The Children's Cabinet

Monday, August 29, 2016
DOA Conference Room A
10:00 a.m. – 11:3 0 a.m.
Meeting Minutes
Approved 9/26/2016

Members in Attendance: Elizabeth Roberts, Chair; Ken Wagner, Vice Chair; Rebecca Boss; Jennifer Griffith; Scott Jensen; Jamia McDonald; Nicole Alexander Scott, MD. **Absent**: The Honorable Gina Raimondo; Michael DiBiase; Melba Depena; Jim Purcell.

❖ Call to Order and Agenda Overview:

Secretary Roberts called the meeting to order and thanked everyone for attending. The Secretary asked for a motion to approve the minutes from the June 27th and July 25th meetings. Director Jensen made a motion to approve and Jamia McDonald made a second motion. Secretary asked the Cabinet if there were any comments or amendments to be made to the minutes. There were none. Secretary asked all those in favor of adopting the minutes, all were in favor, 0 opposed. Motion passed and minutes were adopted.

We received updates at the last meeting regarding several initiatives that impact children and children services – RI Bridges, SIM and RIDE policy changes. Today's meeting will focus on a single topic, children's behavioral health, which many of the Cabinet's staff as well as the community provider staff have been working together. The goal is to begin identifying opportunities for coordinated action that can improve behavioral health outcomes for our children, adolescents and young adults in Rhode Island.

Dacia will provide a bit of background on this issue, and we will then engage in an open conversation with all of you, as well as a few specific individuals whom we have asked to prepare a few comments for discussion.

❖ Children's Behavioral Health

Dacia Read reported that since the Children's Cabinet re-convened, we have discussed the impact of behavioral health on child outcomes including academic and physical health, as well as the impact of adult behavioral health on children.

When the Cabinet launched its strategic plan, we prioritized identifying opportunities to improve child and adolescent behavioral health outcomes, and included five specific indicators related to mental health and substance abuse to our first data dashboard.

Children's Cabinet Dashboard Indicators (2015):

- **2,744** children under 18 hospitalized with primary diagnosis of mental disorder.
- **26.4%** of HS students reported feeling depressed, sad or hopeless in the last two months.
- **11%** of children under 18 report attempting suicide one or more times in the last year.
- **24%** of high school students report using marijuana in past 30 days.
- **26%** of high school students report current alcohol consumption

The Cabinet also committed to mapping children's behavioral health services before the end of this year, and I am glad to report that we are now in the midst of that important work, and strengthened by an important partnership with the State Innovation Model (SIM) project, which provides technical assistance through the Providence Plan to complete our mapping and provides another forum for payer, provider, and community discussion on this issue.

In many, if not all, of the conversations with stakeholders on this issue, it has been clear that any changes made in this area need to be tied into our all payer health reform efforts, and the state is now positioned to develop a robust series of strategies to improve outcomes for kids and families by leveraging the experience and expertise of our Children's Cabinet stakeholders and those convened through SIM.

As we work to bridge conversations at multiple tables, I want to take a moment to align and/or begin to define shared terms.

1. **Population Health**: Physical and behavioral health of the population.
2. **Children's Behavioral Health**: Mental health and substance abuse of children ages 0-21.
   (With respect age range, the strategic plan had it from 0-24, because we understood that under the education and job context that there is a transition and a lot of the WIOA work is 16-24. As it relates to children's behavioral health, the statutory age range for many of program services and health plans goes up through age 21.)

3. **Children's Behavioral Health Services:** Prevention, residential and community-based treatment, and other community-based, social-emotional supports.

The first two definitions here are used by our partners at the SIM table, and have been regularly recognized and used by public/private stakeholders. The third, is one that I am hoping to get some reactions to from this group.

What's been apparent in speaking to staff from different agencies, is that we have developed more than one way across state government to address the mental health and substance use of children and adolescents, and if we are going to add or improve any elements of the behavioral health service array in RI, our efforts will be strengthened by assessing how all of the parts of our system make up a whole.

