

**Meeting Minutes of
The Governor's Council on Behavioral Health
1:30 P.M., Tuesday, January 11, 2005**

The Governor's Council on Behavioral Health met at 1:30 p.m. on Tuesday, January 11, 2005 in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Richard Leclerc, Chair, Carrie Blake, Kai Cameron, Diane Dwyer, Stephen P. Erickson, Joseph Le, Noreen Mattis, Peter Mendoza, Reed Cosper, and Elizabeth Earls.

Ex-Officio Janet Andersen, George McCahey, and Chris Counihan, DCYF; Marie Strauss, Members Elderly Affairs; Collen Polsely, Department of Health; Craig Stenning and Katharine Present: Lyon, Ph.D., MHRH; and Fred Friedman, DOC.

Guests: Mitch Henderson, Bob Crossley, Sue Medeiros, Janice Pangman, Sister Carol Weaver, and Tom Coderre.

Staff: Jim McNulty, Corinna Roy and Mary Ann Nassa.

Once a quorum was established, the Chair, Richard Leclerc, called the meeting to order at 1:35 p.m.

After introductions were conducted, the Chair welcomed guests. The Chair entertained a motion to accept the Minutes of December 9, 2004. Liz Earls motioned to approve the minutes, and Joseph Lee seconded the motion. All were in favor, and the minutes were approved as written.

Richard Leclerc distributed a copy of a *letter received from Governor Carcieri supporting Project Hope (See Attachment I)*. Richard stated that the letter is acknowledgement of the Council's recent letter and our position requesting continued funding for Project Hope.

COUNCIL SUBCOMMITTEES

Emerging Population Report

Richard Leclerc reminded the Council that copies of the **Emerging Population Report** were distributed at the last meeting as well as the prior meeting.

Richard opened discussion regarding a document, which was e-mailed today from the Rhode Island Council of Community Mental Health Organizations (RICCMHO) looking to amend the Emerging Population Report with supplemental material. Richard distributed copies of the e-mailed report *RICCMHO Community Support Services Committee Response to the Governor's Council Subcommittee Report on Emerging Populations (See Attachment II)*.

Liz Earls explained that the RI Council's Service Design Committee had begun its work after the death of Glen Hayes, and the work of that committee synchronized well with the work of the Emerging Populations Committee. In terms of the timing of the report, Liz stated that they wanted to make sure that the Governor's Council had seen the report prior to taking additional action. Liz stated that they do not see this as an opposing report, but see that there were some recommendations that they would like to see as additions to the Emerging Populations Report. Those who participated in that subcommittee spent a lot of time grappling with who made up this population.

Liz asked that the components of the Service Design Committee's Report, which is Attachment I of the distributed report, *Service Design Elements/Recommendations*, be organized into four or five

recommendations around service design, specifically around the Mobile Treatment Team, and be added to the recommendations that are being offered in the Emerging Population Report.

Richard asked the Council if there were any questions or discussion?

Reed Cospers questioned the second paragraph of the cover sheet to the RICCMHO report and the relationship between The Executive Summary's quote: "Craig Stenning's requested a subcommittee be formed to consider what underlay the 100 percent increase in state-funded acute psychiatric hospitalizations." Reed did not see the relationship and asked that Liz talk about the connection.

Liz stated that the Service Design Committee had worked for about a year on their report prior to the formation of the Emerging Populations Subcommittee. The RI Council came to the Governor's Council stating that they had been struggling with this issue and thought that a bigger service system or bigger advocacy group needed to take it on. They recognized a significant population exists with specific characteristics that require a lot of services. At the same time the Department of MHRH was observing an incredible spike in the use of the Butler contract days, and with significant data about the folks in those beds, the RI Council assumed that there was a connection between MHRH's concerns and the RI Councils concerns and, in turn the client populations being investigated by these two groups.

