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Megan: Hello, everyone and welcome to this Hear From Your Peers webinar, building your behavioral health referral network in the context of Healthy Start. I'm Megan Hiltner with the Healthy Start EPIC Center. We have approximately 90 minutes set aside for this webinar. The webinar is being recorded and the recording along with the transcript and the slides will be posted to the EPIC Center's website following the webinar. We do want your participation in the webinar so if at any point you have a question or a comment, please chat them into the chat box at the bottom left corner of your screen. We will only be taking questions through the chat box, and we do want your feedback at the end of the event. So please take a moment following the webinar and complete the survey that will pop up on your screen immediately after the webinar. Here's how we structured our webinar for today. First, you're gonna hear some remarks from Dawn Levinson. She's the behavioral health adviser to the Division of Healthy Start and Perinatal Services. Then you'll hear from experts and Healthy Start grantees on this topic, and then we'll open it up for questions and answers and resource sharing and wrap up.

Before we get to that and the presentation, we wanna do a quick pre-test knowledge check. So if you'll take a moment and complete this poll, this poll question on your screen. The first question here is, Sam says, "Treatment locator resource includes information on only select sites in the U.S. Is that true or false?" So what do you think? Is that a true statement or a false statement? If you will click in using the radio button, true or false. And I see a couple of folks are already clicking in. We'll give it another second or two here. And we will revisit some of these knowledge check questions at the end to see if your position has changed on this. So it looks like the majority of folks think that that is a false statement.

All right. Let's get to another question here, the second question. "Behavioral health providers are required by law to serve all clients that need services without programmatic eligibility requirements. Is that yes or no? Are behavioral health providers required by law to serve all clients that need services without programmatic eligibility requirements?" And I see folks are on it. Click "yes" or "no." What do you think? And we didn't get as many folks that weighed in on this one, but those folks that weighed in, everyone thinks that is a no, and, again, we'll revisit that at the end.

A third and final pre-test question here. "The goal of making a referral is to ensure the client is linked to correct services and that they follow through. Is that true or false? Is the goal of making a referral to ensure

the client is linked to correct services and that they follow through?" And folks were quicker on that one, and everyone thinks that's true. Thanks folks for answering those questions. We will be covering those topics throughout this webinar, and we will, again, check in on those questions at the end of the webinar. So now, I'd like to turn it over to Dawn Levinson for some welcoming remarks and introduction. Dawn.

Dawn: Hi. Thank you, Megan. Good afternoon, everyone. This is Dawn Levinson. I am the behavioral health lead in the Division of Healthy Start and Perinatal Services, and I'm also a coordinator of all things behavioral health and HRSA's Maternal and Child Health Bureau. And I am pleased to be the division representative on today's webinar. I always like to mention on the webinars that I'm always available to our grantees at any time. If you want to chat or consult about any resources related to mental and/or substance use disorders, and I believe my contact information was on the earlier welcome slide, but always accessible to you.

So the goal of today's webinar is to focus on building a strong referral network to behavioral health services that are culturally competent. Since there is no health without mental health, ensuring timely access to behavioral health treatment and support for pregnant and parenting women in Healthy Start programs will improve outcomes for a healthy pregnancy and healthy baby. Specifically, the webinar has the following objectives. You will hear about the general structure of a behavioral health network in the context of a health services system. You will learn strategies for developing a plan to establish a referral network. This will include identifying and initiating relationships with partners to grow your referral network. And you'll be hearing about the components of making an effective referral.

Today our webinar also features two Healthy Start programs that will share examples of projects and programs that have grown an effective behavioral health network. And today, we're going to start off by hearing from our colleague Sharon Ross-Donaldson, who is the CEO and president of the Center for Health Equity in Quincy, Florida. She will be followed by Amy Pepin who is a senior consultant with JSI's Community Health Institute. And then we will wrap up today's session with our colleagues Georgea Madeira, Senior Director of Programs at SHIELDS for Families in Los Angeles, California, and also Danielle Lowe, the youth services director at SHIELDS for Families. So without further ado, I want to welcome everyone, speakers and participants, and thank all of you for your time today, thank you.

Megan: Thank so much, Dawn for that. Oh, and so sorry Sharon, I'm not gonna interrupt anymore. I just wanted to say just everyone, we're so lucky to hear from Sharon, who is gonna kick things off by just telling her Healthy Start story of building a behavioral health system within your Healthy Start project. So, Sharon, take it away.