While there may be some traditional diagnosis-driven services that are traditionally referred to as "children's behavioral health services," for the purposes of our shared system mapping exercise and subsequent efforts to apply our collective impact to improve outcomes, I'd like to propose that this group use an expanded definition like the one here, as we discuss methods to improve outcomes from each of the touch points we have with children and families at each agency.

Secretary Roberts asked if there were any comments.

Brother Michael from Ocean Tides inquired about the youngsters in the DCYF Training School who may need prescriptions and medical coverage for behavioral issues who lose their coverage once they are released from the training school at the age of 18.

Jamia McDonald clarified that DCYF does not terminate children from its care at the age of 18, however, the department does not take in children who are over 18. Once the 18 year old is released from the Training School, they cannot stay in the care of DCYF, they would need to transition into adult care. Jamia added there are many children in DCYF care that are 18 and over who have been in DCYF care for several years that will also eventually transition into adult care.

Jamia added that DCYF has dual responsibilities; 1.) Abuse and Neglect; and 2.) Behavioral Health issues. A child may come in for one issue and be kept for another. We may remove a child for abuse and neglect and while the child could have some behavioral health issues; that is not the primary reason why the child is in our care. However, if that child is found to have those behavioral health issues, the department will assist in getting that child treatment. This conversation is so important, because there is no clear behavioral health system for a child.

Lisa Guillette from Foster Forward asked whether DCYF has served the purpose of servicing behavioral health issues through the voluntary system.

Jamia informed the group about a law called Voluntary Process, where a family could come to DCYF and say that their child's care has exceeded their ability and asks for help. Jamia stated that the family shouldn't have to come into DCYF custody to get behavioral health support, but that has been the only mechanism for it. What has happened is, the children come into DCYF to get that specific care, and then they are in a mixed world of children who are in our care for abuse and neglect, when they only have behavioral health issues.

Dacia referred back to the Children's Behavioral Health definition, stating it's important for everyone at the table as we are talking about mental health and substance use, where we do have a bit of a dual responsibility on both of those issues. There are a lot of different agencies playing a role in the current continuum we have which includes

some prevention and intervention strategies. This example of transition and gaps in services would be one of those examples of where we would want clear outcomes we would want to move towards shifting.

Acting Director Boss added that for children, substance use disorders and prevention treatment is in BHDDH where we have planning, funding and oversight of those programs, but only for the substance use disorder piece, not on the mental health side, which sometimes makes it difficult to coordinate those services. We've had opportunity to apply for grants that are moving us in this direction with the help of the Children's Cabinet. Looking at the Children's Behavioral Health Services definition, I would say you are looking at the continuum of care from prevention to in-patient psychiatric care. Supporting the continuum from early identification to outpatient based services which would include treatment and the community based social and emotional support that would support behavioral health.

Secretary Roberts added that in-patient hospitalization should also be included, which is also a significant issue.

Tanja Kubas-Meyer from the RI Coalition for Children and Families stated one perspective they would be anxious to see, is some responsibility taken for the 21 year old age group on the mental health side. That transition does not appear to happen very effectively. From another perspective, of an evaluation of a project they are doing with Rhode Island College on Trauma Informed Care, there are a lot of clinicians working in homeless shelters and they are seeing a lot of people who have been on their own since their late teens and they are not getting that transition into adult services because it is taking longer. In that respect, you might want to call that young adult behavioral health rather than children's behavioral health, but getting them transitioned to adult services by their early 20's is important.

Leanne Barrett from Kids Count suggested to have some recognition in the definition of parental mental health, maternal depression and the two generation treatment of the biological and environmental component that affects DCYF and a lot of other departments.

Brenda Amodei of BHDDH stated there is a lot of research now in the finding the lifespan of emerging adulthood, she suggested considering the age of 26 which is consistent with insurance and makes planning a lot more holistic when thinking about payment.

Sam Salganik of RI Parent Information Network inquired as to whether the definition is intended to also include school based services?

