

**Governor's Council on Behavioral Health's
Prevention Advisory Committee**
July 30, 2015 | 10 AM – 12 PM | Barry Hall 226

Meeting Minutes

1. Introductions

Sandra Del Sesto – PAC Committee Chair
Bette McHugh – BHDDH, State SYNAR Coordinator
Leigh Reposa – RI Youth Suicide Prevention Project
Angela Paradis – Brown University
Paul Florin – URI
Terri Censabella - BHDDH
Laura Hosley sitting in for Sarah Dinklage
Linda Barovier - BHDDH
Jeffery Hill – DOH
Nancy DeNuccio - Chair Ocean State Prevention Alliance
Pam Shayer – Coalition
Lynn Hernandez – Brown University
Karina Wood – Health Ed Public Policy Director
Elizabeth Kretchman – BHDDH, Prevention Coordinator
Shannon Spurllock – Rhode Island Prevention Resource Center
August Oddleifson – Rhode Island Prevention Resource Center
Ty Sweeney – Rhode Island Prevention Resource Center

2. Review and Approve minutes from April PAC Meeting

- a. Motion to accept, second from Leigh, no discussion, unanimous in favor

3. PAC process changes

- a. Updates to be provided in writing prior to meeting
 - i. We want this to be a working group. Send report 1 week – 10 days before meetings. Allows time on agenda for people to ask questions without spending time listening to report that we could read.
 - 1. Template should be created to facilitate reporting – August to create form
 - 2. Reports should be from the main prevention projects, not necessarily from every group, every time. Focus on state-wide projects. People representing coalitions: only share what you believe needs to be brought to the table.
 - ii. Proposal to meet every two months (6 meetings per year) vs. quarterly
 - 1. Motion, second (Pam), discussion: meetings should be about 1.5 hours and still be at 10:00am. Add in a break to allow for bathroom breaks and networking (10 minutes for a 2 hour meeting). Unanimous in favor.

4. SYNAR Update – Bette McHugh

- a. In process of doing contracts with municipal police departments for this fiscal year. Got legislature to allocate money.

- i. Block grant supplements our existing funds, but the money is still not sufficient to get job done.
 - b. Will be sending requests for assistance from police departments per request from advisory council. Required to do annual report by Dec 31 on progress and what state has done to reduce tobacco use.
 - i. Not yet sufficiently compliant.
 - ii. Want to work with coalitions to come up with best practices to allow us to submit accurate report without burdening coalitions. Violation rate is going up, not down. This places us in jeopardy of losing 40% of block grant.
 - 1. Council generally reviews report before submission, but feedback is sparse so maybe PAC group would be best for reviewing the report.
 - c. Wish to include ENDS products as “tobacco products.”
 - i. Children are using this technology for tobacco and marijuana. Child protectant packaging on liquid nicotine did not pass, nor did ENDS policy that was attached to it. Therefore, schools are forced to draft their own policy.
 - 1. Compliance checks can cover any products defined as a tobacco product under state law. Anything besides ENDS products at this time. Police departments can choose whatever products they want to assess. Violation rates in all states that do not classify ENDS as tobacco products are increasing.
 - 2. Need funding to make it effective
 - 3. Baseline use is assessed via YRBS; baseline youth access is measured via compliance checks
 - 4. If violation breaks a municipal ordinance that matches state law, all of the money goes into the municipality. Municipal ordinance is required to match state law in order for events to qualify for inclusion in report.
 - a. Need to spread the word about the municipal ordinance matching condition

5. Overview: National Perspectives of Prevention and Mental Health – Elizabeth Kretchman

- a. Handout
- b. 2 block grants (one for substance abuse prevention/treatment, one for community health services).
 - i. 2 year application and a report in between each application. SYNAR has separate report.
 - ii. Block grants differ in number of required practices, stakeholder requirements, etc. Both SAMHSA and BHDDH believe it is key to collect and report data at state and federal levels for quality and cost effectiveness.
 - iii. SAMHSA has streamlined strategic plan to meet evolving needs in Behavioral Health field, as well as fiscal changes (ACA). Recently introduced Leading Change – Advancing Behavioral Health of the nation. Reflects SAMHSA programmatic s and policies. 6 strategic initiatives. Three important ones are prevention of substance abuse and mental illness, healthcare and health system services integration (behavioral health and prevention through a public health lens), and workforce development.
 - 1. Prevention of substance abuse prevention and severe mental illness/emotional disturbance

- a. Maximize opportunities to create environments where people can manage physical mental and behavioral health. Build on protective factors.
- b. We want Rhode Islanders to manage their health. Focus on college age students, transition aged youths, those at risk for first episodes of mental illness and substance abuse.
- c. Health disparities are of paramount importance: ethnic minorities, veterans, LGBTQ community.
- d. Within CSAP we have 4 goals: emotional health and wellness, complications of substance abuse and mental illness (identifying and responding to emerging behavioral health issues). Prevent and reduce underage drinking/young adult problem drinking (college students). Prevent and reduce attempted suicide among populations at high risk. Prevent and reduce prescription drugs and illicit opioid abuse and misuse. Data shows that we have a national problem with substance abuse and misuse. Some rates have gone down in RI for traditional tobacco and alcohol, but increase in marijuana use. Based on YRBS, perception of harm is declining so we expect use to go up.
 - i. E-cig use is not on YRBS, but is on RI student survey, which should be implemented spring 2016 (data should be back before school year ends). Task force should play a role in making sure schools are (capable of) administering surveys.
 - 1. How can we finance surveys? Town budget? School budgets? Coalitions? (\$2.40/student).
 - 2. Workforce development – Prevention Resource Center has been providing technical assistance to build capacity. PRS training program is great.
- c. Priority areas (will be sent out)
- d. Primary prevention goals fall under “prevention of opiate abuse,” but we are hoping to develop a more comprehensive plan

