

**Community Service Network 6 Meeting
DHHS Office, 161 Marginal Way, Portland**

**March 20, 2009
DRAFT Minutes**

Members Present:

<input checked="" type="checkbox"/> AIN – Jan Burns	<input checked="" type="checkbox"/> Freeport Counseling Cntr – Phoebe Prosky	<input checked="" type="checkbox"/> Riverview Psychiatric Center – Dr. William Nelson
<input checked="" type="checkbox"/> Amistad – Peter Driscoll	<input type="checkbox"/> Goodwill	<input checked="" type="checkbox"/> Shalom House – Mary Haynes Ridgers
<input checked="" type="checkbox"/> Catholic Charities of Maine– Sally Temm (Alt. Rep.)	<input type="checkbox"/> Gorham House	<input type="checkbox"/> SMART Child & Family Svcs. (Excused absence)
<input type="checkbox"/> Community Counseling Ctr.	<input checked="" type="checkbox"/> Maine Medical Center – Christine McKenzie (Alt. Rep.)	<input type="checkbox"/> Spring Harbor Hospital
<input checked="" type="checkbox"/> Consumer Council – Karen Evans, David Bouthilette	<input checked="" type="checkbox"/> Mercy Hospital – Burma Wilkins	<input type="checkbox"/> Spurwink/Portland Help Ctr. (Excused absence)
<input checked="" type="checkbox"/> Counseling Services, Inc. – Lois Jones (Alt. Rep.)	<input checked="" type="checkbox"/> Mid-Coast Hospital – Tom Kivler	<input type="checkbox"/> Sweetser (Excused absence)
<input checked="" type="checkbox"/> Creative Work Systems – Susan Percy	<input checked="" type="checkbox"/> NAMI-ME Families – Alyce Woodall	<input type="checkbox"/> Sweetser Peer Center
<input checked="" type="checkbox"/> Crossroads for Women – Polly Haight Frawley (Sub.)	<input checked="" type="checkbox"/> Northeast Occupational Exchange – Jennifer Tingley Prince	<input checked="" type="checkbox"/> Transitions Counseling Inc. – Kelli Star Fox
<input checked="" type="checkbox"/> First Atlantic/Hathorne House – Larry Davis (Alt. Rep.)	<input type="checkbox"/> Parkview Adventist Med. Ctr.	<input type="checkbox"/> Volunteers of America
	<input type="checkbox"/> Preble Street	<input checked="" type="checkbox"/> Youth Alternatives / Ingraham – Pat McKenzie
	<input type="checkbox"/> PSL-Services	

Others present:

<ul style="list-style-type: none"> • MMC-Voc. Serv. – Anne Marquis, Employment Specialist • MMC-Voc. Ser. – Deborah Rousseau, Program Coordinator 	<ul style="list-style-type: none"> • Connections for Kids – Genevieve Gardner, Heather Boot • COSIG-DHHS – Claudia Bepko - presenter • Todd Goodwin, VP, Admin. - Comm. Counseling Center – presenter 	<ul style="list-style-type: none"> • Support & Recovery – Robert L. Sheehan • Clinical Services Dental Clinic (Preble St.) – Dr. Mary Dowd (left after speaking) • Maine Vocational Rehabilitation Associates - attendee did not sign in
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Staff Present:

- DHHS: Carlton Lewis, Ron Welch; Muskie: Phyllis vonHerrlich, Scott Bernier

Agenda Item	Discussion
I. Welcome, Introductions and Reminder to sign in	<p>Carlton Lewis welcomed participants and reminded those who had not done so to sign in; introductions followed.</p> <p>Announcements:</p> <p><u>Dental Clinic Services</u></p> <ul style="list-style-type: none"> • Mr. Lewis recognized guest Dr. Mary Dowd, who had asked to speak. • <u>Dr. Dowd is from Clinical Services Dental Clinic, 63 Preble Street Portland (a dental clinic for those currently receiving case work services through Maine DHHS – see link: http://www.mainedentalaccess.org/f_clinics.shtml - click on <i>Dental Clinics and Services for Low Income Persons In Maine</i>).</u>

