State Advisory Council Minutes
Monday, June 2, 2014

Members
Elizabeth Cannata, Claudia Carbonari, MD, Kelly Cronin, Donna Grant, Patricia Lorenson, Regina Moller, Regina Roundtree, Susan Sherrick

Also in Attendance:
Commissioner Joette Katz, Susan Smith, Elizabeth Duryea, Mary Painter

Absent
Janice Andersen (excused), Dino Depina, Jaquelyn Farrell, Ivy Farinella, Samantha Pahde,

Welcome & Introductions Patricia Lorenson

DCF Substance Abuse Service & Domestic Violence Initiatives Mary Painter

The DCF Substance Abuse Team Organization Structure and *the Substance Abuse & Family Violence Services* grid was distributed. (Attached to the minutes)
Mary Painter, Director of Substance Abuse and Domestic Violence presented an overview of what DCF is doing related to substance abuse and domestic violence.

At a recent listening forum for Public Act 13-178 and in discussion about substance abuse, Ms. Painter realized that people are not aware of the host adolescent substance abuse services that DCF offers. As a result, the unit is gathering and designing informational material about adolescent substance abuse (similar to some of the suicide prevention material) to be made available to the public.

The focus of the unit is to have a strong infrastructure of training and substance abuse consultants within the department.
- All the DCF regions (fourteen area offices) have substance abuse specialist, domestic violence specialist, and nursing staff available. This format follows the internal structure the department has established for mental health specialists. The CPS workers (who cannot be experts in all of these fields) now have a place to go.
-Assure that people understand the current drug trends of prescription drug abuse and heroine. Care giving parents have received training regarding prescription drug abuse, heroine and methadone.
-Recently have changed and up-graded our drug screening options for care givers who go through Project Safe so there are more opiates covered in the panel which now includes benzodiazepines.
-Work is being done on policy issues related to these drug trends. The department is looking to change the protocol for committed kids who end up on opiates to make it similar to the process used for kids who end up on psychotropic medications.
-Relating to adolescent substance abuse- CT has a large Evidence Based Service system that has evolved over the years, beginning with Peter Panzarella 20 years ago
-Multi-Systemic Therapy--CT has the largest amount of teams collectively in the country. Even if the statistic has changed, we certainly have the most adaptations.
-Families Integrated Transitions-kids coming out of JJ system back into the community,
-Transition Age Youth MST-for older adolescents involved with juvenile or criminal justice system
-Problem Sexual Behavior MST - we are the only statewide continuum of this service
-Building Stronger Families- for care givers who have kids age 6 – 17,
-Multi Dimensional Family Therapy- which is the largest set of teams internationally (according the model developer)
-Just introduced is ACRA ACC (Adolescent Community Reinforcement Approach -Assertive Continuing Care) a hybrid of clinic-based and community family-based services. It targets the low to moderate substance using kids and even some of the higher end kids as they transition out of MST and MDFT but still

need services. That really completes the continuum for the community and home based services. This was just rolled that out last year. It is in five regions and we are working in a partnership with CSSD (Court Support Services Division) to add a sixth region.
-We have been very successful sharing services and sharing all the QA costs with CSSD.

-In response to a question about availability to give an overview for the region to talk substance abuse. Mary Painter suggested our Substance Abuse Specialist in the regions are available to speak and she will assure that SAC get connected with them.

-Response to Commissioner's question as to what the capacity is going to be in each of these services.
-The capacities of adolescent services are holding steady. Have not done an expansion of MST, MDFT.
-ACRA ACC (Adolescent Community Reinforcement Approach Assertive Continuing Care), (which is not listed in the attachment and needs to be added) is similar to the capacity we had for ASA (Adolescent Substance Abuse). (ACRA ACC is now in place of ASAD out patient. It is a family based model and provides family services, couple services, and individual services. It's a hybrid of clinic based and home based work. It is the job of the agency and the provider to engage that family and get out to see them.)
-In terms of our utilization, this is a fairly good setup. We don't have a lot of wait list, which makes it possible to change the distribution of where our teams are to meet underutilization and overutilization.

-In response to Regina Roundtree and the way the drug use is trending: kids are using more prescription drugs, the level of severity that they are going to reach with those kinds of substances is going to be quicker and more severe and they will need a higher level of care. The kids have always been there, the drug trends are changing, they need services quicker and more intensively. We have gotten better at identifying what we need in screening.
-In addition, we are not doing a much more expansion because CSSD is doing a lot of expansion with this and they are adding MST teams, a couple of MDFT programs based on their need.

