

**Meeting Minutes of
The Governor's Council on Behavioral Health
8:30 A.M., Thursday, February 15, 2007**

The Governor's Council on Behavioral Health met at 8:30 a.m. on Thursday, February 15, 2007, in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Richard Leclerc, Chair; Cynthia Barry; Kai Cameron; Elizabeth Earls; Stephanie Culhane; Mark Fields; Mitch Henderson; Richard Hill; Joseph Le; Peter Mendoza; Neil Corkery; Reed Cosper; Representative Bruce Long.

Ex-Officio

Members Present: Craig Stenning, MHRH; Jeanne Smith, Carol Fox and Sandy Woods, DCYF; Fred Friedman, Department of Corrections; Mary Ann Ciano, Department of Elderly Affairs; Frank Spinelli, Department of Human Services.

Guests: Linda Hurley; David Spencer; Marie Kuhn; Dale Klatzker; Fay Baker; David Lauterbach; and Melissa Siple.

Staff: Becky Boss, Corinna Roy, Charles Williams, Kristen Quinlan, and Mary Ann Nassa.

Once a quorum was established, the Chair, Richard Leclerc, called the meeting to order at 8:35 a.m. After introductions were conducted, Richard entertained a motion to accept the Minutes of January 9, 2007. Peter Mendoza motioned to accept the minutes and Bruce Long seconded the motion. All were in favor, and the minutes were approved as submitted.

SUBSTANCE ABUSE UTILIZATION REVIEW

Craig Stenning acknowledged the attendance of representatives from the five prime agencies that provide State-funded substance abuse outpatient services. Craig distributed the following documents: **SA Outpatient Clients Served in DBH Funded Slots updated 2/13/07 (See Attachment I)** and **Substance Abuse Outpatient Client Admissions that were DCYF Referrals vs. All Across FYS – DBH Funded Slots Only (See Attachment II)**.

Craig reviewed the history of the Rhode Island Substance Abuse System. To access State-Supported Substance Abuse Services, the individual needs to fall below 200 percent of the federal poverty level and not have private insurance or Medicaid available to them. Approximately three years ago the Department conducted a review of the substance abuse outpatient system that was in place for individuals who were uninsured and indigent. At that time, the outpatient system included a number of agencies throughout the State, and there was no regional system as has been in place for Mental Health. Many of the small substance abuse treatment programs began in the 70's, and some of the larger agencies came into existence and merged with many of the smaller programs in the 80's. In the 90's some agencies were absorbed by the mental health centers. There were concerns over access to and intensity of service because there were three or four programs in one geographical area and only one or none in some other geographical areas. Findings from a review of how frequent clients were accessing outpatient services demonstrated that they were low, creating concern about the utilization of state slots.

An RFP was developed to revise the system using a regional approach, with one prime agency in five regions which are Northern, Providence, South County, Newport and Kent County. In the RFP, the prime agencies were asked to provide services throughout their geographical area, which they could provide themselves and/or provide through subcontracts with others. The service mix was to include what traditionally had been known as Outpatient Services, but also Intensive Outpatient, Partial

Hospitalization and Day Services. Craig stated that three years ago there was very little Intensive Outpatient, which is a minimum of nine hours per week of direct service, and very little Partial Hospitalization which is a minimum of twenty hours per week of direct service. Prior to this, outpatient clients received visits approximately once or twice a month which is not the most effective treatment, especially for someone with a significant substance abuse problem during the beginning stages of treatment.

Craig stated that applications were received, and there are now five regions in existence. The models are a little different in each region. By design those models were allowed to develop and mature individually. In addition, the RFP required more case management and the ability to provide co-occurring services. The RFP was written and designed so that no one agency could qualify to do everything within the RFP, forcing collaboration.

Craig reviewed *Attachment I* which represents the current *Dynamic Capacity over the past Fiscal Year 2006 and for the first seven months of 2007*. It is divided in the categories of Outpatient, Intensive Outpatient and Partial Hospitalization/Day Treatment.