	<ul style="list-style-type: none"> • They are having a relatively high percentage of “no shows” and would like to fill the timeslots with walk-in appointments (generally, the clinic does not have walk in services). • In an attempt to make good use of the dental professionals’ time, she invited agencies to inform their clients of the availability of walk-in services. She is looking for people who would be willing to come and wait to see if there is a “no show” and be able to step in take the appointment. • Amistad noted that they have a staff person who helps clients get good health care. Amistad offered to receive short-notice about appointment times and extend this information to those receiving services at Amistad. Dr. Dowd noted that sometimes they know the day before, sometimes in the morning of the appointment, but often not. Those willing to come and wait would help fill the no-show slots. She said she would be happy to talk with Amistad – and others – who would be interested in either approach to fill appointments. She noted the clinic’s phone number: 822-0232. ACTION: Amistad will contact Clinical Services Dental Clinic to see if they can help fill the slots for appointment no-shows. <p><u>Poison HELPLine Information</u></p> <ul style="list-style-type: none"> • Mr. Lewis reported on the state focus on poison prevention and encouraged attendees to take a supply of brochures, magnets, and stickers (available at the meeting) back to their agencies to have available for their clients. The OAMHS Medical Director is promoting this information to MH service providers because: (1) 15% of calls to poison help are associated with psychotropic medications, (2) anti-depressants are the #1 misused medication. <p><u>Agenda Changes</u></p> <ul style="list-style-type: none"> • A report on WRAP funds will be added. • NAMI-ME asked to make an announcement: Alyce Woodall announced that NAMI of Maine will hold their annual fundraising event on May 9 – the NAMI Maine Walk. Glenn Close is the chair this year and will be leading the walk. Ms. Woodall encouraged CSN 6 members to participate in this event by forming teams and securing sponsors.
<p>II. Minutes – review & approval</p>	<p>The minutes for January 16, 2009 were reviewed and approved as presented. A representative from the Consumer Council System of Maine asked to have the minutes (and other meeting materials) mailed to her in a timely manner so she would receive them before the meetings. This request will be shared with those handling the meeting mailings.</p> <p>ACTION: The request from the Consumer Council representative for timely mailing to her for meeting materials will conveyed to Muskie School staff who manage this.</p> <p>ACTION: The minutes for the January 16, 2009, were accepted as presented.</p>
<p>III. WRAP FUNDS</p>	<p>Ron Welch announced that they are still looking for a provider agency to disperse WRAP funds for CSN 6.</p> <ul style="list-style-type: none"> • Catholic Charities has determined they are not able to do the WRAP administration because the staff time they anticipated to have available (from changes in APS work) has not been realized. They do not have the time that WRAP work requires, so must relinquish this responsibility. • There are still funds to disperse from this fiscal year. • Any agency interested in doing this is invited to contact Carlton Lewis at the Region I office. • Staff from Counseling Services, Inc. offered to speak with Catholic Charities. Counseling Services, Inc. already manages the WRAP funds for CSN 7. • Staff from Youth Alternatives offered to collaborate on this and will contact Catholic Charities.

