

**MEETING MINUTES FOR THE
GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH
THURSDAY, OCTOBER 8, 2015**

Members present: Linda Bryan, Richard Antonelli, Bruce Long, Maxine Heywood, Esther Picon, Anne Mulready, Brian Sullivan, Cherie Cruz, Sarah Dinklage

Appointed members present: David Spencer (CEO of Substance Abuse and Mental Health Leadership Council of Rhode Island); Megan Clingham (MHA)

Ex-officio members present: Ruth Anne Dougherty, Chris Strnad (DCYF); Lou Cerbo (DOC); Alice Woods (DOE); Jeffrey Hill (DOH); Sharon Kernan (EOHHS); Michelle Brophy, Linda Barovier (BHDDH), Ruth Anne Dougherty, Chris Strnad (DCYF)

Guests: Lisa Tomasso (TPC/Anchor); Lisa Conlan (PSNRI); Tina Spears (RIPIN); Dana Parker and Judith Drake (NAMI of RI); Rena Sheehan (BCBSRI); Denise Cushaney (NETSMART); Shannon Spurlock (RIPEC); Rob Elven RISDDA

Staff: Jim Dealy

Review of minutes (Anne Mulready): Introductions were made of all attendees. Motion was made and seconded to approve the Minutes presented. There were no comments or revisions. A Motion was made for acceptance and passed.

Prevention Subcommittee (Elizabeth Kretchman): One of the tasks for the Prevention Advisory Committee – which is a committee under this Council – was to guide prevention efforts throughout the State. The current Strategic Plan ends 2015. There is a current 3-5 year prevention plan which is currently being updated. A task that we have undertaken at this point is to brainstorm, develop and update our Prevention Strategic Plan. We had discussions at our last two meetings in July and in September around some common themes. There are several theme areas regarding partnerships, alcohol, tobacco and other drugs specific content, work force developments, across Behavioral Health (not just for Prevention) and infrastructure development. We are having several meetings and will have Minutes to share on the Secretary of State's website and will share here as well. Our next meeting is on December 3, 2015, from 10:00 AM-12:00 PM. All are welcome.

Healthy Transitions Committee (Anne Mulready): We are in the process of update the report that the Governor's Council's Transitioning Youth sub-committee wrote in March

2012. This is a long-term process for the Committee. We are trying to resolve some of the issues in the Finance Report which is the work-plan for the future. We have a meeting on October 13th at 3:00 PM in Conference Room 126 at Barry Hall which is open to the public. This is a sub-committee of the Council, and Council members are encouraged to attend. We hope to address issues around culturally appropriate services, individualized care and evidence-based practices for youth 16-25. There is an upcoming “listening session” for youth and young adults on October 22nd. Youths who participate will be given a non-cash reward of a gift card to either Wal-Mart or to a gas station.

Block Grant planning update (Michelle Brophy): BHDDH’s Division of Behavioral Healthcare and DCYF meet every first Thursday of the month from 9:00 AM-10:30 AM in Conference Room 126 at Barry Hall to work on next year’s Block Grant plan. We encourage the Council to attend the meetings. At the first meeting in September, we reviewed the role of the Governor’s Council in planning the Block Grant, how the Block Grant funds services, where we are here today and what services we feel are needed, but are not receiving funding. We have a tight time-line to implement changes to how we use next year’s Block Grant funds. We have to decide what changes to propose in December because the process for R & D of any new services has to begin in January. Ideally what we would like is to have as many members of the Governor’s Council as possible attend at least once a month. Comments can be submitted for review as well.

Marijuana Initiative (Paul Florin): Paul is a psychology professor working with the URI Community Research and Services Team, one of whose functions is to assist state departments to evaluate their programs, including the Marijuana and Other Drug (MOD) Initiative.

Several years ago, a statewide prevention needs assessment identified marijuana use by youth and young adults as a major problem. Rhode Island marijuana use was among the highest in the country. In response, BHDDH used Substance Abuse Block Grant funds to issue an RFP for marijuana and other drug youth prevention programs, and nine communities were selected to participate.

The RFP addressed SAMHSA concerns about the effectiveness of drug abuse prevention programs. In 1993, the Institutes of Medicine concluded that there was no evidence for the effectiveness of any such programs that were funded by the government. As a result, it spent the next several decades developing evidence-based prevention programs, mostly in controlled university settings. The next phase of these efforts was to bring these evidence based practices from small, controlled settings “to scale” in communities. The challenge

was unsure that these EBPs were being implemented with “fidelity” to their design. Fidelity is the concept that the developers of a program specify certain critical ingredients in their curriculum – both the numbers sections that they employ and various kinds of content that they employ in their curriculum. It is both the “dose strength” of their curriculum and its “content”. With this in mind, BHDDH, directed Paul’s team to develop program implementation measures and BHDDH required all of the teachers and educators delivering these evidence-based curriculum to complete these measures.