The first region listed is Bristol, Newport County (BNC) with CODAC as the lead agency and the following partners: East Bay Mental Health, Newport County Community Mental Health, Child and Family Services, and Newport Hospital as the partner that provides partial hospitalization. The second region listed is Kent County (KC) with The Kent Center as the lead agency with the following partners: CIW/Gateway, and the Kent House. The third region listed is North Northwest (NNW) with Tri-Hab as the lead agency with their partners: Family Resources, Tri-Town and NRI. The fourth region listed is Providence (PVD) with The Providence Center as the lead agency with their partners: Tri-Hab, CODAC, MAP and several small agencies. The fifth region listed is Washington County (WC) with Phoenix House as the lead agency with their partners: SSTAR; South County Community Action in Warwick, Westerly and Wakefield; and private practitioners, Joe Hyde to do mental health.

Craig indicated from the report that state slots within the Outpatient System have been full. He stated that from one perspective it is good because initially three years ago, the statewide average was much lower; and from a utilization and efficiency and effectiveness perspective, it is good. From the point of view of getting people into treatment, there are some problems. In three of the five areas, there have not been and continue not to be waiting lists. In two of the areas there has been somewhat of a waiting list. In Newport County there is a waiting list because it is such a confined area, and in the Northern area there has also been a waiting list from time-to-time, but they have made some adjustments by hiring a part-time counselor to deal with DCYF issues.

Craig described the difference between the Dynamic Capacity illustrated on Page 1 of Attachment I and the Static Capacity illustrated on Page 2 of Attachment I. Static Capacity represents how many people can be seen at present, and the Dynamic Capacity is the capacity that exists over the course of a year which is effected by length-of-stay. Craig stated that length-of-stays are being monitored, and agencies are required to justify anyone who has been in Outpatient Treatment for more than six months. Most models of Outpatient Treatment look at someone being fairly successful within a period of time between four and six months. Once they pass that six-month mark, it must be justified that their stay in treatment is clinically driven.

Craig reviewed *Attachment II*, which represents *the Substance Abuse Outpatient Client Admissions referred by DCYF*. The graph at the bottom refers to the percentage of the overall admissions into

Outpatient slots from DCYF. It is divided into two years because FY07 admissions only include the period between 7/1/06-1/31/07, and over half of FY07 admissions are still active. As shown in each of the cases for Day Treatment, Intensive Outpatient and Outpatient, the numbers of referrals from DCYF have slightly increased during each of the years. Craig stated that this continues to be an area they are working on, but from discussions held with the primes, there should not be a problem in at least three of the regions. Craig noted that the average length-of-stay for DCYF individuals compared to all others is greater and part of that may be because of concerns and demands that DCYF has that are unique to their system versus the average referral. It is alleged that if some of those length-of-stays could be reduced, it would free up space in the system for additional referrals. Craig additionally noted that if DCYF is concerned about certain individuals with a significant substance abuse problem, the referral could be made into Intensive Outpatient rather than into Outpatient, and there is room in all five regions for that category.

Sandy Woods stated that all of the primes have a central intake number. When social workers, who lack the experience and the background to make the decisions, make referrals, they refer to that central intake number. Craig stated that he thinks that it is an issue of education and that the central number is the referral for all three of those services, and the lead agency is responsible for placing people in all three of those levels of care. Craig further stated that once the agency has completed their assessment, and it is determined that the individual would qualify for Intensive Outpatient and DCYF agrees, then there is room in the system for those more severe cases. Craig suggested that if there are no slots available, then the lead agencies and DCYF is advised to take a serious look at Intensive Outpatient and schedule the assessment at that level. However, sometimes people refuse the higher level of treatment.

Linda Hurley stated that approximately 93 to 95 percent of the clients that receive the funded treatment slots are referred by either Family Court or the Department of Corrections creating leverage with clients and that DCYF is the greatest leverage because of custody and other issues. In Newport County, access is an issue. Linda explained that they have a standardized assessment based on ASAM that occurs at every one of the partners' sites so that individuals can come to the point of access which they feel will work for them, and from that point, if necessary, referrals are made to the appropriate level of care.