	<ul style="list-style-type: none"> • Any agency interested in discussing this should contact Catholic Charities and keep the Region I DHHS office informed. • There is some urgency to this; the goal is to have the issue resolved in about a week. <p>ACTION: Staff from Counseling Services, Inc. will speak with Catholic Charities re: managing the WRAP funds and Youth Alternatives / Ingraham will contact to see how they can help.</p>
<p>IV. FEEDBACK ON OAMHS COMMUNICATIONS</p>	<p>There were no concerns about OAHMS communication with the provider agencies since the last meeting.</p>
<p>V. CO-OCCURRING REPORT</p>	<p>Ron introduced Claudia Bepko and Todd Goodwin to report on the Co-occurring State Integration Initiative (COSII). Claudia is the coordinator for COSII, and Todd is vice president for administration at Community Counseling Center, one of the pilot sites.</p> <p>Claudia noted that agencies recently received information from the state that all agencies will soon be required to be “co-occurring capable.” Materials on COSII were available. The state received a 5-year SAMHSA grant in 2005 (one of 19 awarded) to help expand and improve integrated treatment for people with mental health and substance abuse disorders. Given the amount of money spent in this area, and based on a study of the services delivery system (done in the late 1990s), the federal agency saw that significant change would be needed to make the system work better to meet the needs of those being served. Integrated care that responds to the needs of the client is best practice; the Maine system does not currently do that. Maine has had a focus on co-occurring since 1992, when the Co-Occurring Collaborative of Southern Maine was formed (now called Co-Occurring Collaborative Serving Maine). COCSM offers training and set up agreements with service providers to assist in the transition to integrated services. The COSII work focuses on change at the systems level and on working with agencies. The work includes looking at structure and policy: licensing, reimbursement, screening and assessment, workforce development, and data development. Over the five-year period, 30 pilot sites will be involved and supported with training, technical assistance and mentoring as they implement new co-occurring approaches. Additionally assistance will be provided to other agencies. Ultimately the grant is expected to help remove structural barriers to integrated treatment at the policy, funding, contracting, training, and program levels. Extensive data will be collected. This is the first time that co-occurring data has been collected in Maine using client surveys. The grant also includes work with consumer groups, because in an integrated approach to services, it is very clear that consumer involvement and peer support are key.</p> <p>A Steering Committee and other subcommittees work on the infrastructure issues and make recommendations for policy and practice changes. Subcommittees report to the Steering Committee, who in turn, advises the Co-Directors. Pilot agencies implement recommended practice changes.</p> <p>The grant provides for 3 years of infrastructure development and a final two years of evaluation activities. Extensive evaluation on the outcomes of the grant and the work of the pilots and sub-committees is underway now. The Co-Occurring Collaborative of Southern Maine is the partner agency for this initiative</p> <p>The new DHHS policy on integrated care that states all providers need to have Co-occurring Capability. (Co-occurring Capability is defined as “the capacity of a substance abuse, mental health, or dually licensed program to design it policies, procedures, screening, assessment, program content, treatment planning, discharge planning, interagency relationships, and</p>

staff competencies to routinely provide integrated co-occurring disorder services to individuals and families who present for care within the context of the program’s mission, design, licensure, and resources”~ from the Maine COSII Clinical Practices Committee document, 12/3/07.) Language about Co-occurring will be phased in until all contracts reflect this. A manual is forthcoming for practitioners and agencies. They will be guided by the Co-occurring Disabilities documents of DHHS, including policy and procedure statements, scope of practice guidelines, definitions, competencies, and peer support program information. Providers are supported and guided through the step-by-step process of moving to integrated service delivery. Providers, stakeholders, and are involved in the full scope of work of the grant. As the initiative on integrated care moves forward, it will expand to encompass primary care.

There is outreach now to all agencies to offer technical support and training. A meeting takes place every other month in each region (for this region it is the third Thursday of the month). Any interested person can attend. Also, in May there will be regional information and training sessions for non-pilot agencies. Agencies should take advantage of the free training and join the Co-occurring Collaborative of Southern Maine, which will continue even after the grant ends. A Web sit is being developed, and all materials will be available there.

Todd reported on Community Counseling Center’s experience as a pilot site.

It was a great experience – CCC uncovered much valuable information about the agency.

CCC made significant changes to make it “easier, nicer, friendlier” for clients.

They have worked on:

- Building the competency of their clinical staff

- Updating their materials – assessment tools, etc. – to reflect integrated services

- Upgraded their technology (e.g. phones) to make a welcoming environment

- The agency action plan that came out of their participation as a pilot site touched all parts of the agency (physical plant, staff, as well as clinical practice.

Agency is a much better place as a result of participating in the pilot and getting the feedback from the consumers will only add to that improvement.

Question: For substance abuse, is it a larger co-pay than for MH problems?

Answer: Under Medicaid, dual diagnosis is covered so it is the same. There are some inconsistencies in billing codes that have not been addressed yet. The grant will be sending some recommendations based on the pilot experience. Pointing out that they need to integrate more at all levels will be one of the recommendations.