Sharon: Thank you. Next slide. So I wanted to give everybody a little background regarding our organization. So I'm the CEO and president, and I'm also a licensed clinician that actually carries a clinical case load, small clinical case load within our organization. We are the Center for Health Equity, we've been around since 2,000. We are a nonprofit 501C3. Our mission within the Center for Health Equity has really just been dedicated to public service and participatory research from a community-based level that truly focuses on eliminating disparities in health due to race, gender, age, socioeconomic status, etc.

We're located in a rural community of Quincy, Florida. Quincy, Florida is about 30 miles outside of the capital, which is the city of Tallahassee. Our target population is African-American women, from low income moms that range from the age of 14 to 44. And on occasions, we do pick up young moms as young as 11, and older moms as old as 46. But our real target is 14 to 44 in their pre and interconceptional years of life. Our two primary methods of service delivery has been delivering home visiting services as well as doing peer support groups in three different arenas. We do peer support groups at a community level. We do peer support groups in the high schools, and at one point we were doing it in the middle schools, and we do peer support groups in our jail and our prison that is there in the community. My staff as well as myself have over 30 years of experience in doing programmatic implementation of programs, and a lot of experience around local and maternal health as well as behavioral health.

The composition of our particular staff, and this, I will talk about a little bit later, really came out of our view of building a behavioral health, is all of our home visitors are master's degrees clinicians, we have an RN, and we also have, which we're very fortunate to have, is master's level social work interns that help us with the capacity to do the work that we do.

Next slide. So, when we look at…thinking about…because we were already operating our federal Healthy Start projects since 2000. And we look at some of the needs, a few years down the road in terms of...and I

would say maybe like 10 years ago, we started looking at the needs in terms of in our rural community, there was limited to no behavioral health services offered in the community. So a lot of our consumers had to go to the neighboring towns to get services. But one of the biggest problems that we had in the community was that we had limited transportation, we don't have a true transportation service per se, and the county is rural, but it's very big. And many of our consumers did not have transportation so that even if they could get a referral to the neighboring county, which was usually anywhere from 30 to 45 minutes away, they didn't have transportation to get there. Many of the consumers, when we started doing our psycho-social assessment, we identified many, many of the federal Healthy Start consumers, they were being assessed and they were identified with having mental health issues and concerns that needed to be addressed. Initially, when the federal Healthy Start in Gadsden started, it was a paraprofessional model and it had maybe one or two BSWs, but everybody else was truly paraprofessionals.

And so, when we did our assessment within the community, and when we started doing more in-depth biopsychosocial and identifying that a lot of the consumers had the mental health issues, we then asked ourselves, the ethical question is, do we continue to assess knowing that we would identify issues with nowhere to refer our families, or do we create an avenue to provide services to fulfill that gap? And so, what we chose was to figure out how could we provide behavioral health services in a very rural community, with limited transportation, with few behavioral health providers.

Next slide. So what we did was we started working at... Okay, so if we were to figure out how to do this, where would we start? So we started with some assessment questions, our own internal capacity assessment questions. And we look at what exactly would a model look like within the context of Healthy Start that really kept the true blue nature of the federal Healthy Start project, looking at maternal and child health, and included a true behavioral health focus offering the behavioral health services. We looked at what might that might look like. Then we started thinking, "Okay, in terms of if we were to do that, would this be something that would require additional funding just to even test how would that work in combination with all of the things that we did with pre an interconceptional care and then adding a behavioral health component. So we started looking in terms of what would we want our staffing composition to look like. We looked at our internal staff capacity which at the time, the majority of our home visitors were

paraprofessionals, and, like I said, we had one BSW.

And then we started also saying, "Okay, so if we were to do this, what kind of partnerships would we have to establish? And where would those partnerships come from, because, you know, I already said, we are in a rural community with limited to no providers within the community. So where could we find partnerships in order to not only build this, but also to sustain the continuing development of our behavioral health services.