Reed stated that he is very supportive of including the work of the Service Design Committee into the Emerging Populations Report, but at the same time he feels that what generated the group was an identifiable CSP client, and Reed has trouble with that overlap. Reed stated that the patients that are filling Butler beds are truly what are ordinarily called GOP, and are not the sort of client that the Service Design Committee was looking at. Reed feels that distinctions should be maintained and the report and recommendations of the RI Council be attached to the emerging populations report as an addendum.

Liz stated that they believe that these folks are both CSP and non-CSP, and have a history with substance abuse.

Reed stated that he would prefer that some clarity of distinctions be maintained rather than collapsing them together.

Richard Leclerc stated that whether or not the RI Council report is integrated into the emerging populations report, the extent to which the RI Council report will be attended to as part of the Emerging Population's submission is dependent upon on its recommendations inclusion in the Emerging Populations' Report recommendations.

Jim McNulty stated that he thinks that it is possible to come up with a concise number of recommendations that he would be glad to work with Liz on to distill the Service Design Committee's recommendations.

Richard asked if there were any other questions?

Reed Cospers stated that he thought it would be fairly easy to adjust the introductory paragraph to make reference so that it is organically included. Further, Reed asked Liz about Attachment I, Service Design Elements/Recommendations, bullet number three, second sentence: De-

emphasizing the coercive nature of forcing medication, intake paperwork and a minimum number of services on a person and emphasizing the supportive nature of what we might offer them to meet their immediate needs which would increase the probability an involuntary person would engage more readily.

Reed stated that Anthony T. who stabbed a man and killed him was a client with a long history of psychosis and mental health problems and non-compliance and his own father had schizophrenia and killed someone. Reed stated in his view that Glen is still dead and Anthony would not benefit if the interventions had been more passive and less coercive. Reed stated in his opinion Anthony belonged in a hospital a long time prior to the incident. Reed stated that there are very few Anthonys in the world and what we should be doing when we identify them is get them into a place where safety is an issue.

Bob Crossley responded that Reed was correct, and this is predicated on the current system in place as well as Anthony's criminal history. At that point even though he committed crimes, there was no criminal hold on him; therefore, in reality there was no court that could put a forensic hold or any kind of court order on him. This was more about keeping the clinician safe than keeping society safe. Bob stated that if we had a statewide system that was integrated with police, probation, parole and the court system all talking about the people like Anthony, he would be willing to change that recommendation. He thinks that a more collaborative way of treating or serving this kind of person is necessary within the system.

Richard Leclerc stated his understanding is that although this committee's work was generated by an incident, it is not a case-result report; therefore, the recommendations are not case specific, but they are generally looking at a whole population. Richard asked what they had found out about the characteristics of the population? Are there numbers, prevalence, impact on certain services, and was that part of the work the committee did to arrive at these recommendations.

Bob Crossley stated that there are approximately 15 to 20 individuals within each CMHC who fit this profile being dealt with right now either in case work or MTT, totaling approximately 100 to 150 active statewide. Liz Earls added that although they are not the majority, they are recognized as requiring a lot of service across a number of systems.

There was some discussion on why the RI Council's report was not incorporated at an earlier time.

Richard Leclerc asked if there was any need or request to discuss the RI Council report's request for clarification on the four "Actions" listed on Page 2 of their report. Craig Stenning stated that this is first time these questions have been brought to their attention. He added that the "risk corridors" were explained at the September 14, 2004 meeting (as cited in the minutes). Craig explained that if the need for bed days exceeded the contracted 4,600, MHRH and Butler Hospital would share in the cost of those bed days, and if they fell below 3,900 bed days, they would share in the savings.

Craig stated that also addressed at the same meeting was Item 2, "GOP Funds." As cited in the Minutes of September 14, 2004 Craig Stenning stated "State GOP money, which is a small amount of money given out in contracts to various community mental health organizations within the state. Craig reported that this pool of money has gradually decreased over the last ten years, as the cost of the Medicaid share for the CSP populations has increased. At the time, it was assumed that if more was spent in this area, more people could be reached prior to their need for hospitalization. Definitive language has been added to the current contracts for use of the general outpatient money limiting the funds appropriated either for emergency services or general outpatient services by

listing priority populations. People coming out of Butler Hospital are listed as a priority population.”