Sandy Woods stated that the majority of the DCYF referrals that a social worker makes to a substance abuse treatment agency go there for an evaluation. Sandy Woods stated that by referring to an agency, DCYF wants the agency to determine if the individual has a problem, what they need to do and if it is safe for children to be in that home where that adult may or may not have a substance abuse problem. Then that agency should give that information to the court.

Richard Leclerc recommended that the primes along with Becky Boss and DCYF meet and talk about the referral mechanism and how to go about getting the individual into the right slot. Subsequently, a report could be made to the Council regarding how it is resolved. Fay Baker added that she would like to add transportation issues and the no-show issues to that agenda. She believes that all agencies struggle in those areas.

David Spencer stated that in the NNW region they are providing case management services out of their grant allocation – i.e., psychiatric evaluations, medications, mental health treatment in addition to the treatment services. David contributes many successes to those wrap-around services in addition to the treatment. He stated that they are in the process of working up some comparative data; and when that is completed, he will share it with the Council.

Becky Boss added that in the NNW region, through a recent Robert Wood Johnson Foundation grant, they are looking at developing a continuing care level-of-care, which has potential to move people through the system more fluidly and decrease the length-of-stays in active treatment.

Peter Mendoza stated that when comparing the findings at Washington County (WC) with other regions, the Partial Hospitalization is at 33.3 percent and Intensive Outpatient is at zero percent, he attributes that to no public transportation. They subcontract their Intensive Outpatient and Partial Hospitalization with SSTAR. He added that they have a 22 percent no-show rate for their assessments. He suggested collaboration with other providers in the WC area to firm up the Intensive Outpatient.

Dale Klatzker stated that a collaborative effort is a work in progress, and does not think that any one model will work perfectly everywhere in the state based on size, volume, geography, history, relationships and so on.

Stephanie Culhane suggested that a tool be developed to act as a diagnostic mechanism upon the initial referral. Peter Mendoza stated that there is a tool that is used at the agency level where they look at six dimensions and see where the client falls.

Craig Stenning stated that the problems do not exist at the agency level because all of the primes are seasoned agencies that specifically have looked at the assessment and intake issue, and an accurate assessment cannot be accomplished until a clinician sees the individual.

After some discussion, Richard clarified that the assessment is tied to an outpatient slot; and therefore if outpatient slots are full the person does not get assessed, and it cannot be determined whether or not they need a higher level of care even if it is available. Richard suggested that this issue should also be included in the agenda of the meeting with the primes and DCYF.

Dale Klatzker recommended an inservice training be provided by the primes to educate the DCYF social worker staff about the available services as well as the signs of substance abuse.

Craig stated that with a major shift in a system that has existed as-is for 20 years, he believes there have been major improvements in utilization, and a doubling in intensity-of-service. He called attention to the fact that even with a concentration on DCYF in today's meeting, there are eight or nine other areas of pressure on the system from other significant populations such as the homeless, the women's population, the HIV population, the AIDS population, and the re-entry population with the overcrowded conditions at the ACI and their need to get 500 individuals out with the solution being more substance abuse treatment, etc. Craig commended the primes for their good job of juggling the various pressures put on them, which will continue, along with making improvements in the system.

David Lauterbach stated that this program has recognized unaddressed trauma issues and believes that it has had an impact on recidivism. The old model did not address these issues, and because of the new integration of substance abuse into mental health services, people's lives are being turned around.

Representative Long asked if the capacity issue is a problem for only state slots or for insured individuals as well. Sandy Woods stated that during the fall of 2006, some agencies were not able to accept a referral no matter what the paying source was. Richard Leclerc asked for one of the primes to comment on whether or not someone has insurance and presents and faces the same issue.