Next slide. And so, here's what we did. And we're very, very excited about this, because this really gave us an opportunity to do the work that we did. So, when we looked at our staff and composition, we said, you know, since we were going out, and I was going out with a team, and I was doing a lot of the biopsychosocial assessments, because I was the LCSW on the team, since we were going out and we were doing these psycho-socials, and we were identifying people with the mental health issues, what would a team look like that could be able to work with this? So we looked at our current home visiting team, and we decided that for us to be able to continue to assess, continue to identify issues, but really be able to work with those issues, what would we have to do? And as an organization, we decided to change from a paraprofessional, BSW-type level model to a master's level clinician model where all of the home visitors were master's level clinicians that could go out and not only do the biopsychosocial, not only do the home visiting and do the pre and interconceptional care and the postpartum care, but also, if we had identified any clinical issues, also be able to serve those particular clients.

One of the things that we decided to do because we were in a rural area and we didn't have a lot of industry happening, so we went to our neighboring community of Tallahassee and we established a wonderful relationship with the Florida State University College of Social Work. And out of that, we worked with the College of Social Work to craft and offer a phenomenal master's level internship for their master's students coming out who wanted an internship that was truly community-based, wanted an internship where there two groups involved, wanted an internship where they had an opportunity to do clinical work, wanted an internship where they had an opportunity to also work at a true grassroots level as well as get their clinical hours in as interns.

The other thing that we did was we worked really closely to encourage our internal staff to obtain higher education in terms of...for our staff that

did not have degrees, we encouraged them to go back to school and get degrees, particularly degrees in social work. For our BSW staff, we encouraged them to go on to get master's degrees, because we were very committed to our staff, and what we did within an agency was we offered flexible schedules so that they could attend school, and then when they were ready to do their internships, they were able to do the internship at the agency. As one of the results of coming into our agency at the master's level, another thing that we offered was free clinical supervision for the master's level clinicians that were seeking to get their professional license. Because, you know, we were realistic about this really is a rural community. And so, we didn't have enormous salaries to entice people to come, and we also knew that it was a drive at least 30 minutes from the hub area, which is Tallahassee, where a lot of our master's level folks had come from, unless we had an internal person who went back that was from the community, and we had two, and they decided to continue to work there at the agency.

So as a part of what we do, is we offer the clinical supervision free of charge, and if they were not working within our agency and they wanted to become licensed, they would probably have to pay anywhere from $75 to $150 an hour. So that was the one thing that we did in terms of recruitment and retention. The other thing that we did was we looked at, "Okay, so, let's test how we can make this model work." So we searched around looking for different funding sources. One of the things we found was through our Blue Foundation, we wrote a grant. We got a very small grant. It wasn't a lot of money, but it was enough money to fund us for two years to be able to bring in two other disciplines into the team, an RN and a nutritionist and an additional LCSW to help work, to solidify what would this clinical team look like.

One of the things that we did right up front, because we knew the funding may not last very long with our entire team, was cross-trained on what our nutritional staff person did, and also trained on a lot of the health screenings that our nurse did in case our money dried up. And so, that allowed us to roll out for the first two years and fine-tune what we call was our biopsychosocial team that consisted of clinicians, MSW clinicians being home visitors, and an RN and a nutritionist that worked within the team and, of course, the LCSW.

So what do we do to, kind of, sustain and continue doing this work after our two years of funding ran out? Well, we've created the partnership that we have with FSU, the Florida State University, and we became to them one of their number one place to place their interns. So on

average, we typically have anywhere from one to four master's level interns interning in our agency on every single semester. So capacity wise, we continue to bring a cohort in that works with us for a full semester. And then another cohort comes in, and we always had one of the staff MSWs to serve as their supervisor, so the case never felt like it was dropped. A new partnership that we've just established, and I cannot stress partnerships are so important in doing this, particularly when you don't have other dollars to support it, another partnership that we established recently, it was the FSU College of Nursing, and now what we're going to have starting this semester, is nursing students who will also be working in our agency each semester to do the nursing part of what we established in the test in biopsychosocial team. And then out of this what grew, and this actually what sustainable dollars, was because we were in a rural community, because there were not a lot of clinical professionals there, we actually established a partnership with our community-based agency, which is our child welfare entity, where now they are purchasing services from us as the Center for Health Equity, the behavioral health services to work with some of their child welfare families that's in the child welfare system, particularly the mommies and the babies.

So we're staying really focused on what we're doing from the federal Healthy Start aspect, but working with the mommies and the babies, doing individual therapy, doing child-parent psychotherapy and doing parenting, being a part of running route, and these were aspects of things that we had expertise in doing, but because they too had difficulty, because there was no one in our rural community providing it, now they have contracted where we provide some of those services. And so now, we've been able to expand the behavioral health network piece of it, where now we also have contracted MSWs and LCSWs that take on cases on a very part-time level.

