Meeting date, time and location: 6.23, 3pm, videoconference

Meeting facilitators and presenters: Susan Lindberg, Kayla David

Attendees: Kyle Edward (NHPRI, Behavioral Health Manager), Colleen Judge (Director-School Based Services, RI Student Assistance Services), Shannon Ciccone (Perspectives Corporation - Clinical Director), Sarah Kelly-Palmer (VP @ FSRI), Maayan Rosenfield (EOHHS intern), Marti Rosenberg (EOHHS), Jacqueline Ferreira (Trudeau, Early Intervention Program Director), Marcia Tryon (Newport Mental Health- Manager of Children and Family Services), Jessica Clark (Asst Director Outpatient, St Marys Home for Children), Jason Lanzillo (Director of Children Services - Frank Olean Center), James DiNunzio (Director of Behavioral Health for NHPRI), Kathleen Donise, MD (Director Lifespan Pediatric Behavioral Health Emerg Svc), Melissa Worcester (Executive Director of BH – Optum), Jim Simon (LICSW, Senior Director, Perspectives Deaf & Hard of Hearing Services), Laura Scussel (Program Manager of Youth and Family services at Thrive Behavioral Health), Andrea Chait (CEO, Momentum), Maria Terrero-kamara (RI Department of Children Youth and Families, Clinical Social Worker), Emily Matthews (LMHC Clinical Supervisor, Trauma Response Team at FSRI), Susan Duffy, MD (Hasbro CH ED), Fernando(Fred) Barbosa (Senior Director of Residential services and Foster Care at Child and Family services), Kayla David (LMFT FSRI), Margaret Holland McDuff (CEO FSRI), Cindy M. Gordon (LICSW, Newport Mental Health), Nicole Saunders (LMHC), Tina Spears (CPNRI)

Topic	**Leader**	**Content**
Introductions and review of last time	Susan Lindberg	• Introduce Kayla David, new co-chair • Susan Lindberg: 7 workgroups exist, gives some context – we're in a four month sprint to create a deliverable to take advantage of funding opportunities. • One of the main things we're missing in RI is mobile crisis - one of the keys to crisis response outlined by SAMHSA. We're also missing prevention, were much more reactive. Kayla David: Last time we broke out into groups and identified gaps. Gaps include: capacity (lack of physicians), gaps in available programs depending on insurance, reimbursement, not leaving open spots because don't get paid for that, not appropriately using the services we have, lack of communication around EHS, tough relationships with insurance companies • Needs: statewide no wrong door, SPoA, lack of beds – need to expand workforce and also many beds being used longterm because not needed • (See slides) - reviewed what else is happening in the state and federally on this issue (e.g. Unite Us platform for social and health services all in one), EOHHS MCO procurement o Federal: 988 single number for all behavioral health emergencies

		• ARPA: allowing states for 85% matching for development of mobile crisis intervention, want firehouse ability to be dispatched and go to any crisis at any moment (24/7) - 4 standards:
		  ○ Has at least one BH professional and one other professional (must be team)
		  ○ Screening, assessment, stabilization, de-escalation, coordination
		  ○ Trained in trauma-informed de-escalation
		  ○ Maintaining connections with community providers
		• Review of other practices and models (see slides), need to think about the role of police, might make some communities uncomfortable
		• Kayla David: Best practices of mobile response and stabilization services (specifically thinking about kids) (see slides for details): Might look different for youth crises from adult crisis, gatekeeper model (unite us), best practice of rapidly accessing any environment - if can rapidly respond and connect with services, de-escalate and stabilize --> less hospital and ER, potentially standardized screening. Challenge is relies on strong workforce. Need funding for follow-up, use downtime to coordinate with existing providers, thinking about how to fund this. Ideally using strengths of family, natural support structures. Think about geographic gaps, make sure universal access, also equity and culture lens

