategy IV - Improve residential support options to prevent children from inappropriately leaving for residential treatment out of town, including increasing compensation for foster parents and reimbursement options for nontraditional programs and expanding intensive Medicaid services to support foster families.

- Claudia Munoz commented that through the years TX DFPS has seen more complex needs with children who have co-occurring problems. MST would not work because of the complexity of the foster parent requirement and missing (in many cases the biological family).
- We need the expansion and availability of psychiatry and psychologist supports in our community. The effectiveness of virtual options is not clear for this population.
- Group therapy, psychiatry once a month, but at the end of the day the foster family is burdened with the risks for breakdowns and acting out that lead to inpatient care or justice involvement.
    - The support for caregivers is vital and sorely lacking in our community.
    - The places where they go are to residential treatment centers which is traumatic.
    - Is there a way to have CPAN for foster families – respite care availability?
    - Child without placement is still a concern despite efforts to prevent these situations.
    - Behavioral interventions? Mentor/mentee would spend time with the family and if needed would call in higher level professional support. Do we have this in our community. The support would be college (e.g. senior students or intern level students) professionals in training that would be covered by a stipend. Seek out the data surrounding this sort of intervention. This concept includes support for jobs and other activities. New Mexico Medicaid used to cover that type of services.
    - Do we need to expand the QMHP credential?

Value proposition - Well coordinated availability of top specialty care approaches for those in need contributes to increased likelihood of successful and lasting recovery.

Work Group Leads

The group agreed that it was premature to identify a lead at this meeting. This will be an agenda item for the next meeting targeted for the second or third Tuesday in October.

Adjourn: The meeting adjourned at 9:40 am.