

**Meeting Minutes of
The Governor's Council on Behavioral Health
1:00 P.M., Tuesday, May 10, 2005**

The Governor's Council on Behavioral Health met at 1:00 p.m. on Tuesday, May 10, 2005 in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Richard Leclerc, Chair; Cynthia Barry, Sandra DelSesto, Diane Dwyer, Peter Mendoza, Nicki Sahlin, Ph.D., Elizabeth Earls, and Bruce Long.

Ex-Officio Members Present: Kathleen Spangler, MHRH Acting Director; Marie Strauss, Elderly Affairs; Craig Stenning and Katharine Lyon, Ph.D., MHRH; George McCahey, DCYF; Frederic Friedman, DOC; and Tom DiPaola, Department of Education.

Guests: David Hamel, Governor's Policy Office.

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

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

After introducing David Hamel of the Governor's Policy Office, the Chair entertained a motion to accept the Minutes of April 14, 2005. Liz Earls motioned to approve the minutes, and Cynthia Barry seconded the motion. All were in favor, and the minutes were approved as written.

OLD/NEW BUSINESS

Richard Leclerc asked that Kathleen Spangler, Acting Director of MHRH, update the Council on the Transformation grant.

Ms. Spangler stated that a comprehensive group of people reviewed the Transformation grant including its data requirements, the length of time necessary to put all of the data together, and the function and the role of the office of Health and Human Services and the Secretariat. It was determined that it made the most sense to defer applying for the grant in the first round, rather Rhode Island would use this year to put together the data and the working groups that would be required for a good application in the second round. Ms. Spangler stated that although the mental health system has the data, with less than 4 weeks to prepare and with the kind of information that is required from other state agencies along with the wrapping up of the budget and the legislative session, it would make it difficult to make this everyone's top priority. Therefore, it was decided to apply next year with the understanding of what needs to be done between this year and next year.

**GOVERNOR'S COUNCIL GOALS AND PRIORITIES
FOR THE NEXT 12 MONTHS**

Richard Leclerc announced that the main purpose of this meeting was to go over the priorities for the next 12 months and beyond. Richard referred to *Issues for Council Focus In Upcoming Year* mailed with the Minutes of April 14 as Attachment II as a guide. The information compiled within that list has been the result of suggestions made over the course of the last year as well as the ideas developed when the Council first met and set priorities. The data was presented by flip chart. Richard suggested that as the Council reviewed the proposed items that they add any additional suggestions. He said that the group would discuss some of the key elements and then each person would get three votes for specific categories and then it would be narrowed further at the next meeting.

Discussion followed and the following changes indicated in ***BOLD PRINT*** represent the changes brought about by the discussions:

1) Young adults/Emerging Populations

- a) Service development for clients not currently being served well, in particular young clients with mental health problems, who also are using drugs
- b) Further study of the individuals using three and four “service areas”(*subcommittee report*)
- c) Investigate the creation of a multi-disciplinary team, similar in structure and objective to the system’s current Mobile Treatment Teams, but with the mission of seeking and reaching out to those individuals who are the least likely to seek and/or continue with treatment (*subcommittee report*)
- d) **ADD: Review a product produced by Rhode Island Coalition with partners.**
- e) **ADD: Funding for services for the uninsured.**

Jim McNulty stated that after a meeting with the Mental Health Coalition it was requested that a meeting between Rick Harris, the chair, and Richard Leclerc be arranged to discuss the areas listed in Number 1 in terms of looking at the current system of care and making recommendations about building appropriate levels of care.

Liz Earls stated that the RI Council is also interested in terms of what these services are. Liz suggested that maybe the Governor’s Council could serve as a place to review that material and synthesize it versus actually describing and developing it.

2) Children

- a) Transition **ADD: for youth and children into the adult** behavioral health services
- b) Early identification and intervention of behavioral health issues
- c) Development of better services for youth (incl. Co-occurring) **ADD: mental health, substance abuse and other?**
- d) Better service delivery to youth with **ADD: multiple** disabilities
- e) **ADD: Unmet needs of high school students related to prevention of alcohol and other substances**
- f) **ADD: Look at reimbursement rates for early screening I primary care for alcohol/substance use.**

The following is discussion around the subject of children:

Sandra DelSesto stated that after doing needs assessments using School Accountability for Learning and Teaching (SALT) data within all of the communities for the task forces, they have noticed that regardless of the community, at the high school level, at least 10 percent of students reported that they use alcohol on a regular basis, which is 20 or more times a month, and smoking marijuana regularly. These are kids in school, not dropouts. This is a significant issue and an unmet need that is not being addressed that affects their performance and attendance. This data has been consistent over the past two years.