Craig further stated that a letter had been sent to the CEOs of the eight mental health centers clearly stating that priority for the contract funds should be given to individuals coming out of Butler Hospital.

Regarding Item 3, “Not all regions, which were awarded substance abuse outpatient grants, have intermediate care,” Craig stated that the five contracts for the five regions all required the provision of intermediate care.

Item 7, “The SDC is aware of the Annual Conference hosted and planned by the two departments. Is there additional action?” Dr. Kate Lyon stated that it is an annual conference between DOC and MHRH and the plan is to continue to have that conference.

Richard Leclerc clarified that the questions raised here may not be addressing the concerns the Committee had and that through discussion he hears people wanting to make changes to the recommendations. If this is not accomplished now, it will have to be done between now and the next meeting. Richard asked if the Council was prepared to make the changes now or if was there any other discussion?

Reed moved that we append and integrate the RI Council’s Service Design Committee’s report with the Emerging Population Report and come back with a final report at the next meeting. Liz Earls seconded the motion. Richard reiterated that the motion is to return at the next meeting with revised recommendations that incorporate the Service Design Committee’s report and makes other changes that may need to be articulated at that point.

Liz Earls suggested that they might want to flesh out the “Action” statements so that when the report goes to the Governor it will be clearer in the Emerging Population Report.

All were in favor. Motion carried to table this discussion until the recommendations are revised and incorporate the RI Council recommendations.

UPDATES FROM DCYF

Janet Andersen presented the report for DCYF. Janet stated that there has been a tremendous amount of work being done in terms of revising and identifying areas of gaps in services for children’s behavioral health. These gaps include a broad range of publicly funded behavioral health services for all populations that are served by DCYF, child welfare, and juvenile justice. Several of the initiatives currently underway are both clinically driven and budget driven in areas where there have been huge deficits.

One of areas addressed is psychiatric hospitalizations and children who have had to be hospitalized longer because there was no appropriate level of service in the community for them to step down to. Janet expressed that they have tackled that on several fronts. One was the development of additional residential services in the State; and as they identified what the gaps in services were, they have developed several levels of care and are in the process of developing a couple more. Primarily, they are looking at sub-acute psychiatric step-down residential care and have developed what DCYF calls Intensive Residential Treatment Programs (IRTP). NHP Beacon Health has developed, from a managed care perspective, an equivalent program called Acute Residential Treatment (ARTS). The

ARTS, because it is managed care, thus requiring medical necessity criteria, tends to have a little shorter length-of-stay. The IRTP level of care allows the kids to stay a little bit longer. It provides step down services for kids who are coming directly out of the hospital with a need for greater stabilization, or a longer length-of-stay in a sub-acute psychiatric setting if they need to stabilize or medications need to be checked out prior to going into a longer term residential or home. The length of stay could be for up to a year or more.

Janet stated that another program is coming up in February, which should have been introduced over a year ago, but experienced multiple delays because of the changes in the fire code, which required a number of residential programs having to make physical changes to get their facilities up to code.

They have been looking at each of the residential programs currently in place in two ways:

1. Because they have seen more complex children who have much more sexually aggressive behaviors and dual-diagnosis and triple-diagnosis than they had in the past; can some of them be beefed-up by enhancing the clinical services to be able to handle effectively more complex children?
2. The Children Intensive Services (CIS) program which was a community-based, home-based service that has been around approximately 14 years. Much work was done with the community, with providers, families, as well as the state partners to look at how to redesign that program. The new CIS program has been up and running for eight months. They are now seeing that this program is truly able to work with children in in-patient hospitals and work to get those children back out again. The hope that once that program was geared up that it also would help with the hospital population has begun to be realized.