Dacia stated that community based, social/emotional supports could include that kind of interpretation. In the mapping process with RIDE, Medicaid and EOHHS agencies there are supports for social/emotional as well as school based mental health and other types of public programming in schools, so we could look to that as part of this definition, but if you feel it should be more concrete, we will add that recommendation for consideration.

Sam stated the he believes it is important in the continuum of care for children and he suggested that to be part of the mapping process.

Dr. William Hollingshead suggested that the numbers be taken out of the age definition and talk about a comprehensive definition that encompasses the whole issue across two generations.

Lisa Guillette stated that as we think about the abuse and neglect group, recognizing that there are some children in that group that have behavioral health issues and so many children in that group who also have permanency issues, that we keep a focus on the two generation strategy so that we have a robust family network for families.

Dacia stated that if anyone would like to add more recommendations for the definition piece, there is a comment box on the Children's Cabinet Website where they can all be collected in one place. Dacia continued with her presentation and stated that the mapping they are doing with ProvPlan allows us to see programs, services and grants across state agencies so we can have a sense of what types of programs and services that families are interacting with.

Just as aligning terms is critical to coordinated, outcome-driven action in this area, so is understanding how social and system issues currently the promotion of strong behavioral health outcomes for children and adolescents in RI. Last fall, we took one step toward uncovering the social and system issues impacting outcomes for children and adolescents through what has been referred to as the Truven Report – a report resulting from a study completed by Truven Health Analytics.

The report highlighted comparative findings related to risk and the prevalence of behavioral health conditions amongst children and families in Rhode Island.

> **Finding**: Children in RI face greater economic, social and familial risks for developing mental health and substance use disorders than children in other New England states and the nation.
>
> **Risks**
> - Unemployment is higher than in other NE states
> - More children live in single parent households
> - One in five children are poor
>
> **Immediate**
> - Higher rates of adverse childhood experiences
> - Subsequent Behavioral Health conditions (ADHD, major depression) than other states
>
> **Long-term**
> - Higher prevalence rate of disease
> - Higher rates of drug use & dependence

The report providing several recommendations to the state – some are purely operational, others are more related to system design and evaluation.

Below are the primary recommendations:

> **Recommendations**
> - Reduce Risks
> - Increase use of evidence-based, community-based prevention and intervention services.
> - Promote a population health approach to behavioral health care
>
> **Reduce Risks**
> - Reduce impact of parental mental health and addiction issues on infants and child development
> - Increase access and early responses
> - Increase supply of supports
>
> **Responsive Service Models**
> - Targeted responses to high rates of overdose
> - Increasing utilization of community based services
> - Expanding prevention and discharge supports
>
> **Population Health Approach**
> - Monitor the impact of behavioral health on population health outcomes to inform service delivery system

The entire children's cabinet plays a roll reducing risks identified through the Truven report. Together, the next sets of questions that we can ask ourselves relate to how well our continuum of services promote improved outcomes, and how we can expand, enhance or align our efforts to do so.

> **Reduce Risks**
> - -Real Jobs RI + WIOA
> - -NAS & ACE workgroups
> - -Home Visiting
> - -Early Intervention

- -First Connections
- -Getting to Kindergarten
- -SIM Child Psychiatry
- -DCYF Caseworker Expansion

Responsive Service Models
- -Governor's Overdose Task Force
- -Certified Community Behavioral Health Center Expansion
- -DCYF Outcome-Based Procurement
- -RIDE's Multi-Tiered Systems of In-School Support
- -DOH School-Based Behavioral Health

Population Health
- -SIM Interagency Population Health Planning
- -Cross Agency Service and Funding Mapping

These questions are informed by our Cabinet-led system mapping effort. To inform this process, we pulled a cross-agency staff team together earlier this summer. There, we developed a scope for the mapping exercise that allows us to look across agencies at all of the (expanded definition) services that the state current provides or facilitates to promote children's mental health and reduce substance abuse. We also mapped services across agencies, and the result is that we're doing a lot.