Now, though we have done this, and we wanted to do it because we said we would never drop this, because now we were providing these behavioral health services in the community, what we continue to do, is we continue to look forward to seek additional funding to support these models, because we need to support this particular model, because we've seen the success on it, and we know that this really works, but we know it will take additional funding to do it. But the walk away that I really want you, or the take-away that I want you all to leave with is that we actually started with what we had, and we just really looked at how we delivered services in order to do this, and look at who were the folks out there that could also have an ability to build the capacity to do this.

And one of the things that we always wanted to do was meet the needs of the community and all of our behavioral health services still remain home-based, and this is so beneficial to our consumers, because many of them do not have transportation. So all of our therapists go into the home to provide their services. I just wanna make sure I stayed... Oh, did I stay within my timeline, Megan?

Megan: Well, Sharon, I'm gonna put up your last slide here with your contact information. Thank you for that overview. And I loved how you wrapped it up right at the end with that key take-away, that you started with what you had, and I really do think that the questions you posed with the assessment questions are great questions, whether it's a program in a rural setting like yours, or in a more urban setting. And you all will hear another story during this webinar from a more urban setting as well. But, Sharon, I posted out there to the group, if they had any questions, that they could chat them in, but it doesn't look like there are any right now at the moment. So thank you for those intro remarks and telling your story.

Right now, we're gonna now take a step, sort of, back and you're gonna now hear from Amy Pepin who is gonna, kind of, give you a bigger, kind of, landscape perspective of the larger behavioral health system in general. So, Amy, I'm gonna turn it over to you now to provide that overview.

Amy: Hi, folks. This is Amy Pepin out of New Hampshire, and I'm a clinical social worker with more than 25 years of experience working directly with people and also managing programs and consulting with systems that address alcohol and other drugs and other behavioral health problems. So what we thought would be helpful, would be to just take a minute and think about the system that you may need to interface with, and have a really think about this from an organizational level. And so, we're going to think about organizational planning. We're gonna think about some helpful mechanisms to identify potential behavioral health providers that are local to you, or that you may be able to connect with via telehealth. And then talk about some strategies for developing most programmatic relationships once you've identified who it is you think you want to be referring on your families too.

Next slide, please. Thanks. So, it is important for us to think about this process from an organizational level and not from a client level. I'm speaking to bills and accessible, efficient, effective behavioral health

referral network that you're gonna be able to use in a really timely way, and that is going to be culturally competent, or the folks that you work with take some upfront work. You all know that it's not what you want to be doing when you have the client sitting in front of you. You wanna have that answer at the tip of your fingertips. So, it's important to really think about it from an organizational level and think about relationship building at that level to really know what types of services it is that you're actually looking for for your clients. For example, it is far, far too often that folks with an identified alcohol or other drug problems are immediately referred to a residential provider, or what's thought of as a rehab facility, that which may not at all be the level of care that they require, and especially, because you're working with soon to be, or recent moms, they're not folks that are gonna be super amenable to being away from home or separated from babies, so it might not be a level of care that's appropriate.

So really thinking about what levels of care you need, and whether you have the internal capacity to do assessment and diagnostic interviews that really lead to that kind of level of care planning because if you're not able to do that internally, that's really what you're looking for. You're looking for folks that can do that assessment and level of care planning and identify what the actual behavioral diagnosis is, and what type of treatment is likely to be most successful for that client, and also what type of treatment that client is willing to engage in at that time because we have to meet folks where they're at, which you are also very good at doing.

So you have to be able to think about that and think about it as an organization. When we're looking for behavioral health services, what is it that we're really looking for? Because then you know who you want to be reaching out to and partnering with in your community. The other piece about that is that a lot of Healthy Start programs are embedded in larger organizations, and it's important to take that step up a level and really try to identify and then maximize existing relationships that your organization has. Your CEO may regularly be in meetings with the CEO from the community mental health center, but never once have they ever had a conversation about the fact that you folks are on the ground desperately trying to find behavioral health services for the moms that you're working with. And so, you wanna be able to explore that. Are there other relationships in your organization that could be pathways to introductions and opening doors and getting you to sit down at a table with the other organization in a way that's gonna be really productive, and is, kind of, a short cut in the relationship building process.