The Rhode Island communities did quite well. The “fidelity” was measured at 80-100%. The teachers felt that their students were engaged with their curriculum. Once the data comes in this spring, the proof will be available as to how effective the curricula were.

Several of these communities have indicated that after the MOD (marijuana and other drug) initiative funding ends, their communities will pick-up and continue to deliver these evidence-based curricula at their own expense. This is tremendous evidence of the communities finding that this is a worthwhile endeavor that they should continue with their own money.

This initiative has not paid particular attention to the non-medical use of prescription drugs because these issues were not as prominent when the needs assessment was done. Hopefully, the next round of the RFPs will address these drugs more directly. The curriculum includes marijuana-specific information and also social skills development. Not only is it affecting the individual students within the schools in terms of their knowledge, attitudes and behaviors. It is also supposed to be changing the communities’ social norms and the perception of the harm caused by marijuana and other drugs. Doing this in a social environment where marijuana is increasingly seen as presenting few risks is challenging. The task becomes one of convincing youth that, while marijuana may be helpful to some individuals, it causes problems for others, including youth.

More detail of Paul’s presentation is contained in the attached Power Point presentation. Paul will report back to the Council when the outcomes research is finished in the Spring.

Update from BHDDH (Michelle Brophy): We have been advised we have been awarded our Certified Community Behavioral Health Clinic Grant.

Update from EOHHS (Sharon Kiernan): With regard to the Reinventing Medicaid initiative, we are still trying to determine which approaches are doable and which are not; what the savings are and what are the ways to accomplish more effective services. Deidre Gifford, the state’s Medicaid director, has announced she will be leaving at the end of October. A successor has not been announced.

We have been working closely with DCYF around two separate initiatives, HBTS Pass and Respite. As of January 1, 2016, these services previously managed by CEDARR will be moved in the managed care plans. We are working very actively with the health plans to work on the different things they need to do to understand the services, making sure they have the correct providers they will need to add to their provider networks. We will maintain a fee for service management ourselves for folks who are not in managed care who are receiving these services. We have had a few stakeholder meetings – the last having been held last week. They have primarily been attended by providers who are a bit anxious but I think they have been provided details. The CEDARR providers will be losing a little piece of what they have been doing which is the oversight and authorization for those services. We are working closely with them. That's still a work-in-progress. Brendan Duhamel and Jason Lyon are the chief people working on that.

Council members requested an update around the CEDARR piece, which will have a big impact on children's behavioral health. Sharon said that families are providing feedback and a survey is being issued so we can have family input. To Medicaid's knowledge, the managed care plans are working to insure that all the services are put in place. We are just waiting for meetings scheduled with the plans to take place so we can have a little more input as to what is in the best interest of all involved.

Update from DCYF (Chris Strnad): With the help of OHHS, we have invigorated our partnership with NHP around behavioral services for kids involved with DCYF. Specifically, we are working with them on procuring access to a mobile crisis emergency response benefit through NHP. We are working to make sure that can be accessed in a location other than in a hospital emergency department into homes and community locations. We are also working with them on outpatient services benefit – making sure that the therapeutic interventions are available through that benefit.

Sharon mentioned that one of the efforts of Medicare has been to provide alternatives to the emergency rooms. Since there are currently no alternatives, the emergency rooms become the default service provider. Mobile crisis alternatives are needed for many reasons – reduction in costs, greater team approach helping families stay together, stabilization of the child. For children with serious emotional disturbance in their families, it's really about the teaming and make sure a good crisis plan is in place. Right now too

many crisis plans are built with “911” or emergency rooms. That’s the culture, the behavior we have to change. Most families will not reach out for help until they reach a crisis.

It was suggested that information be provided to pediatricians for assistance in properly directing these children and their needs.

DCYF has also begun implementing structured decision-making, which is an evidenced-based model for making child protective decisions about whether children can safely remain in their current environment.

Old/New Business (Anne Mulready): Marc Fields asked me to tell the Council that he is very interested in having some legislative participation in the Council. He has spoken to staff from Senate President Paiva-Weed’s office and directly to Senator Josh Miller, both of whom expressed interest in participating in the Council. We should really make a concerted effort to do that. The Membership Committee will meet and propel this forward.

The meeting was adjourned by vote of the members.

Next Meeting: Tuesday, November 10, 2015, 1:00 P.M.

Barry Hall

Conference Room 126

14 Harrington Road, Cranston, RI 02920

Statutory and Public members, please let Jim Dealy know if you cannot attend

This meeting is open to the public.

If you plan to attend and you require special accommodations to ensure equal participation, please contact Jim Dealy at the Division of Behavioral Healthcare Services at 462-0118.