The final thing that Janet wanted to mention was what DCYF calls a Child-by-Child II Project. That is a group of folks looking at every single child who has been in the hospital over 90 days and is looking at that child's diagnosis, and why they are there. The program staff ask if it is appropriate for them to still be there? What needs to happen for them to be able to move out to a different level of care? It is a very slow process.

Janet stated that a Letter of Interest will be coming out very soon that will be looking at bringing new providers into the State along with providers in the State who have the competency to work with children with a full range of developmental disabilities.

Janet described DCYF services known as wrap-around services that are being pieced together. It is a lot of home-based work, behavioral intervention, respite is involved, and collaboration with managed care organizations, particularly with Beacon Health. They are in the process of standardizing practice and tracking procedures. They are monitoring the implementation of service delivery once the children get out of the hospital. They are partnering with the Department of Human Services (DHS) to develop specialized, Home-based, Therapeutic Services (HBTS) that will be targeted for and particularly designed for children coming out of the hospital particularly those who have dual diagnosis, developmental disabilities and mental health issues.

Janet stated that the areas that DCYF recognizes as still being unmet are overnight respite, transportation for medical appointments, even though it is covered by Medicaid, and an increased option for therapeutic recreation. Those are things in the making within the system that DHS has been putting into its enhanced HBTS services that are connected with CEDAR, but there is much

work that needs to be done within the system to make that part of the system function properly. DCYF is working with DHS to do that.

Janet introduced Chris Counihan to report on the CIS program. Chris distributed an *Overview of CIS Results and Outcomes and Accomplishments (See Attachment III)*.

Chris stated that the mission of the Department was to stride for standard program operations. The second thing the standards did was to recognize that children and families needs are ever changing and to give the providers some recognition for providing the intensity of level of services required to meet the changing needs of the children and their families. Chris stated that last April they started to look at requests for services from the providers on a case-by-case basis to replicate the managed care format with the providers to review the cases for eligibility. The providers made sure that DCYF's authorizations got to EDS who pays the claims for these services.

Nine months into the program they report positive results reflected in *Attachment III*. Chris reviewed the distributed handout.

DCYF has performed site visits to all of the providers; looking at charts, talking with staff, reviewing management systems and then responding back to them with things that needed to be worked on. One of the things that they found, across the board, is that they need to work on engaging families. But because of the way the system is set up, they focus on the child, yet the mission of the Department and the goal of the program is to work with the families. By talking with the providers they have learned that there are logistical issues related to medical records in talking about mom's substance abuse or mom's mental illness because it is a potential HIPPA violation. But they continue to work with the families and consider the parents as important as the child in terms of what they know to be the best practices.

There was some discussion around Attachment III. Janet Andersen stated that in another six months they will have more quantitative data that the Council members were asking for, as well as qualitative data on the effect the changes have had on the system and on the children and families. They now have baseline data and they will be able, with the help of Yale, to look at what effect the changes have had.

Janet stated that the children that fit the criteria for CIS are in the CIS system, but those who don't meet that criteria are flooding the hospital emergency rooms and are getting stuck in medical hospitals because there are not enough rooms in the psychiatric hospital. They have put additional utilization review into the children in the hospitals and have now added Qualidyne for all of the children who are fee-for-service and not in managed care but are fee-for-service Medicaid. Qualidyne is doing the utilization review for those children to see the appropriateness of their being in the hospital, and that happens within 24 hours of being hospitalized.

In terms of diversion they have not had a mobile crisis team such as exists in the adult system. They are now looking at an emergency services system for children. They have pulled together data on where the kids come from, when they go into psychiatric emergency hospital rooms, what are the numbers from the community mental health centers, and what is the emergency services system handling right now in terms of numbers? They have researched and pulled together the concepts that they had already been looking at and have come forth with some key recommendations. What

they plan to do is look at policy changes and possibly recommendation for some legislative regulations and then an RFP.