The other piece is while you want to make sure that you are focused on the services that your clients most frequently need, you also wanna make sure that you're meeting the needs of your staff people and that you're going to create a referral process with these organizations that is going to be streamlined and the most useful, or else it's not going to get used. And you can do all of the relationship building that you want, and you can craft these lovely, you know, memorandums with other organizations, but they're never gonna get a referral if there's not a good, solid relationship with the on the ground staff folks, and a level of trust and understanding there.

Next slide, please. So who are these organizations? It was great to see that everyone was aware of SAMHSA's treatment locator and understands that the SAMHSA treatment locator lists all of the federally funded alcohol and other drug treatment providers in every state and territory. That is a good jumping off place, particularly for populations that are going to have challenges if there's out of pocket costs and some things like that, federally-funded treatment providers within the parameters of their programming really do need to accept whoever shows up. And pregnant women are one of the priority populations for substance use disorder treatment.

So, checking out the behavioral health treatment locator, understanding who's listed in your region and really reaching out and having conversations with them is an important first step. If that's not something that folks have done recently, and I would say recently is within the last year, those contacts don't change quick, but they do change regularly. The other two resources on there are the buprenorphine treatment locator and the methadone treatment locator, both of which are incredibly important resources for pregnant and parenting women.

In addition, you're all very familiar with your own state systems of federally qualified health centers and community mental health centers, and can connect with your state alcohol and other drugs authority, whatever their name may be in your own state. They're all places that provide behavioral health treatments, but also provide resource lists of local community behavioral health capacity and have their own referral relationships.

The other piece, of course, is to understand the independent practitioners that practice in your region, both licensed mental health counselors, licensed social workers, licensed alcohol and drug

counselors that practice independently and do outpatient services for the private nonprofit organizations that provide substance use disorder treatment in your region. While many of those practitioners may be for profit and not have [inaudible 00:34:44] fee skills or not accept Medicaid and the other types of support that your clients would want to take advantage of. Many of them will, and this is a you won't know unless you ask situation, which, you know, sounds like an eye roller from somebody up in New Hampshire talking to folks. But honestly, we've worked in system change projects all over the country, and it's surprising to get in a room in folks' home community where people have never had the conversation. Or if you're like me and you've been doing this for a long time, you think you already know the answer, but you haven't asked the question recently. And it's important to remember that there is absolutely no harm in reaching out to your core regional infrastructure to say, "Hey, you know what we do, right? Can we talk about what you do and how you might be able to support the moms that we're working with especially around their behavioral health challenges?" It sounds simple but it could really bear some fruit.

Can I have my next slide? So, once you come up with what the landscape is of folks that you think might or do provide the services that you've identified that you want to be able to have good referral relationships with, I really recommend dating your referral services, and I really use that "dating" word intentionally, because you want to get to know them. You want your staff that would be making referrals to get to know their staff that would be taking the referrals. You want your clinicians that would be sending their folks to these people to meet their clinicians. It can really be incredibly helpful. This hand-off is facilitated by relationship, and in smaller communities, that can be…seems simpler, though it can be more charged because people can know each other in a lot of different contexts, and in larger communities it can feel difficult, because it can feel cumbersome or an unnecessary part of a process when all you're trying to do is get a list of where are the places I can send my folks. Successful referrals though don't happen just from a list, and I think we're gonna hear that in our next example, they take more than that.

So, to really date, to get to know each other, to understand eligibility, to understand the services that are available, to understand the levels of care that they provide, to understand if they provide that referral and assessment, to help you decide what level of care folks need, and to the extent that you can, to formalize that relationship between the two organizations, to say, "Hey, we've decided we wanna be referral

partners." And what that means, that we're gonna have this easy way that we do it, whatever that easy way is. You know, back in the day, it used to mean a fax. It doesn't mean that now. But both are able to structure and formalize referral relationships that really streamline and helps make more accessible and efficient and timely that referral relationship, so that when you're sitting with a mom who says, "Yeah, I think I really need help with this." You can say, "You know what? Let's call my friend over at the blah, blah center. I was just over there for a meeting a couple of weeks ago, they're really nice people." And you know you have a system and you know someone is gonna answer the phone on the other end and be ready to take your client's information. So, I hope in some way that that was helpful and I'll be happy to answer any questions. I believe, Megan, we're taking question at that end? [crosstalk 00:39:20]