Question: How has change been? Was it difficult?

Answer (Pilot Site): Yes – change of this type is difficult, so we have been doing lots of training.

Comment (COSII): Systems change is difficult. The grant provided pilots sites with the “Rapid Cycle Change Process” material. This has taken hold in every agency where we introduced it. Change is quick with this process – you get results. The training approach path: 1) executives were involved first, 2) policies and administrative functions were scrutinized, 3) the services (direct care) were looked at, and 4) a change team was formed. Most people (agencies providing services) are afraid to treat co-occurring. We help staff do that.

Comment/Question: There are limitations to what agencies can have in the large picture of changing the culture – have you done outreach to the academic programs that train those going into the MH field?

Response: The heads of the clinical social work programs have been sitting on our committees and we have provided them with material that can be integrated into courses. There are a number of points that have to be considered – the manner and speed in which established courses can be changed is one. There is also the whole area of the professional licensing boards

	<p>and changing what is required for a license – this work is ongoing. Change of the magnitude that we are addressing could easily take ten years. This is a five-year project and it is coming to an end. The Co-Occurring Collaboration Serving Maine will continue (information on joining this was provided). Ms. Bepko encourage agencies to contact her at Claudia.bepko@maine.gov or 207-287-7360.</p> <p>ACTION: Contact Claudia Bepko for information about co-occurring disorders and integrated service delivery.</p>
<p>VI. EMPLOYMENT Report from Support & Recovery on employment initiative</p>	<p>Sally Temm introduced Anne Marguis, the new employment specialist with the employment initiative out of MMC-Voc. Serv. Anne is working out of Catholic Charities. She provided a printed report to those present and noted the following:</p> <ul style="list-style-type: none"> ➤ The caseload goal is 25 host agency clients and five clients referred from other CSN agencies. ➤ There are currently 24 clients, with five new intakes scheduled. ➤ Three clients have requested that their job search be put on hold, stating they will contact the ES when ready. ➤ One client has moved out of the region. ➤ Participants are working in the following employment areas: in hospital and social services fields and in the hotel industry. ➤ Clients are volunteering at social services organizations. ➤ Clients are enrolled at Southern Maine Community College. ➤ In the next few months, the ESN will be compiling an employment and educational resource directory for the region. ➤ In an effort to accommodate consumers that are on a wait list, they are encouraged to attend the vocational services group that meets every Thursday for one hour. This service helps with identifying job skills, writing resumes, and addressing the issue of being “work ready.” <p>Question: How does one make referrals to this program? Response: There are five slots open to those who score “strong / urgent” on the <i>Need for Change</i> scale. (Contact Sally Temm at Catholic Charities or Deborah Rousseau at MMC Vocational Services if you need help using the <i>Need for Change</i> tool.) Once the tool survey has been done and analyzed, send the recommendation to Anne or Deb Rousseau. Request: Could a one-page information sheet on how to use the <i>Need for Change</i> tool and how to make referrals (with contact information) be prepared? Response: Yes. ACTION: A one-page information sheet on how to use the <i>Need for Change</i> tool, referral process, and contact information will be prepared. Question: What is the cost? Response (DHHS): We have not done this specific calculation. We are looking at the grant in terms of getting people through the whole process – from acceptance in the program to employment. Question: How much does it cost to get a job in this system? Response: It is a reasonable question, and we will do that after the program has been running for a while. Comment: An issue is that DOL-Voc. Rehab. has a million dollar cut in services, how can we respond to the increased demand? OAMHS met with DOL to discuss this. Stimulus money will offset some. The “Ticket to Work” program (see http://www.ssa.gov/work/aboutticket.html) is something we need to look at, since this program is currently not much used in Maine. The state is allotted 75,000 “tickets” and only about 1% is currently being used. The program is underused and not</p>