David Hamel stated that the transition of children into behavioral health services falls under children and he thinks that a way of looking at it would be to look at youth and young adults, between 16 to 23, or 14 to 25 would frame the issue differently. He feels that this is not just a children’s issue, but an adult issue also. Those children who have a tough transition are adults when it appears and having it listed under children doesn’t conceptualize it correctly. He suggested that it be transition issues for youth and young adults.

George McCahey clarified the meaning of “transition issues” to be if children are in the care and custody of the Department of DCYF and undergoing mental health treatment and they are starting to age in the system chronologically. That is where that barrier seems to rest – i.e., certain diagnosis could be sufficient for DCYF to intervene for whatever level of care is needed, but the diagnosis is not always clear therefore youth are not always brought successfully into the adult system.

Liz Earls stated that then it is really preparation for adolescents in the children’s behavioral health system transitioning into the adult behavioral system.

David Hamel stated that when looking at transition issues, the children’s system is responsible for getting those youth ready to enter the adult system and the adult system is responsible for receiving those individuals.

Kathleen Spangler stated that it would be helpful to define co-occurring because it depends on which groups are in the room, that is which constitutes “co” in the occurring. David Hamel stated that co-occurring is behavioral health with some other disabling condition.

3) Elderly

- a) Expand services to the **ADD: community-dwelling elderly ADD: to be more accessible**
- b) Access to psychiatrists, **ADD: behavioral health education to the staff at nursing homes.**

4) Homeless

- a) Better services to homeless with MH/SA issues
- b) **ADD: Supportive Housing for homeless individuals with behavioral health issues.**

5) Consumers involved in criminal justice system

- a) Expand drug court treatment instead of jail, advocacy for addicts by having non-violent drug offenses expunged so they can find employment (decriminalization of addiction)
- b) Implement a therapeutic model for mentally ill prisoners (Access report)
- c) Increase support for prison diversion programs (Access report)
- d) Better services to clients in correctional facilities
- e) Better services to clients leaving correctional facilities **ADD: Discharge Planning**
- f) **ADD: Access to consumers in the ACI to hear complaints, monitor care, by advocates and other consumer identified persons.**

6) Improve services to non-English-speaking consumers

- a) Determine and make recommendations on **how to conduct outreach into culturally diverse communities** to attract professionals and make people aware of services available.
- b) **Workforce issues**, lack of credentialed and bilingual **ADD: bi-cultural** workers
- c) **ADD: Fund advocacy to work with non-English speaking consumers.**

7) Pregnant women, and women with infants and young children

- a) Increase the proportion of pregnant women, and women with infants and young children who are screened for depression.

8) Quality of service

- a) Look at **best practices in Rhode Island**, such as evidence-based practices: what is currently in place, what are their outcomes, and how are those systems supported, so that we can advocate for those systems to the Governor for their continuation.

- b) Look into best practices in substance abuse and moving our providers towards offering them statewide
- c) Monitor the new model or revolutionary approach to **general outpatient services**. Review the provider's reports on their new approach to integrated partnerships for care, watch, how they evolve, and the outcomes of their process.
- d) Improve **timeliness of services** by implementing statewide adherence to a **standard risk scale (Access report)**
- e) Increase quality/supply of behavioral health professionals
- f) Improve quality/competence/retention of direct service staff/increase pay
- g) More evidence-based practices developed and implemented
- h) Uniform standards and practice guidelines for mental health and substance abuse
- i) Provide a wider array of services to all people
- j) Train law enforcement officers **ADD: and first responders** in MH issues.