Key System Mapping Questions
- What programs and services do we provide?
  - Which populations do they reach?
  - What outcomes do they achieve?
- What grants and other funds do we utilize to shape and/or assess our overall system of supports?

Strategies:
- Convene Cross Agency Advisory Team
- Map services and grants across agencies

The next level review that we've asked of ProvPlan is to explore includes the: what, how much, for who, in what way, etc. While they do that, we also want to ask next phase questions related to the sufficiency of our service continuum, and how we can improve outcomes.

Next Phase Questions
- Are we satisfied with our current system of supports?
- How can we expand and improve our system of supports to improve child and adolescent outcomes?

Strategies:
- Stakeholder Input
  - SIM (payers + providers)
  - EOHHS TF (all 5 EOHHS agencies and community stakeholders)
  - CC Stakeholders (all 10 CC agencies and community stakeholders)

Before we open dialogue to the group, we've asked some of our constant partners in this work from Hasbro, RIPIN and PSN to share some insights for discussion.

Pat Flanagan from Hasbro could not join us today, however, she asked that her comments be shared:

> "As a provider, helping families navigate the "non system" of behavioral health services is daunting. By my reconning, there are childhood behavioral health services housed at DOH, RIDE, BDDH, DHS (Medicaid, and within Medicaid, MCO's put some services in their medical "bucket" and some in their behavioral health partners UBH and Beacon) and DCYF. Knowing who to send where for what services is difficult, addressing gaps in services is impossible.

> The way we have put high level services for severely emotionally disturbed children in DCYF can have traumatizing effect for families. The biggest problem with current silo'ed non-system is the lack of ability to think strategically about children's behavioral health needs and to build programs and services that recognize the needs of families and children and are responsive to the dynamics of their behavioral health issues."

Dacia commented that Dr. Flanagan's suggestions are pushing us to think about this outside of any one agency and about what outcomes we want to improve because we don't currently have the interventions as a state, that either the state could be working to push forward and/or our partners in the health coverage companies could be working with us to expand access and capacity.

Dacia asked Lisa Conlan Lewis from Parent Support Network to address the group.

Lisa Conlan Lewis presented background on the Parent Support Network stating its existence since the late 1980's representing children, youth and families on all levels of behavioral health needs. In the mid-1980's there was a national crisis where Rhode Island was sending 300 or more children to out of state placement for high-end residential services. When we think about our numbers now on how we are challenged by them, we can think about where we were. At that time children were treated as little adults, there weren't children systems. Then there was this trajectory that we needed to build children's services in the State of Rhode Island and through the early Childhood Adolescent Service System Program (CASSP) grants and SAMHSA grants, a behavioral health statewide system was established. DCYF at that time did have home and community based funding, but not close to the amount they really needed. If it weren't for the support of SAMHSA grants that were coming in, we probably wouldn't have been able to deliver the level of service and get innovative around home and community based services. From that point we built a behavioral health system that was built on the principles of the system of care. Shortly thereafter, things started to shift and managed care came in, which put tension on how many of those services fall under DCYF and the community; and how many started to fall under managed care health insurance plans. Also, at that time there was a lot of work going on such as looking at how we better support child welfare and the child family service review activities that were taking place and how to better coordinate between DCYF and DHS in regards to managed care. DCYF worked very hard with the communities and the providers to build the Children's Intensive Services Program, an intensive 6 month home and community based service that worked well for our families and started to reduce the level of children going into out-of-home placement. We started to then build more residential and group home opportunities here in the state.