Janet Andersen stated that there is still a lot of work to be done in the system to keep kids out of hospitals and there is another level of development needed within the community to ensure adequate services for kids and their families.

Janet added that there are two other things going on in DCYF in terms of follow up on the System of Care Task Force. There is a group of parents and DCYF staff that meets every Monday morning to look at a redesign of the service system. Coming out of that is a small subcommittee that Janet is chairing called the External Subcommittee, which looks at the external system. Sheila Pirus who is a national consultant, who has done a lot of system-of-care development with multiple states across the country and knows Rhode Island because she has done some work with DHS and DCYF, MHRH and the Department of Education, was brought in to come up with a managed system. Over the course of years with the work that was done together, and the task force report riding on the heels of that, this is the time to make some major change in the system. What they are looking at and with the help of Sheila Pirus is a design for managing the services of the top two to five percent of the children, those kids who are the most complex kids, which means multiple diagnoses. Because they are the most complex, they have probably utilized the most services and the most expensive services. Core recommendations are being developed about what they think this system needs to look like. These recommendations will be presented to stakeholders, including this Council.

Finally, in response to Tom DiPaolo question about education and the impact the increasing number of state residentials is having on the LEAs due to the work DCYF on night-to-night placements. DCYF now has over a year of no night-to-night placements, and as a result of looking at what the system needed, they did a lot of system building. They are now developing a tracking system within DCYF.

UPDATES FOR MHRH

Dr. Katharine Lyon presented the MHRH report. Dr. Lyon stated that Jim McNulty has facilitated Joel Stark coming to Rhode Island to do a presentation on Respect and Dignity in response to some concerns that have been raised nationally on this subject. Joel is the former Director of Consumer Affairs from Alabama and he is doing his presentation, which is actually a training through SAMHSA, tomorrow, Wednesday, January 12, 2005 from 2 to 4 p.m. at the Regan Building.

Dr. Lyon stated that they would be doing a series of focus groups with providers. E-mail has been sent out to all of the folks that they need to work with inviting them to come and spend up to 90 minutes in each of the facilities to hear about what is going on with the providers at this point. The first one will be with Phoenix House on Wednesday.

Meetings will begin next week with the five different outpatient providers for substance abuse treatment prime contractors.

MHRH will be conducting a large Behavioral Healthcare Disaster Drill in March that will bring the whole system up so that they can keep on their toes with disaster work.

Legislatively, MHRH is involved with a couple of bills: one is Parents Who Permit Underage Drinking in Their Homes, and also the new machines "Alcohol without Liquid." This machine

vaporizes alcohol and can deliver it to the system without having to go through the digestive system, which is incredibly lethal and addictive. States and the FDA nationally are looking at outlawing these machines.

A new incident reporting form has been developed and sent out to the hospitals that MHRH provides Facilities Status.

MHRH is about to finish up their Prevention Standards. They should be promulgated within the next couple of months after having a legal review.

MHRH is working on a new monitoring tool for licensing with the new Behavioral Healthcare Regulations and as that comes on board, they will share it with everyone.

MHRH is doing a fair amount of committee work with the Department of Human Services looking at the use of emergency room services for folks with behavioral healthcare issues and whether there is a better way to provide services for those folks.

MHRH is working on the Medicare Modernization Act in a work group with DHS, and also with drug discounts looking at the possibility of importing drugs from Canada.

ADJOURNMENT AND NEXT MEETING

There was no further business. Upon motion made and seconded, the meeting adjourned at 2:30 p.m. The next meeting of the Council is scheduled for **Thursday, February 10, 2005 at 8:30 a.m. in the first floor Conference Room 126 at the Barry Hall Building.**

Minutes respectfully recorded and submitted by:
Mary Ann Nassa

Attachments: I – *Letter Received From Governor Carcieri Supporting Project Hope*
II – *RICCMHO Community Support Services Committee Response to the Governor’s Council Subcommittee Report on Emerging Populations*
III—*Overview of CIS Results and Outcomes and Accomplishments*