	<p>readily accessible to the community. We will have more information over the next 60 days and will share that with you.</p> <p>Comment (DHHS): The five slots allotted in the program for other CSN agencies (other than the host agency for the Emp. Ser. Program) were seen as a way to get agencies to begin to think about employment support as one of the services they need to address (either to offer or refer out). In the second or third year of this program we will do a cost / benefit analysis – once there are a sufficient number of cases and there has been time to see how it works.</p> <p>OAMHS works with a subcommittee of the State Rehab. Council looking at employment for those receiving Long Term Supports. We are going to do a survey with a group of 40 who work fulltime to gather data (and may also look at part time) to see what worked, what experiences led to success. The goal is to have this done by late summer or early fall. We may do a comparison with studies out of Fountain House (NY), which is a program that has had good success.</p> <p>Comments: It was pointed out that Fountain House is funded entirely with private funds, so their model may vary considerably from a state model (public funds). One agency noted they had clients who work both in fulltime or part time jobs and whether or not they might be included. It was clarified that this survey was for those on Long Term Supports, but others might be able to be considered in the survey. Some creativity in assisting MH clients find meaningful employment was encouraged – options for volunteer work are important, in that volunteer work can help develop skills – as well as help the agencies that offer the volunteer slots.</p> <p>Comment (DHHS): The CSNs have been meeting for two years now, and work has emerged as an important component for clients.</p>
<p>Break 10:20 to 10:35 a.m.</p>	
<p>VII. CRISIS PLANNING</p>	<p>Pat McKenzie gave a brief update and noted that she will do an extended presentation for the next meeting, particularly on the principles of the program. All the MOUs have been signed – a huge success. Will the agreements immediately change the way business is done – probably not, but the MOUs provide a framework to hold the service providers accountable.</p> <p>Comment/Question: Someone who sat on the Crisis Planning Subcommittee (of this CSN) indicated that some of the agencies had not completed the plan submissions on time and that the state was considering sending out an RFP.</p> <p>Clarification (DHHS): Reviews of the plans are still going on. There may still be some RFPs in some areas, but the state is moving ahead with contracts. The CSN 6 plan was a good plan.</p> <p>Question: When it comes to Crisis Teams and Emergency Rooms working together (in MH), why does it take so long in some ERs to have someone seen?</p> <p>Response MOUs address this (both from the perspective of not overusing ERs and how to get appropriate treatment quickly).</p> <p>Comments: Peer Support can help in such situations. Research has shown that it is not good to wait for so long. Peer support may not be able to shorten the wait time, but they can make contact with the client and help out to make the process easier. Efforts need to be made to do better in serving clients – we can do better in serving families, clients, and crisis workers. It was noted that a crisis team will now be at Mercy Hospital ER. Peers can advocate for crisis teams in ERs – and push to get this to happen. Crisis teams in ERs are helpful.</p> <p>Question: What is the biggest barrier to receiving service quickly? Medical clearance?</p> <p>Response: It is not really one thing – it could be related to clearance or availability of a bed or getting supports in place – any number of issues can add time.</p> <p>Comment: Access to an available bet – sometimes agencies can find this more quickly – particularly if they have experience doing this.</p> <p>Question: How have families been involved?</p> <p>Response: In terms of children’s crisis services, the Child Team is in the ER and can respond to the family quickly. The</p>

