August 1, 2019

Rhode Island Community-Academic Partnership for Behavioral Health

Draft Agenda for Stakeholder-Engaged Research

The Rhode Island Community-Academic Partnership for Behavioral Health (RICAP) is a collaboration between Brown University and the Substance use and Mental Health Leadership Council of Rhode Island. Additional participants include the Mental Health Association of Rhode Island, National Alliance on Mental Illness -- Rhode Island, RICARES (the statewide association of recovery communities), and Oasis Wellness and Recovery Center. RICAP engages people with lived experience of mental health and substance use disorders, behavioral health agencies and providers, academic investigators, and other stakeholders, in an ongoing, structured partnership.

Under the direction of our Steering Committee, which includes representatives from all of the partner organizations and other public and private agencies, we have sponsored three symposia with from 35 to 50 participants each. The first, an overview of Rhode Island's behavioral health system, enabled people from all relevant sectors to learn from each other about the resources available for behavioral health in the state, and some of their limitations. The second featured voices of people with lived experience of mental health and substance use disorders. Their honest and moving stories were the basis for the conceptual organization of our third symposium, which featured small group discussions to generate priority topics for stakeholder engaged research. The bulleted items under each topic headline were intended to be suggestive, not exclusive.

1. Timely diagnosis and prevention

Facilitator: Ron Seifer

* Differences and overlap between SUD and mental illness
* Identification of affected/at risk students in schools and appropriate responses
* Primary Care
* Community based programs
* Military

2. Families of children, adolescents and adults

 Facilitator: Christine Brown

* Differences in family involvement in SUD and mental illness
* How to support families affected by behavioral health problems
* How to positively engage families of people living with behavioral health issues

3. Co-occurring SUD and other mental disorders

 Facilitator: James McNulty

* Concepts of recovery for people with co-occurring disorders
* Integrated vs. parallel treatment
* Clinical settings, site and system level issues

4. Recovery pathways

 Facilitator: Stephen Gumbley

* Definition/conception of recovery for SUD vs. mental illness
* Natural history of illness and recovery
* Non-abstinent recovery
* Differences in severity
* Agency and choice; how to design programs to give people captaincy in their own recovery

5. Criminal Justice

 Facilitator: Mavis Nimoh

* Diversion (pre vs. post-arrest), alternative sentencing
* Juvenile justice system, disproportionate minority contact, diversion, positive resources
* Management and treatment within correctional institutions
* Re-entry

This report summarizes the results of these discussions. We will now work to match investigators with community partners to develop specific research proposals. The five topic areas are by no means mutually exclusive. They overlap in many ways, and several overarching themes emerged as well. Studies therefore may draw on ideas from more than one group. This summary includes cross-referencing among the discussion groups, indicated by letters.

**A**=Service integration/collaboration

**B**=Information and Referral Resources

**C**=Access barriers including payment systems

**D**=Peer support models

**E**=Person and family-centered care/services

**F**=Stigma – person level (internalized); provider level; community level

**G**= Integrated information systems

**H**=Social determinants

**Group 1: Timely diagnosis and prevention**

1. Early identification of children who are showing behavioral issues that may indicate behavioral health needs, and promoting access to a spectrum of care settings.

* Natural points of contact
	+ Schools vary in competence and capacity to identify problems and link to appropriate services.
	+ Other potential points of contact include pre-school, youth programs (e.g. Boys and Girls Clubs), faith-based youth groups, sports programs, libraries.
* Linking children and families to appropriate level of services
	+ What are good paradigms for individuals who don’t respond to first-line treatment modalities?
	+ Disruptive behaviors – Should they be addressed at an early age? What are the processes that can be put into place for children nor responding to natural inhibitors of disruptive behaviors?
	+ Integration/collaboration across agencies (schools, behavioral health and health care providers, community-based youth programs) **A**

2. How can students, families and teachers find out about and link to available resources in the community

* Communication mechanisms, referral resources – expand BHLink to families of children **B**
* Access barriers **C**
	+ Insurance
	+ Work force shortage
	+ Geography
* Family peer support models **D**
* Support and quality monitoring to navigate transitions

3: How to promote flexibility and development of patient-centered care.

* Trauma- informed, culturally competent, sexuality competent and person centered care **E**
* How to better integrate in the traditional and non-traditional settings
* Family centered care models
* Childhood illnesses (i.e., cutting, suicide, etc.)
* Barriers to access (setting specific, insurers, etc.) **C**
* Disconnect between leadership and front line staff

**Group 2: Families of Children, Adolescents, and Adults**

1. Challenges and stressors for families of adult children and adolescents with BHD

* Stigma – families blocked by providers **F**
	+ Families are called “toxic”
	+ Families accused of “enabling,” need guidance and support in knowing how to balance nurturing and support with limit setting
* Family members feel fear, frustration and guilt **E**
	+ Family perspective/voice in treatment and services is not heard
		- Heterogeneity of treatment effect – not one solution for all
	+ Treatment is of individuals, does not address family unit
* Accessibility of programs and resources **C**
	+ Payment systems do not support family-oriented services
	+ Resources difficult to find and navigate
* Family support for transitions, turning 21
* Family systems issues
* Generational transmission
* Effect on siblings
* Families grow together, evolve over time