Dale Klitzker stated that currently in the Providence area service is available, but it depends on human resource issues and recruiting and retaining a workforce along with a balance of resources. If someone is bilingual, the waiting list is long throughout the state, and a solution to that issue is needed.

Becky Boss reiterated the workforce issue and the fact that nationally the workforce is depleting and it has to do primarily with low reimbursement rates and this parity issue remains a national issue as well. Becky further suggested the recognition of substance abuse addictions as a “chronic disease” that is lifelong and needs a continuum of care model to keep clients connected, but not necessarily occupying an active spot.

Mitch Henderson questioned if there was some flexibility among regions to help each other or are the five areas completely independent of each other. David Spencer stated that the primes have engaged in discussion regarding referring clients, but the problem is transportation for several of the clients.

Richard Leclerc asked Craig if this program is scheduled for any budget cuts. Craig stated that the Governor’s budget has been made public and the major reduction in Behavioral Health is a program called Buyrite which is a proposal out of the Office of Health and Human Services (OHHS). Between the five departments that make up OHHS, overlapping contracts exist and they are proposing to combine them into one contract to create a savings on administration overhead and/or they all pay different rates, and if the rates become uniform, there could be some additional savings. Therefore, there is a three percent cut for all contracts in all rates that are paid to the community. Also, there is a three percent reduction in the Medicaid share and a three percent reduction in every contract, including the Outpatient contracts. Craig stated that there will be a meeting of all the Departments and somehow they will create rate unification.

Representative Long stated that legislation has been introduced to double the tax on beer. He asked where that money will be used if it should pass. Craig stated that it is ear-matched for substance abuse treatment. Craig stated that it was originally intended as new money for expansion, but now it will cover the budget cuts and bring substance abuse programs close to back to where they are right now.

BEHAVIORAL HEALTH DATA ELEMENTS

Kristen Quinlan reported that at the last meeting of the Governor’s Council it was determined that members would forward suggested performance measures to Kristen for collection to establish how well the system is working. Kristen stated that she received comments from three individuals, and each of them submitted a list of measures. Kristen reviewed each of those measures to check to see what is already collected and how feasible the other measures may be. Kristen distributed a list of *Suggested Measures (See Attachment III)* and whether they are presently collected data. Kristen distributed a list of *Division of Behavioral Health (DBH) Data Sources (See Attachment IV)*. Kristen also distributed a list of *National Outcome Measures (NOMS) (See Attachment V)* from Substance Abuse and Mental Health Services Administration (SAMHSA) which has been developed in an effort to gain information about substance abuse and mental health treatment and prevention across the nation. The NOMS include specific outcome measures across 10 domains. The chart illustrates Rhode Island’s current mechanism for data collection for each outcome across service area.

Richard Leclerc suggested that given the time element, that the information be reviewed with a focus on the suggested measures, and then select those measures that would be an indication of how well the system is performing or not performing. Richard thanked Kristen for putting the information together.

Corinna suggested that a subcommittee of the Council be formed to look at data and follow these elements.

Craig stated that the NOMS have been ten years in the making and the mental health and substance abuse sides of SAMHSA have not been able to come to an agreement to use the same outcome measures. Craig reported that one of the initiatives developed by Director Ellen Nelson of the Department of MHRH is a committee looking at quality along with data and what kind of outcome measures should be used across the whole Department. Craig stated that the first meeting of the group, which is open to everyone, was scheduled for February 14th, but was cancelled because of the weather and will be reschedule some time within the next two weeks.

Richard supported Corinna with her suggestion regarding forming a subcommittee that would meet and review this information and report back at the April meeting as to what the recommendations would be for some outcome measures, and at that time the Council can modify it according to the discussions at the meeting. Richard asked if there were any volunteers interested in serving on the subcommittee. Liz Earls, Reed Cosper and Mitch Henderson along with Corinna Roy will serve on the subcommittee. Richard encouraged anyone who decided to serve on the subcommittee at a later date to e-mail him at rleclerc@gatewayhealth.org or Corinna at croy@mhrh.ri.gov. Representative Long requested that an e-mail be sent to all members regarding the meeting date and time. Richard stated that they will poll those members who have expressed interest, and then let everyone know of that date.