-Relating to connecting services with the community that is trying to connect families to these services, Ms. Painter will be meeting with the statewide work group of methadone providers in July in order to bridge our relationship with them. It was noted that part of the problem is that the folks running the methadone clinics are trying to keep a low profile in the community due to lack of community acceptance for the service. A public relations campaign in the community is necessary.
-Responding to what regions are having more utilization or wait list. Mary Painter stated that it is divided by region but it is not necessarily due to the trends there but rather it happens if there is a staffing issue. For example, if there is a transition in one of the teams and they are short staffed and we can't bring those families in then they end up on a wait list.
-In response to Ms. Roundtree, currently we cannot identify prescription drug used by parts of the state.
-Donna Grant asked what systems we have in place to collect the data on issues around substance abuse- by drug type and by cohort. Is it the kids, the parents? In the northeast we have an incredible surge in the heroine issues particularly the adults, which ultimately leads to parenting issues the kids. It is really hard to find a partner to get the data on that to bring the services to address that. We know we have more kids being born addicted, more babies on methadone at birth. We are the region that just had a fatality (not DCF involved) for a child left alone while mom was getting methadone. The family is doing things right- dad is at work, mom is dealing with her sobriety-making bad choices about how to access those services when they are living oppressed with no income to hire a babysitter. The two-year old is a fatality from being left alone and accidently choking. Just a week ago we found out that methadone services are available in Putnam- the hospital did not know it, one of the most active service providers did not know it. How can we connect what is on this paper better with the community that is trying to connect families to these services.
Mary Painter agreed and stated that that is what has come up in the community forums. We are starting with getting marketing informational material out into the community which outlines what is available and where.
DCF being more involved at the local level-we would be glad to involve our Substance Abuse Specialist as well.

Mary Painter will be meeting with the statewide methadone work group in July because we have found similar stories to happening and we need to bridge our relationship with them.
-Donna Grant further noted that part of the problem may be that the folks running the methadone clinics are trying to keep a low profile in the community. They recognize that there is not a lot of community acceptance for this service and are not letting people know it is available. So those who should know are not even aware that it is there and problem continues to grow. Public relations is necessary in the community.

-Concern was expressed with the increase of CON applications and the many private providers (some for-profit) opening adolescent outpatient clinics and how is that connecting to what the department is doing. The concern is that there are no evidence-based models and clinics are opening because they know there is need and profit for them. This particular one is located in Old Saybrook.
-Ms. Painter noted that they have to obtain their license through DCF. The department recently met with the Newport Academy which is a for-profit program. We worked with them to negotiate a rate and capacity to take some of our children. We've done that on a couple of occasions and it has worked well. Most of them are committed philosophically to treating all children- which facilitates working something out.
-GAIN (Global Appraisal of Individual Needs) is the data we use to collect the data from all of our providers which gives us good information from the adolescents, in part because it is self-report. It is very useful, because they say what they are doing versus the clinician's perception of what they are doing. The target population is all of our contracted adolescent providers that provide adolescent services. Because they are contracted through the department we are still only focusing on DCF involved youth.
-Additional data is also received through the National Data Collection on High-risk Behavior that goes out to the high schools. It is received annually and contains a lot of information about what kids are doing. It has held consistent over the years with primary abuse being alcohol and marijuana. The prescription drug use is trending up slowly.
-With many of these programs- the grant funding allows for kids in the community not necessarily DCF involved to receive these services. So they have to meet a level of need but they don't have to have department involvement.

-Back to meeting need: Part of the reason we introduced ACRA ACC was because we know there are kids out there that are low and moderate risk users. We don't know the volume (except from the National Data Collection material that we receive which is given by state). But we know they are out there and we trying to build that into the service delivery system. They don't emerge suddenly at the MDFT or MST level of care, needing a higher end service for substance abuse.
ACRA is open to all kids in the community. The idea of the model is that it is the job of the providers to find them and engage the kids. They need to go to the school, build up their community referral base on their own based on the community.
We do see kids in our system who have commercial insurance using our system which is a topic for another day.
-There is a comprehensive list of contracted providers for services- Ms. Painter will make it available to SAC.