2. Possible Solutions/Interventions

* Family peer support (Resources, Education and Support Together; Family Task Force) **D**
* Workforce development, train and credential family peer support specialists
* Payment reform to provide resources
* Evidence-based supports and practices
	+ “Conscious discipline,” mindfulness
	+ Community reinforcement and family training
	+ Techniques to address problem behavior
* Interventions to address stigma **F**
* Among providers
* Among school personnel
* At the community level (e.g. social marketing campaigns)
* Legal support for families
* Develop cross-system information system for ascertainment and monitoring: schools, clinical, police **G**

**Group 3: Co-occurring SUD and other mental disorders**

1. Social determinants, prevention, early detection and access to services **H**

* What are the “upstream causes”?
	+ Early identification of unmet social needs and subsequent tailored intervention that address SDoH
	+ Underinvestment in social services that address the broader determinants of health
	+ Is there research on correlation between funding of interventions to specifically address SDoH and outcomes
	+ How can Health Equity Zones (HEZ’s) be leveraged to transform practice?
	+ What have we learned about community engagement/ownership and sustainable adoption of promising practices?
* PCP not asking questions about MH or SUD routinely enough? Would they feel efficacious in addressing needs identified from screening?
	+ Are there particular practices in Rhode Island that are doing a good job with this?

2. Barriers to developing integrated approaches to treatment

* Stigma **F**
	+ Internal and internalized
	+ What is the role of organization culture in mitigating or ameliorating stigma
* Patient – Provider communication **E**
	+ Common language to articulate “what is going on”. Particularly in a primary care setting.
* Integration of behavioral and physical health **A**
	+ Data informing best practices
	+ What are the funding restraints and associated costs
	+ What is the role of specialty practices?
	+ To what extent is patient involved in choosing treatment? How is consumer agency being supported?
* Core 4-6 interventions to deploy when someone presents with co-occurring disorders
	+ Common framework?
	+ How do we effectively operationalize a “no wrong door” approach?
* Effectiveness of EBP’s across MH and SUD
	+ Comparative effectiveness across modality
	+ To what extent are particular approaches effective in each domain?

**Group 4: Recovery Pathways**

1. Person-centered care **E**

* Metrics in Recovery -- How do we define success/effectiveness?
* How is severity related to delivery of care?
	+ Unassisted Recovery: how to support
	+ Social capital
	+ Behavioral activation
	+ Motivation and personal agency
	+ Transition from assisted care to unassisted
	+ Gaps during transition
* What are perceived barriers to patient-centered care from providers and patients?
	+ Who’s in charge? “Adherence” vs. collaboration
	+ Provider stigma and internalized stigma **F**
	+ Recovery capital 🡪 measuring assets and managing vulnerability
* Problem Solving in Recovery
	+ Proximal Goals
* Workforce training
	+ Better training to develop skills (ex. motivational interviews)
	+ Changing attitude of interventionists
* What are the barriers to including tobacco in Recovery process?

2. Care/service modalities

* Peer support **D**
	+ What is the state of peer support in Rhode Island?
	+ Is it effective?
	+ CER of stand-alone vs. part of a larger health institution Workforce development
	+ Once trained, how are peer recovery specialists monitored/evaluated?
	+ Interaction outside of the 12-step format
		- Model such as Mutual Aid
* Assessment of patients
	+ Effectiveness of targeted care
* Homelessness 🡪 Barriers to accessing care **H**
	+ Housing first model
* Systems Change **C**
	+ Reimbursement method
	+ Social determinants (environment) **H**

**Group 5: Criminal Justice**

1. Outcome metrics and data

* Recidivism vs. more holistic outcome metrics
* “Super” users’ demographics (MA) and interventions across CJ involvement
* MAT outcomes following release
* Data & technology **G**
	+ Collection
	+ Analysis
	+ Reporting
	+ Stakeholder Engagement
	+ RIDOC, DHS, EOHHS integration
	+ EHR and Current Care

2. Policies and Practices

* Intersectional Criminalization **H**
	+ Homelessness
	+ Open container reform
	+ Felony records and Employment
	+ Civil Fines and Bail
	+ ACI re-traumatization
	+ Racial/ethnic disparities in prosecution/sentencing
	+ Probation/parole success or failure
	+ Intake success or failure – RIDOC Intake Service Center not connecting inmates with care or with care team in community
	+ Disenfranchisement
* Juvenile -> ACI pipeline
* Diversion and alternative sentencing
	+ Outcomes
	+ conditions
	+ care personnel
	+ probation over-reliance
	+ stakeholder representation
* State vs. Local police power, Branches of government and over-coordination: problem of implementing consistent diversion or decriminalization policies
* Evaluation of Inmate Exclusion Waiver
* Rehabilitative services **E**
	+ Care personnel: CHW, PRS, Clinician – both a recovery and a treatment lens should be included
	+ Affordable housing
	+ Expungement
* Families with CJ involvement
	+ Reunification/Separation