9) Broader systemic policy issues

- a) **Parity** between behavioral health and physical health especially related to reimbursement rates
- b) Reimbursement system for behavioral health services
- c) Refurbish Adolph Meyer hospital
- d) ~~Rewrite commitment laws to require more for involuntary commitment~~
ADD: Investigate involuntary commitment and treatment laws.
- e) Raise excise tax on beer wine and liquor
- f) Ensure that MHRH has the resources it needs to lead and monitor the mental health system/match needs with available funds
- g) Better geographic dispersion of service providers to accommodate need rather than population
- h) **ADD: Support provider index legislation.**

10) Policy/advocacy

- a) Investigate **insurance company's** avoidance of paying benefits to addicts, better accessibility to quality care for consumers with private insurance
- b) Investigate how to keep **Prevention Task Forces** viable given recent cuts
- c) Advocacy for employees fired for admitting the need for treatment
- d) Advocacy for addicts to be included in Americans with Disabilities Act
- e) Parity in mental health/substance abuse with primary health care **ADD: Note reimbursement rates.**
- f) **ADD: Tracking implications of Medicare Part D on dual eligible.**

11) Collaboration

- a) Collaboration between primary care and behavioral health
- b) Better collaboration between MH & SA providers, and better integrated service delivery
- c) Linking **ADD: behavioral health services provided in** schools to children and adult **ADD: behavioral health** service system.

12) Access issues

- a) Access to appropriate housing
 - i) Affordable housing and in-home supportive services, accessibility of supervised living (group homes), outside of family homes
 - ii) Include housing in treatment plans

- iii) More community-based slots for people who are entering hospitals/assisted living Access to outpatient services for behavioral health service consumers with a wide level of disorders
- b) Access to psychiatrists via inpatient care, hospitals, assisted living, etc.
- c) Better access to psychotropic medications
- d) Expand peer-run support centers
- e) Increase the proportion of adults with recognized ~~depression~~ **ADD: mental illnesses** who receive treatment.

13) Consumer service/treatment issues

- a) Address specific problems/addictions
 - i) Consumers' history of **ADD: trauma** ~~sexual abuse~~
 - ii) ~~Technology addiction~~
- ~~b) Reduce consumer reliance on medications~~
- c) Develop an employment system for clients.

Once review of the above was concluded, Richard asked if there were any other items that need to be added separately or added to the above categories. There were no further additions.

Richard then asked that everyone select the top three priority areas within the thirteen by placing a black dot next to the category.

The following represents the top vote getters:

1. **Quality of Services** with 8 votes
2. **Collaboration** with 7 votes
3. **Children** with 7 votes
4. **Elderly** with 4 votes
5. **Consumers involved with criminal justice** with 4 votes
6. **Policy/Advocacy** with 4 votes

Richard suggested having some discussion of these top choices and voting again next time on the specific subcategories. Some of them are too broad and need to be defined in more detail. Richard asked those present to examine each of the categories and distinguish what would stand out as one of the top priorities.

Nicki Sahlin suggested that under children, the juvenile criminal justice system.

Representative Bruce Long suggested that a subcategory be added under Collaboration so that the primary care physician would be able to be reimbursed for collaboration with other systems and identify those children who have the profile that would lead to the use of alcohol and substance abuse.

Tom DiPaola stated that to avoid redundancy in the children's area he would suggest that there are at least two other groups convening in this regard: the Children's Behavioral Health Advisory Committee that is an advisory committee to DCYF; and the second is the Children's Policy Coalition, which has a much broader scope than children's behavioral health.

Craig Stenning stated that when the federal government does its review, they are looking for what topics the Council has chosen that have a beginning and an end with documentation of its accomplishments within a one-year period of time. Craig stressed that the topic needs to be narrowed down to a plan which can create change in that particular area and at the end of 12 months it can be

determined whether it has been a success or not. Craig stated that the federal block grant requirements include the existence of a planning group, the Governor's Council, and the establishment of up to three work goals for the group for the year and cautioned that it should not be too general a topic and should lend itself to day-to-day work.

Richard suggested that between now and the next meeting that he and Corinna will cull out some of the redundancy within the issues and create some more specific issues which will be forwarded with the minutes and voted on at the next meeting.

ADJOURNMENT AND NEXT MEETING

There was no further business. Upon motion made and seconded, the meeting adjourned at 3:00 p.m. The next meeting of the Council is scheduled for **Thursday, June 9, 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
Governor's Council Secretary