Megan: We are. Thank you, Amy. But I did thought if there were any quick questions that folks have they could chat them in. But there are none in the chat box right now. But, Amy, thank you so much. I think that paired with Sharon's presentation from the start and you're, kind of, broader landscape, kind of, talking more about maybe a less co-located system of referral. I think that your points were spot on and I loved the, "dating" reference. I think that's a great way of putting it all into perspective. So, Amy, still no questions here, so if you'll hold tight, maybe folks will have them as we move along with the presentation. So, now folks, it is a privilege to introduce our next presenter, another Healthy Start grantee program that's gonna share with you about how they structure behavioral health referrals and services in their program. Ms. Danielle Lowe, and Mr. Georgea Madeira. So, Danielle and Georgea, I'll turn it over to you to take it away.

Danielle: Thank you. Hello, everyone. I'm Danielle, sorry about my voice.

Georgea: Hey, I'm Georgea Madeira. I'm a licensed marriage and family therapist and senior director at SHIELDS. Next slide. I think they wanted to start...

Megan: Exactly. Sorry. I was just chiming in to help let folks know we wanted to find out how many of you that are joining have a program that's co-located with behavioral health services. This will help Danielle and Georgea really, kind of, understand where you all are coming from. So if you'll respond with, yes, your program is co-located with behavioral health services or no, that will help us. And Danielle and Georgea, there

are folks that are chiming in. I'm gonna give folks another second or two here to respond. And right now we're at four yes and two no, I'll skip to the results. So, Danielle and Georgea, as you can see, we've got four folks that are responding that they are co-located and two that are not that have joined the webinar.

Danielle: I'd say thank you, guys.

Georgea: I think we wanted to start with saying that the goal to referral and linkage is to make sure that we're linking clients to the services that they need right then and there. And to do that, we have kind of like some stats that we think is important and the first one would be starting with the right staff and staff training.

Danielle: Yeah. So a lot like what was said before, you know, it's just important to make sure that you have those staff that are very invested in the community, and that also have, you know, a high level of training, So, we're looking at education and the employee you are offering those educational opportunities to make sure that the community has the most highly skilled staff to really work with this very vulnerable population. And for us that goes right in line with building that rapport because once you have the staff that are trained in all aspects including the cultural part, understanding that community and what those clientele says on a daily basis, that really is just the staff who are going in and building that rapport because it can be very overwhelming for someone to walk in and using those services. So just being sensitive and taking that step back to remember what that person is dealing with as they walk through those doors.

Of course, we all have to gather the consent to make sure that we can talk to other people, that we can go ahead and advocate for our clients. So, of course, a golden rule, we gather that consent for all of our clients, and then really gather that history of the client just to make sure that we're linking to the appropriate services so that that parent have the medical care that they need, that they understand the medical system, if they had a negative experience that's traumatizing them and making them resistant [SP] to even participating in those services, so really taking that time to gather that information and have an understanding of where they're coming from when they walk through the door. And we know that some of our families may come with multiple areas that they need to be addressed. So really sitting down so they're not overwhelmed and prioritizing which ones do we need to conquer first, what avenues, so we can go ahead and set them up. And then they see

that they're successful with those areas, which makes them a little bit more confident to take on all the other areas that they're potentially going to have to say, wow, they're connected to us.

Georgea: And I think something important about that too is that most of our clients are connected with multiple systems, like they might have case with the Department of Children and Family Services, or they are on probation, or their children are on probation, or, you know, they need social services, in general, assistance. So it's important that…or they have some kind of court mandate that they have to complete within a certain period of time. So it's important that we gather all that information too, and that we help them prioritize and get links to all the services that they need within that deadline that they are given by the different systems.

And the warm hand-off is very important when we are training staff, that we help them understand that referral is not giving families or clients just a piece of paper with, you know, a bunch of different addresses and agencies and phone numbers, but really modeling for them and calling with them and helping them navigate each one of the systems and the services that they need. And even someone mentioned before about transportation. A lot of clients don't have transportation. So making sure that we help them with the transportation. So it's not just linking them to the service, but helping them break the barriers that are there in our systems to help them be successful.