6. Facilitated discussion: “Strategic Planning for Prevention in RI”– Shannon Spurlock

- a. Committee members were asked to form small groups and suggest strategies to improve each of the five following domains. Suggestions were placed on sticky notes and affixed to boards representing each domain. Each point was reviewed and opened to discussion.
- b. What should RI be focusing on for the next 3-5 years?
 - i. Partnerships
 - 1. Identify and implement collaborative strategies for drug misuse, abuse and prevention programs with DOH
 - 2. Make contracting process more user friendly
 - 3. Expand collaborative partnerships and relationship with researchers
 - 4. Work more closely with colleges and universities, particularly public ones
 - 5. Remove political barriers to coordinating services between departments
 - ii. Sustainability
 - 1. Identify three policy priorities per year and focus advocacy (prevention) on them
 - 2. Have RISAPA work plan guided by SAMHSA strategic initiatives

3. Sustain data collection with broader reach – coordinate with researchers that have funding to collect the same data that the state is interested in. Maximize resources and avoid duplicating resources. Disseminate that info to everyone
 4. Community data dashboard with key indicators – because it is hard at community level to collect and interpret data, provide cross-community indicators to facilitate communication and grant writing etc.
- iii. ATOD-specific content
1. Work on prescription practices with docs and health services. Majority of doctors don't use registry even though they are signed up to be a part of it. No mandate to use, just register
 2. Tobacco specific programs focusing on populations disproportionately at risk for tobacco use
- iv. Workforce development
1. Cross-train primary care with behavioral health and schools
 - a. Addiction and recovery process – trauma informed and culturally competent. Increase capacity of health care providers, BH, and schools on addiction and recovery process (schools can mean all types of health educators, health teachers, etc)
 2. Integrate training for mental health and substance abuse. Providers should be able to address comorbidities. Team service delivery as opposed to chaotic network of referrals.
 3. Special training regarding tobacco control/prevention for providers (health centers, mental health providers). Emphasis on holistic approach. This may belong on infrastructure tab too. Recommend a systems approach
 4. Establish minimum standards of working hours including reporting data. Requirements for a reporter in Block Island are same for providence. We need to know what the same core responsibilities are in order to get what needs to be done finished. We want to be able to establish how long it takes to do specific types of work and having some kind of broader definition from state to construct minimum requirements
 5. Support varied levels of evidence based practices. Be able to develop a plan that can cater to beginners, experienced, and veteran/expert professionals. Trickle down; utilize a formal mentoring process
 6. Create a core set of minimal capacities for workforce, core competencies around program management—e.g. how to build a budget
 7. Approach RI certification board to integrate prevention and treatment certification process. Understanding both sides of the coin makes for more effective and efficient care
 8. Develop a prevention orientation guide or training for prevention providers. Revitalize it and make consistent across providers. Core capacity building. Utilize current experts to do T/TA
 9. Improve recruitment and retention
 10. Curriculum integration and public/private partnerships. Integrate prevention programs into curricula at schools of public health, nursing, social work, etc so that it can count towards program requirements. Again, building relationships with colleges.

11. Do cross-training on evidence based practices for DOH, DCYF, NMUPD. Best practices across departments.
- v. Infrastructure
 1. Data-guided decisions drive all decisions. State strategic thinking should include data driven decisions around prevention, particularly around topics we KNOW are issues in RI.
 2. Health parity insurance not reimbursing for prevention. How to work with health carriers and the commissioner to include prevention as a billable service
 3. Across department data collection and sharing of reports across schools, researchers, communities and departments. Try to avoid duplicated data collection
 4. Strong statewide survey to inform decisions
 5. Regional needs assessment to maximize limited community resources. Implement same needs assessment across communities to streamline process. It would be helpful to strategically look at prevention services system for cost effectiveness and if not propose a different model that meets community needs and is data driven.
 6. Advocate in a meaningful way that primary prevention be one of BHDDH's primary goals in the future.

7. Prevention Announcements

- a. Events
 - i. Upcoming events handout
 - ii. Student assistance conference
- b. Funding opportunities
 - i. DOH applied for CDC grant.
 - ii. Health equity zone grantees. Some do have a behavioral health focus

8. Closing remarks:

- a. If we are trying to show alignment with SAMHSA then prevention should be included on the RI DOH & BHDDH collaborative brochure
- b. Terri from Chariho will be at Washington fair august 12th-16th (W-Sun)

9. Close: Next PAC Meeting

- a. September 30, 2015 from 10 AM to 12 PM in Barry Hall 126