In 2009-2010 major changes were taking place where all the home and community based service dollars that were under DCYF transferred over to InPlan, and became part of the health insurance plans to accessing those services. There was a decline in the intensity. The Children's Intensive Services Program that was 6 months long, then became known as the CAITS Program which was 6-8 weeks long. Also because of the child welfare challenges, and getting a good review around child and family services, there was a real need to up the focus on child welfare within DCYF, which also resulted in more focus towards the child welfare population and with the behavioral health services going InPlan, now there became a bigger reliance on the Voluntary Placement because there was a fragmentation of services. When those changes occurred and more focus went into child welfare, we saw the reemergence of a redesign within DCYF to a more at-risk support and intensive for those who were formally involved. Children's Behavioral Health started to flounder at that time, because there wasn't any one lead entity for it. DCYF may have been the authority/entity, but they didn't have any of the home and community based dollars to support it. It required a formal agreement with DCYF to get those dollars.

Currently, as family members are trying to access home and community based services through our health plans, if there are children with special health care needs that fit the CEDARS definition, we are jumping through that hoop and as we are exhausting both those supports, we are then turning to DCYF and requesting a Voluntary Process.

It becomes complicated when overlapping children's behavioral health with child welfare, because we are looking at this intergenerational issue. We focus just as much on the parent's health and well-being due to the serious intergenerational trauma, mental health and substance use challenges, many times finding themselves high risk or involved with DCYF, and that needs to happen before we can even assist them in navigating where the child needs to be.

As we begin to think about the solution of where we are going, we need to engage in a conversation that is going to bring all of the partners together, our health plans have to be part of this discussion, and we also need to look at population health because of the intergenerational issues that are involved. Having been involved in many of the department's strategic planning process, children's behavioral health rises to the top. At a time that we need the family and youth's voice the strongest, there have been so many changes in leadership, we are all re-educating everyone in the process, so being able to bring where we were 30 years ago, and how much the system has changed, it doesn't support the system we are in now. The solution in the discussion is, what would the ideal system look like and how do we get there in the continuum and population health focus. Lisa introduced Anatoly Burke, to speak from a young adult perspective who has not only engaged himself through mental health and substance use, but also helping other young adults navigate the system.

Anatoly stated he is from Philadelphia and his experience working through the mental health and substance issue was in Philadelphia. He stated that while working here in Rhode Island there are no detox or rehabilitation facilities for minors, and the problem is they are referred to psych wards, which is incredibly inappropriate, because medications are prescribed by psychiatrists are the number one cause of addiction and overdose. There are children going in needing detox and coming out with prescriptions and painkillers. Most of the people who have been involved with Substance Abuse Disorder were sexually abused as children, and it's very important that all services be age appropriate, and that all services be single sets. The need for these services is going up, and Rhode Island recently closed it's only detox for teenagers.

Lisa added that so many of the families talk about the strong practices they need such as multi-systemic therapy, and other types of evidence-based practices, and the challenge at this point is that in order to get that level of service and support you have to be formally involved with DCYF and the provider agencies. There is a real need to get those strong evidence-based practices down before you have to become formally involved with DCYF, which is a discussion of who helps own that and fund it?

Dacia thanked Lisa and stated that the mapping process not only maps services and type, but also maps dollars. Going back to Lisa's point, it is important to look at where our dollars are going across different payers, because that is one of the things we are talking about with regard to access. Having a good sense of our continuum goals are reflected of things people are providing in different places. Also in reference to Anatoly's point in regard to having age and gender appropriate options and whether they are sufficient, we can look back at that with a different lens during the mapping process.

Dacia asked Sam Salganik from RI Parent Information Network to address the group.