Danielle: Yes. And I think that's just in line with the warm hand-off. Just remember every person that walks through the door requires a different level of need. Some hand-off can be a paper referral and they know how to navigate the system. Other hand-offs are going to be very hand-held, taking the client, sitting there with them, making sure that the other agency is meeting that client's needs. I know we do have a lot of MOUs just throughout organizations, that's how we function, but sometimes that person at the front desk or that person that's receiving that referral is not aware of established MOU and how to greet our participants when we send them over there and sometimes we just can't talk over our participants' heads.

So just to really go there and sit with them to advocate to make sure that, you know, they're getting all the services that they need and they're not intimidated when they walk through that door. So, really, just taking that time on the back end to make sure. There's no cookie cutter way for each individual person to get the services that they need and just taking

account that history and what we really need to get down with that participant to make sure that it happens. And the follow through, calling in to make sure that that scheduled appointment that they made before they left the office, that the participant is following through with that. And if they're not following through with that, what can we do to really assist you with the follow through? The linkage is the first step, but the consistency and the follow through is the main priority. And so, just making sure we're as active as we were in those initial steps throughout the process until it becomes a habit for the participant and they know how to do that independently.

Georgea: Next slide. So, we wanted to talk a little bit about SHIELDS for Families, who we are and what we do. Today, we have 39, 40 programs ranging from substance abuse, all levels of substance abuse treatment, mental health for children and adults. We have case management navigation, we have educational and vocational services. We have a variety of programs within SHIELDS for Families. But we didn't start with all these programs. We started with one program and our CEO, she still has a monthly meeting with clients where the clients go through their needs and strengths of the programs and concerns. And so, we build up SHIELDS for Families based on the needs of the community and the needs that our clients were bringing up to us. So, if they had problems getting to treatment because of lack of transportation, we went ahead and we found…we went in the community, partnered with other agencies or other services that had a transportation. If they had needs for mental health services, back then we didn't have a program for mental health services, we went out in the community, we partnered, we created relationships with other agencies, and, you know, to help…to make sure that our clients were receiving the services that they needed.

And, you know, little by little we started applying for other grants and other contracts, and we now have a lot of programs within SHIELDS.

Danielle: Yes. So, we really just framed this next slide around our overall vision and mission, just believing, building and becoming, that really just encompasses everything that we stand for as an organization. So, believing, just really believing in your participants and that really comes down to the core values and the mission. So having that belief in them when they walk through that door, and understanding that we're here because of them, not vice versa. And so, really having that attitude to when you approach them, so they understand the significance of them being here. Building, it's just really the discovering process, understanding what the needs are and building out based on those

needs. And so, that's really where the collaborative partnership in the community comes into play, by taking an assessment of what our families need versus what we think they need. And then developing those partnerships based off of their voice and what they're saying is a need. And then becoming, it's really that successful, you know, that confirmation and seeing that participant really going through the process, really have an active role in the seat. And in their treatment services, building those new programs based off of those needs, and the integration of all the services, because as we all know, our families don't typically come in with just one agency or one involvement.

And so, just really working with all of those groups to get everyone on the same page and understanding the needs as a community. And really when going after different grants and even collaboration, making sure that the clients' needs are the priority versus the money, because if we let the money drive us, sometimes that can tear us away from our overall mission and our values. So just make sure that the driving force is always the participants and always the community, because that's how we know we're doing that effective treatment, and it's actually gonna continue on and have that ripple down effect within the community as a whole.

Georgea: So, if you have any questions we'll be here.

Megan: Well, thank you so much, Danielle and Georgea for those remarks. And I loved hearing very loud and clear in what you said about the value in listening to the community and building from their needs. I think that was so key. And also highlighting, reminding the key points about what is...what are the keys to making a successful referral. I think in each of the three presenter's presentations, being reminded of what that looks like was essential. So thank you all for those remarks. And, so now folks, if you have any questions please chat them into the chat box. We do have a question, it's here and it's for you, Sharon. And I don't know if you're still in the line. And, just you know, Ms. Sharon Ross-Donaldson is on the go, but...

Sharon: I'm still on.

Megan: You're still on? Okay. We got a question for you.

Sharon: But you have to read it to me because I can't see it.

Megan: Okay. I will read it to you, "Does the home visiting team, or the

biopsychosocial team work with both mothers and fathers and partners?"

Sharon: Yes, we do. We work with both mothers and fathers, and in fact, another…and I think someone said this best, we only listen to what the community has to say, another component that we built was a brother-to-brother program that works with the dad, young dad, and fathers within the program. And that came out of fathers coming to us saying, "We have mental health problems, too." So absolutely, the biopsychosocial team works with the entire family.