	<p>Adult Teams function differently – and “family” in adult situation might be defined differently. A “family” might be an extended group who support that person. The issue of who constitutes an adult’s family in a crisis situation needs to be explored more.</p> <p>Comment: In terms of medical clearance, this is sometimes an issue, and it would be helpful to have a Standard Medical Clearance. It was noted that in Regions I and II, affiliated hospitals have policies in place regarding this (e.g. if MMC has gotten the medical clearance, then their affiliate hospitals accept this, but if you go outside this system, the clearance would have to be gotten again). This is an issue that needs further discussion. We can discuss this at a statewide meeting.</p> <p>ACTION: The issue of medical clearance and how to make it less cumbersome will be put on the agenda for a statewide meeting.</p> <p>ACTION: A Presentation about the CSN 6 Crisis Plan will be scheduled for the next meeting.</p>
<p>VIII. CONSUMER COUNCIL UPDATE</p>	<p>Karen Evans and David Bouthilette reported for the Consumer Council System of Maine.</p> <p>At the state level (Karen reported):</p> <ul style="list-style-type: none"> ➤ The Consumer Council System of Maine has a Legislative Committee. ➤ OAMH staff have spoken at statewide CCSM meetings recently. ➤ There has been good representation at Legislative Hearings on MH legislation, with agencies, families, and consumer groups giving testimony, as well as CCSM members. There are two major bills before the Legislature of particular interest to OAMHS, in addition to the budget hearings and budget process: 1) LD 609, An Act To Amend the Laws Governing Involuntary Hospitalization Procedures When Both Commitment and Involuntary Treatment Are Sought , and 2) LD 341, An Act To Amend the Department of Health and Human Services’ Progressive Treatment Program. Concerns with LD 609 have to do with change in age (lowering) for participation and around lack of due process for individual. ➤ Helen Bailey (Public Policy Director at Disabilities Rights Center) spoke at the statewide CCSM meeting and gave a history of the Consent Decree, reported on PNMI, and discussed participation for their members. <p>At the local level (David reported):</p> <ul style="list-style-type: none"> ➤ The CCSM for CSN 6 has asked Spring Harbor to correct some information in one of their flyers about the availability of peer supports. ➤ Ron Welch attended the local meeting to speak on Community Integration. <ul style="list-style-type: none"> Question: Are they cutting back on case managers? Clarification (DHHS): The eligibility for CI is changing. The change is one of moving from the GAF score to using LOCUS score. It is for new people coming into the system and it is only a consideration for determining the course of the care. For example, a group of those with a low LOCUS score would have “drop in” case management services that they would be able to use as needed – not constant case management assigned – and this is included in another budget line (it will not be in the Medicare line). Closely related to the CI area of services is that of housing – savings can be realized in other service areas if clients have stable housing situations. There was a presentation to the Legislative committee about this (consumers came in support of the presentation) and as a result, funds for BRAP are now part of the budget recommendation. ➤ David invited agency staff in CSN 6 to the local CCSM meetings.

<p>IX. LEGISLATIVE UPDATE</p>	<p>Ron reported briefly on legislation:</p> <ul style="list-style-type: none"> ➤ Only 2 pieces were tabled. ➤ Conversion of the funding for PNMI's to a different funding stream: as a service it will be no different; amount of money will cover needs (although some expressed doubt about this). There are two significant changes: consumers will be required to use 80% of their income to cover room and board expenses (currently it is very inconsistent); for treatment, state is funding up to the ACT level (\$1,300 per month per person). Budgeted amount will cover necessary treatment (one-to-one, counseling, medical management); daily living supports will cover some of the other needs. In these PNMI's, they are not 24/7 – but clients have emergency access. State is confident this will work. <p>Question: Would it be possible to phase this in?</p> <p>Response: We can do that – implement site-by-site – and make sure there is enough money there.</p> <p>Comment: There are Daily Living Skills providers in this region.</p> <p>Comment: Yes, but the rate is so low it is hard to make it happen. We need services back.</p> <p>Response (DHHS): We have not precluded a new BRAP request – it would be an emergency bill.</p> <p>Comment: It is, in part, an issue of change in services that makes it difficult for the agencies – there are implications for staffing.</p> <p>Comment (DHHS): Maine has not (in the past) allowed for the flexibility needed – this is a new program approach.</p> <p>Question: July 1 is the change date?</p> <p>Response: DHHS presented to the Appropriations Committee yesterday. There is another level of scrutiny before the budget is submitted. Consumers may want to appear there.</p>
<p>X. CONSENT DECREE</p>	<p>Ron Welch reported.</p> <p>The report by Elizabeth Jones and Commissioner Harvey's response to that report were available for the discussion. Ron noted that the Department's understanding of the charge to write the report was to look at budgeting and determine if the Department was being appropriated sufficient funds to meet the terms of the decree. This assessment was not in the report, he said. The Department has, therefore, taken steps to look at data / information available from SAMHSA and the recent Count Master decision. Using a conservative SAMHSA estimate for persons with severe and persistent mental illness of 1.7%, an additional 7000 persons would be served at a cost of \$75 M. The issue of income is not looked at, nor is a cut-off point for when the state would not cover services (possibly 200% of poverty). There is a new judge, Andrew Mark Horton, who will be taking over the case. The Commissioner, Attorney General Mills, and Judge Horton will meet next week.</p> <p>The Commissioner has hired Public Consulting Group to look at 1) quality management, 2) contract management, and 3) fiscal management. The report challenges the office in terms of accountability. This will mean serious change. Ongoing reports will be provided.</p> <p>ACTION: Ongoing reports will be provided to the CSNs regarding the work and findings of the Public Consulting Group on the three areas they are assessing (quality management, contract management, and fiscal management).</p>
<p>XI. APS Administrative Burdens Report & other issues</p>	<p>Ron reported.</p> <p>The assessment of the APS system will happen in three phases: 1) gather and analyze data (this is done); 2) develop solutions and report back; 3) department will implement changes. This is a big and complex undertaking – the report will tell us how we will approach this. The report will be distributed to agencies and we can talk in more detail later. APS has been listening to the</p>