Group discussion: what do we already have, where are gaps/what do we need	Susan Lindberg	• Start with what Tides is doing and increasing capacity • Jenna Chaplin (from Tides): second year of mobile crisis team, Hasbro been major referral source, successful in first year but slow in second year from staffing, trying to go from 24 hours to within 1 hour staff show up (avg was a little over 24 hours), schools would call, goal to close out cases within 30 day window and average has been 46 days. Some kids need full in person, but haven't been able to get. Blue cross has been barrier. Trouble finding placement, couldn't close out. • Laura Scussel: troubles with staffing involve what's happening everywhere – struggle to get patients in to handoff service that they need. Statewide, but have trouble going statewide, don't have compensation. • Susan repeating back to clarify about Tides: CCBHC grant funding, statewide, capacity to serve 75 children/year, maybe need to go a little more local • Jenna Caplin: Need separate programs at times - clinicians working in PFN, FFS, etc and mobile crisis

		teams – need separate team and enhanced rates in order to support staff necessary to do that. Not much traction even after posting with high salary. • Susan: Need enhanced rates to help. The 85% matching is to support the enhanced rates of payment and past those three years hopefully fund with savings from ER • Kayla David: provide emergency assessments (now telehealth, before in office – not mobile), holding them longer in this program because not able to connect them. Have behavioral health professionals providing victim services, riding with police. • Sarah Kelly: victim of crime act lead to kick-off of this program, now respond to behavioral health crises because not many other options but their real purpose is to provide support to child victims or viewers of a traumatic crime. A lot of trouble to get and maintain funding especially for clinicians. Lots of time this year spent trying to find money to sustain the program. 16 schools throughout PVD refer to them. Outpatient clinicans have huge caseload, hard because not funded to have firehouse model because of FFS. Right now with a grant looking at alternatives to police for behavioral crisis. Child or adult. • Nicole Sauders: clinicans that ride with police (funded by towns), part of emergency services. Tough to maintain services. Tracked and kept kids out of hospitals. From call to face-to-face usually within several hours of initial call, faster if TPC clients (already have someone on the case). 24/7 for TPC, work for kids and adults. Mostly phone support but some mobile, and staff in hospital. • Sarah Kelly Palmer: Have victim advocate that works with state police, but not designed as behavioral health response. More for traumatic event. Only half-time position funded by BOCA (which is being cut). FSRI applied for CCB expansion grant, focused on children's mobile crisis team in providence. If grant comes through partnering with Providence center. • Laura Scussel: From Thrive in collaboration with Tides. Do go out, but program is not considered mobile crisis, but EOS hotline. Potentially have ability to go out but not what they do now. • Susan Lindberg: Anyone from Gateway? • Henry Sachs: Gateway has home based treatments (CFTL) but not mobile crisis. • Margaret McDuff's: Something with police in South County

		• Sarah Kelly: Hez in South county did CIT training program with police there - mental health trainings with law enforcement officials so that better equipped when responding to scene with behavioral health crisis. • Susan Lindberg: all of these are grant-funded, which is the problem • Laura Scussel: to pay for immediate availability (which requires downtime) is really hard to fund • Susan Lindberg: Mobile crisis team serves medicaid populations, but also trying to legislate that commercial insurance companies would pay for that, and also serve uninsured • Cindy Gordon: from MA, worked on creating this in MA, Medicaid and uninsured were on it, and private insurance would all pay for initial evaluation (up to a week), but after that insurance might not pay for longterm stabilization • Susan Lindberg: Connecticut has good mobile crisis – respond within under an hour, able to work up to 6 weeks. I would advocate for this to last longer. Wants to learn more about MA and CT and what they're doing. • Marcia Tryon: worked a lot on providing services in MA, wraparound model – family dictated what services wanted and driven by family's desires. Got to also chose which provider provided the services. • Susan Lindberg: Reveals reality that there's not a lot out there. We need to build up from the ground. What do we really need to start focusing on – need to narrow down. Dependent on workforce. • Fred Barbosa: Child and family stabilization program has traditionally been focused on DCYF children – working on reunification efforts. However, majority of recent referrals have been BH, trying to maintain stability for kids at home who've been in hospital with BH crises. • Susan Lindberg: we know we need the mobile crisis but if don't have good programs to hand off to, will have cycle.
Action items		• Susan may reach out to hear more from some of the people in the meeting • Will send out powerpoint 6.24 • Volunteer if you want to be a leader
Chat		Marti Rosenberg: The SAMHSA grant would start at the end of August - August 31st I think. Susan Duffy (3:37 PM): incorporate pediatricians into network for follow up care, many now have care coordination in

		practices and often know families, can be helpful with med adjustment especially with pedi PRN help Kayla David (she/her) (3:38 PM): Yes Susan such a good point thank you! Margaret H McDuff's (she/her) (3:42 PM): Yes susan! Nicole Saunders (3:47 PM): TPC does CFIT, but it's a pilot program with BCBS that is different then the old CFIT 6 hours