Megan: Thank you so much. And here's one more question, and I'll put this to everyone. "Do any of you work with tribal communities or tribal populations? And if you do, do you have any key points or lessons learned around connecting that population with referral and referring for behavioral health services?"

Sharon: Well, Megan, this is Sharon. In our area we don't have any tribal population that's really close. Now, our team members, we have worked with, we just happened to, is all the capacities for tribal populations before and one of the things that we did was doing some mental health services with the Miccosukee Indians down in South Florida. And one of the key things for us was really making and establishing a relationship with the head of the tribal community, and our approach for getting in to do the mental health piece was through a true physical health, and the health included mental health as well as physical health. That was our network in to get…to be able to work within the tribal communities.

Megan: Thank you, Sharon, so much. Well, folks, there are no more questions in the chat box right now. So let's...I'm gonna share a couple of resources real quick, and then we're gonna go back and revisit those post test questions, and then we will sign off for the day. So just so you all know, we have another webinar scheduled in June that's on needs assessment in Healthy Start. It's June 21st and that's from 3:00 to 4:00 Eastern Time. There are a bunch of resources regarding alcohol and substance-exposed pregnancy prevention on the EPIC Center's website on the AStEPP web page. I encourage you all to go there and we're gonna be rolling out a few additional new ones, so stay tuned for that. There'll be some infographics and there will be some videos, and, of course, all of these slides will be posted, and we'll also just email them out to everybody who signed up for this webinar.

I also wanted to share that for the SHIELDS for Families team, there is a

video where their program was highlighted. And I will put that in the key take-aways email I send out with this webinar. But it's a really beautiful piece on their program. So I'll share that video out with everyone in that key take-aways email. So let's do a quick wrap up here with the post test questions to see if you heard any of these points come out on the webinar. So the first question, "SAMHSA's treatment locator resource includes information on only select states in the U.S. Is this true or false?"

So if you'll click in using the radio button, and it looks like those of you that are hanging in there, are clicking in and the results are here. And it is, in fact, it is false. There are treatment resources in the locator, so there are resources in all states highlighted in this space, but as Amy pointed out in her presentation, she encouraged everybody to check frequently, because that resource is updated annually, and it's important to sort of stay tuned into the resources that are available to you. So the next question here, "Behavioral health providers are required by law to serve all clients that need services without programmatic eligibility requirements. Is that yes or no?" And the last time... Well, I'll wait to let you all chime in on this one. Folks have weighed in. We're gonna skip to the results here. Everyone says, "No" And that's true. There are many programs that have eligibility requirements, and it's important for you all to know them prior to a referral. As folks shared, it's important to get to know and build relationships with your partners. And when you go to make those referrals, make sure that you are, you know, supporting the individual participant and what they need, and knowing those requirements can help you with that referral process.

So the last question here, "The goal of making a referral is to ensure the client is linked to correct services and that they follow through. Is that true, or is that false?" And folks were really quick on this one. And that is true. And that came through, and I feel like each of the presenter's remarks but definitely when the SHIELDS for Families team was highlighting what are the aspects of making a successful referral, they highlighted that.

So, there are still no... No, wait, we do have one more question in the chat box. And we have a minute left, so I'm gonna ask that. For either of the programs, Sharon or SHIELDS for Families, do your programs have any kind of peer support programs or support groups as part of your behavioral health services?

Danielle: For SHIELDS for Families, we do have it. And our participants

enter into the programs. We have like a big sister, little sister, a big brother, little brother-type program where our participants that have been engaged in services are linked up with a newcomer just to really support them, and so they have someone that, you know understands where they were a few months ago.

Georgea: And for our substance abuse program, our alumni clients, they receive lifelong aftercare, and those groups are led by peers as well, by alumni clients.

Megan: Well, thank you for that so much, Danielle and Georgea for sharing that. Well, all right, everyone. There are no more questions in the chat box, I want to extend a huge thank you to our three presenters, or four presenters for today and the three pieces highlighted. It was very enlightening to hear your remarks and your expertise shared. Thank you for carving out time in your busy schedule. And thanks to all the participants who joined the webinar today. We do appreciate you making time in your busy schedule to join as well. This concludes our webinar. We hope you have a great rest of your afternoon and stay tuned to upcoming webinars as they are rolled out.