Sam Salganik gave background on the RI Parent Information Network, stating it is a 25 year old non-profit based in Rhode Island which mostly helps families navigate school systems to get access to special education for children with special needs as well as access to health insurance. All of their programs are based on care models, and staff are hired who have navigated these systems on behalf of themselves or loved ones. There are approximately 100 staff who assist parents navigate through the early intervention system, the CEDAR program working with kids on Medicaid and home-based services. A lot of the challenges we face are gaps between the disjointed systems, and the bar to get services is very high, and that the model is based on crisis intervention. You get a high level of services only after something awful has happened and that service is usually brief and then there is a gap. Sam gave an example of their clients, three-year old twins who had serious behavioral issues, aggressive behavior, biting and were kicked out of multiple daycares. They received some services through early intervention which ends at age three, this created a gap while they tried to get home-based services quickly. The boy climbed the kitchen counter, grabbed a knife and stabbed his sister, who is okay. Now this sets a course for the boy to go in-patient, going to Bradly Hospital for a few days due to the serious incident, when he comes out there are extensive out-patient services provided with clinicians coming to the home, but ends in about six weeks. The waitlist to get into Home Based Therapeutic Services through Medicaid is approximately 9 months creating another gap. Sam stated that he has seen this high bar to get services in the young adult areas as well, with a young man attending CCRI who was addicted to heroin. His parents intervened by taking him to class, taking his credit cards, and cell phone, but then realized his dealer was meeting him at school and going to his house in the middle of the night. The parents sent him to a rehabilitation program in Florida and it was successful, however, he was commercially insured

and the insurance company won't pay for it. Sam stated that based on his experience a case like his wouldn't win because he was successful with the rehabilitation, whereas cases that he did win, there had been suicide attempts, multiple relapses and multiple failures. The young man was clean for about a year and is now using again, unfortunately the parents can't afford to send him for rehabilitation again with the cost being $15,000 - $20,000. Sam stated there are some programs like CEDARS that can help families navigate these situations and other programs that work but he doesn't believe that these sort of navigation programs have a huge systemic impact. Sam has heard a lot of debate whether it's a lack of access to services; whether it's about providers that do not have enough capacity or whether it's about funding mechanisms and why the carriers won't pay for it. If we are relying on health insurance companies, we have to remember that behavioral health care needs are expensive, and if your insurance company, you don't want to spend that money, but they are also a powerful predictor of other healthcare costs that people will have. When looking across the Medicaid board, the highest utilizers of healthcare services, often have behavioral health needs. If you raise the bar for everyone, that is an example of where a coordinated regulatory purchase can actually have a real impact.

Rebecca Boss added that in recent years we have had two of our primary adolescent residential treatment programs close or merge and become much smaller, not because of lack of funding, but rather for lack of referrals. We don't believe there is a lack of need, and it's really difficult to understand how these things fit together because we are not seeing the numbers referred to the programs we've had in-state.

Secretary Roberts stated that in addition to the discussion about access and insurance, she is interested in talking about what is considered the high-quality evidence based approach. There are some states that don't pay for residential substance use treatment at all, it's not a covered benefit because they don't think it's a high-quality service in this dynamic. It is going to be really important to think about what works and what is the service we should be supporting.

Linda Mendonsa a part-time consultant at the Department of Health and a practicing school nurse for 22 years the last 15 years here in Rhode Island stated that recently at DOH the question was posed to her of what she sees as the most pressing issue around school health. Linda reported that mental health and behavioral health were the two that immediately came to mind. Over the last five years, especially in the last year in speaking with colleagues, there has been an increase of students in their office with mental health issues, whether its anxiety due to society issues, environment, social media. We've always had students with diagnosis of depression, eating disorders, PTSD, but anxiety has become more prevalent from mild to severe. Anecdotally, about 70 percent of the students that come in to her office on a daily basis have some type of psycho-sematic complaint, whether it was a headache, or stomachache which could be a result of anxiety over exams, or bullying, and it takes some time to peel back the layers to see what is really going on with that child. On a positive note, school nurses do have the skills to counsel and try to understand what is happening with the student, but one of the challenges is that we do not have enough support services/staff in the school building or enough referral places. I do see school nursing as part of community health and it's important to recognize that.

Director Jensen asked how many school nurses are deployed in the state.

Linda stated there are approximately 300 school nurses between the public and private/parochial schools. Linda added that in Rhode Island does have a good ratio of school nurses to school buildings compared nationally.

Dr. Alexander Scott stated that one of the things they have discussed is the connection with the counselors or social workers who are in the school to work on strengthening the relationships between the behavioral specialists and the school nurses.