UPDATES FROM MHRH

Craig described three major workgroups that Director Ellen Nelson has established that meet on an ongoing basis and are open to anyone who would like to participate. There is one meeting held each month, rotating through the three different agendas; therefore, each committee meets once every fourth month. The three groups are:

1. Innovations
 - a. Divided into three subgroups:
 - i. Developmental Disabilities
 1. To finalize a revised version of the Health and Wellness Standards.
 2. Establishing a new service level for individuals with developmental disabilities called Shared Living.
 3. In March there will be a review of the RICLAS system which is the public developmental disability residential system
 - ii. Behavioral Health
 1. Developing an entity which would manage the monies associated with psychiatric inpatient care at least of individuals who are funded by Medicaid or perhaps even larger than that.
 2. Developing a new State Behavioral Health Plan.
 - iii. Designing a Stabilization Unit as a new Service to be provided as part of the Eleanor Slater Hospital. That Stabilization Unit initially would be designed for individuals with developmental disabilities and psychiatric issues.
2. Quality
3. Consumer Group – Meeting March 14, 2007

Craig stated that all of these meetings are displayed in a calendar linked to the MHRH webpage: <http://www.mhrh.ri.gov/>, click on Office of the Director, then click **Title:** [Director's Partnership Council Meeting Dates](#)

UPDATES FROM DCYF

Jeanne Smith reported that as of January 23, 2007, the number of children who are 17.5 years of age and older and who are active in DCYF is 1,329, including the juvenile system. This is not necessarily the number of children who will be affected by the cut in DCYF services to persons 18 or older. She stated that this number is fluid, and the census varies daily.

Craig asked how many children will actually be affected by the DCYF cut in services. Liz Earls stated that Jorge Garcia has stated the number of 857, referring to children who are in foster care, group homes, and ILP or in residential settings. Liz Earls clarified that of the 857, 500 of them are in out-of-home placement of some type; therefore, the remainder are at home receiving some type of service.

Jeanne stated that Janet Anderson will be attending the Council meeting next month and will be accompanied by Colleen Carone who is the Chief of Evaluation and Data who will be doing a short presentation.

Craig stated that when DCYF cuts all services to children at the age of 18 the Department that provides mental health services, substance abuse services and developmental disabilities to adults anticipates that these young adults will be on its doorstep seeking services. The Department is trying to get a handle on how many individuals that is. Liz Earls stated that it is anticipated to be approximately 120 individuals who meet CSP and/or some other criteria for MHRH services.

Jeanne stated that there is a group at DCYF who is working on determining the number of children who will be affected by the measures and the children who will be needing services from MHRH. Richard stated that they will add the subject of the impact of the transition of 18 year olds and older to MHRH services to the agenda for March 13.

OLD/NEW BUSINESS

Corinna Roy distributed a copy of the draft of the *2007 Annual Report to the Governor and the General Assembly from the Governor's Council on Behavioral Health (See Attachment VI)*. The report was reviewed. Neil Corkery moved to submit the report to the Governor and Liz Earls seconded the motion. All were in favor, and the motioned was carried to submit the reported as presented.

At a previous meeting, there was inquiry regarding the function of this Planning Council; and Corinna distributed a copy of the *Federal Law and State Law that describes the responsibilities of the Council (See Attachment VII)*

ADJOURNMENT AND NEXT MEETING

There was no further business. Upon motion made and seconded, the meeting adjourned at 10:15 a.m. The next meeting of the Council is scheduled for **Tuesday, March 13, at 1:00 p.m. in the first floor Conference Room 126 at the Barry Hall Building.**

Minutes respectfully recorded and written by:

Mary Ann Nassa
Secretary, Governor's Council on Behavioral Health