	<p>agencies during the data gathering process. A clear issue that has arisen is the lack of comprehensive regulations re: substance abuse dovetailing with those in APS resulting in denials and / or closing of requests. Someone from APS will be here at the next round for reporting.</p> <p>Comment/Concern: There is the issue of how “medical necessity” is understood, particularly in co-occurring cases. The danger or relapse is something agencies workers are attune to. Dr. Ray (at APS) has to make the call, but she does not understand what community workers see as “medical necessity.”</p> <p>Response (DHHS): We will make sure this is addressed.</p> <p>ACTION: APS will be reporting back to the CSNs.</p>
<p>XII. OTHER</p>	<p><u>“Run for You”</u></p> <p>Karen Evans reported on a service recently established in the Region I area – “Run for You,” which offers errand running and other types of service. She handed out a brochure and noted that this program helps to promote independence.</p> <p>Note was made of a timeshare (services share) program in the Portland area and of the clothing drive that Creative Work Systems in doing (contact S. Ferris at Creative Work Systems).</p>
<p>XIII. PUBLIC COMMENT</p>	<p>There were no public comments.</p>
<p>XIV. MEETING RECAP & AGENDA FOR NEXT MEETING</p>	<p>ACTIONS</p> <ul style="list-style-type: none"> ➤ Amistad will contact Clinical Services Dental Clinic to see if they can help fill the slots for appointment no-shows. ➤ The request from the Consumer Council representative for timely mailing to her for meeting materials will conveyed to Muskie School staff who manage this. ➤ The minutes for the January 16, 2009, were accepted as presented. ➤ Staff from Counseling Services, Inc. will speak with Catholic Charities re: managing the WRAP funds and Youth Alternatives / Ingraham will contact to see how they can help. ➤ A one-page information sheet on how to use the <i>Need for Change</i> tool, referral process, and contact information will be prepared. ➤ Contact Claudia Bepko for information about co-occurring disorders and integrated service delivery. ➤ The issue of medical clearance and how to make less cumbersome will be put on the agenda for a statewide meeting. ➤ A Presentation about the CSN 6 Crisis Plan will be scheduled for the next meeting. ➤ Ongoing reports will be provided to the CSNs regarding the work and findings of the Public Consulting Group on the three areas they are assessing (quality management, contract management, and fiscal management). ➤ APS will be reporting back to the CSNs. ➤ DHHS will report back to CSN re: in determining involuntary commitment, who serves on the team and what is the status of someone who has guardianship in relation to this. <p>ISSUES FOR UPCOMING MEETINGS</p> <ul style="list-style-type: none"> ➤ Report on WRAP ➤ Presentation about the CSN 6 Crisis Plan ➤ Report on the work and findings of the Public Consulting Group re: DHHS ➤ Report on APS. ➤ Report back re: in determining involuntary commitment (who serves on team deciding; role of guardian).