Dr. Elizabeth Lowenhaupt representing the Rhode Island Council for Child Mental Health and Psychiatry wanted to highlight that we have a wealth of child psychiatry and psychology resources in Rhode Island, and encouraged the cabinet to include them as well as the pediatricians as they work through mapping the new system.

Trisha Suggs of BHDDH stated that they are working on a two year planning grant through SAMHSA for substance treatment for youth and young adults split between 12-17 and 18–25 years of age. They are currently working on financial mapping, workforce development plan, and policy planning to come up with a new system for

youth and young adults. The SAMHSA grant, however, will not allow for residential programming. SAMHSA believes if you make the system more robust, you won't need to rely on residential programming.

Commissioner Wagner inquired as to what is on the table and how we are going to reimagine the services moving forward.

Secretary Roberts stated that what is on the table, is what do we need? Rather than putting governance first, and the absence of knowing what we want. The question is, what do we have, what do we want, and how do we govern and fund what we want. Right now we are being driven too much by the funding and statutory provisions of what has grown over the last fifty years.

Commissioner Wagner questioned whether it was our goal to fix the existing system or build a whole new system, while the existing system continues to provide services. The Commissioner suggested that we can start with use cases, who are we trying to serve, what are the uses cases and how do we build a system around it.

Dacia Read stated that the Truven Report has outlined our risks, we understand those as well as understanding transition issues through our mapping. Next we will want to extrapolate from there, and may want to look at outcomes specific for adolescents experiencing substance use disorder and determine if there are targeted strategies that we want for that population.

Director Jensen stated that his department is currently doing the same exercise in the workforce system, with the same problems, and proposed that we did something along the lines of the Lean methodology. With the funding streams that we have, if there is a review of how our financial staff are thinking about rules around those funding streams, we could most likely expand them.

Dacia stated that we need to think through what outcomes we are looking for and what strategies to utilize for each target area.

Commissioner Wagner gave the group background on the Lean methodology which tries to reduce steps in the workflow, sometimes it's warranted and sometimes you just eliminate something rather than worrying about steps.

Brother Michael from Tides Family Services stated that in regard to the DCYF children who are going through job training they are more likely not to meet the expected goals. At some point during the discussions we need to have an override for the DCYF children and families, particularly the ones who have a history of being involved, and treat them differently and assist them to overcome the obstacles to succeed.

Director Jensen concurred with Brother Michael.

Tanja Kubas-Meyer from the RI Coalition for Children and Families stated that from the point of view of providers, we have an extensive network of private non-profit organizations that do provide most of the services sought. The expectation that a private non-profit would typically have very low administrative overhead can braid together all the necessary funding streams to provide good capacity at all levels is a hard one for the coalition/providers, and it would be helpful if some of that help was coming from the other end. Despite the importance of the emphasis on evidence-based treatment, at the community level there needs to be grout between the tiles of those evidence-based services and how is the grout funded? There has to be other coordination efforts that are derived between those services.

Director Jensen added that if you can effectively find the right way to braid money, you can fund with a very modest investment gap.

Commissioner Wagner stated it's a networking issue and a complicated system, but structures can be set up so movement through the system is much simpler because people know how to make those connections.

Dacia stated it can be accomplished by starting to align our terms so we are all on the same page in the same conversation of what makes the network flow.

Brenda Amodei from BHDDH suggested that early intervention and prevention should also be part of the conversation. It is important to add prevention to that layer of how the systems can work together and do it across the continuum and not try to put out those treatment fires when a family is in crisis.

Dacia stated that in the next two months we will have the report from ProvPlan of the mapping process, and that will answer some of our questions and allow us to see where we need to align our interventions.

Secretary Roberts asked if there were any further public comment. There was none.

- **Adjournment**:

Secretary Roberts stated the next Children's Cabinet meeting will be held on Monday, September 26th. The Secretary thanked everyone for attending and asked for a motion to adjourn. Director Jensen made a motion to adjourn, Jamia McDonald seconded. All were in favor, 0 opposed. The meeting adjourned at 11:30 a.m.