Responding to Commissioner's inquiry re: ACRA-
-ACRA is serving the same communities of Bridgeport, Middletown Milford, New Haven, Norwich, Waterbury, Willimantic, except New Britain & Meriden (Region 6). We are working with CSSD to add a team to Region 6 soon.

Commissioner inquired about MDFT services not listed for Region 3 nor Region 6.
-Mary Painter responded that what happens with MDFT and MST is that where there are any gaps with one of them the other is available. There are very similar with a slightly different philosophy for example MST's entirely family based and doesn't do work with the individual and the MDFT holds individual sessions with the adolescent. There are some philosophical differences but what is similar is that its intensive home base therapy-they are in the home three days a week working with the family. So if an area does not have one they do have the other.

-Commissioner Katz reviewed which office do not have MST:
Region 1-Bridgeport is covered, not Norwalk
Region 4-Hartford covered, not Manchester,
Region 2-New Haven covered, not Milford
Region 3-Willimantic and Norwich not Middletown.
Region 5 just Waterbury-not Torrington or Danbury.
And Region 6 –New Britain but not Meriden.

-Correction to entry in Organizational Structure report: New Hope Manor is defunct.

-Extensive discussion was carried regarding under estimates noted in the data.
The state data citing "4.6% of high school aged youth who have tried prescription drugs" is a great under estimate.
The national statistics report that 4 – 7% of kids engaging in high-risk behavior also is not reflecting the trend accurately.
Our GAIN data is around that number, not showing higher yet— Dr. Painter agreed with Dr. Carbonari that there are more kids using it (prescription drugs) and the progression for them is rapid. We have to be able to catch them early on and we are looking to the ACRA ACC model to will help with that. If they start engaging in treatment earlier on with the ACRA level of care, then we may be able to identify some of them sooner, because many times these kids don't get involved in treatment until they are hitting an MST level of care.

-Donna Grant asked if there is any thought or plans to partner with DMHAS for outreach. In region 3, since the reduction of food stamps and some of the other federal cuts that made a big difference for the very steeped needs-based population, they have started seeing the hike in adult heroin use. Adults using heroine are self-medicating to take the edge off hunger, having no heat, and just get by. The parental check-out is leading to huge hikes of truancy and these kids will then be those drug using kids because they now have somewhere to do that. This is a DMHAS issue.
Are these conversations happening to create some opportunity to address the kid-issue before they are in crisis-mode?
-Mary Painter stated that DCF is working with DMHAS on a lot of issues.
DPH received some federal funding to deal with prescription drug abuse. They have put together a task force and work group to explore and figure out how to deal with prescription drug abuse. Connecticut needs to step up our prevention efforts. What will help fuel this is Vermont and MA are tackling this much more aggressively than CT is. In addition, the governor of MA declared a state of emergency and ordered $20 million to be devoted to a plan to address this.
-We also have the use of NARCAN in CT which is one prevention effort that DMHAS is talking about a lot.
-Elisabeth Cannata noted that with the expansion of the child, youth and family support centers for kids who would be coming in through FWSN to avoid court involvement, there are teams throughout the state that are collecting data and doing comprehensive assessments of kids. This in terms of partnering with CSSD and data collection-we should be looking at the tools they are using to identify substance abuse and making sure we also have that data to combine.

-Mary Painter stated that CSSD is also getting technical assistance from NIATECS about how they are going to screen. They are a group devoted to helping bridge research and technical support to direct service and they do a lot of initiatives and provide a lot of support for folks. So CSSD is partnering with them to help with that very issue and has asked us to join them at the table.
-And the last way we will get more data is that we've been involved in a project to obtain funds to expand substance abuse services that Elizabeth Duryea may or may not have talked about here or will at some point. Part of what they do is a feasibility analysis and really look at what is needed – what is going on and they have the resources to look at data in a way we have not be able to.

-Comment: Regina Moller stated that primary care physicians also have data that we are not integrating with anything. They all have to do screening of children. CHDI has done some work on that. Either school or the primary care is the spot to catch everybody not just kids.
Mary Painter responded that we have been talking with them about SPERG initiative- and they would like pilot that down to adolescents and work on that with us and figure out where to put that –which would probably be the school based health links. Not just school based ones but all PCPs. They are all doing the same screens.

-Comment: Donna Grant added that another place for data gathering on the front end- instead of coming back around after it has started- is with the Juvenile Review Boards RFP out right now and some departmental help in making them function. The accountability piece and collection of data should be an expectation for anybody receiving some funding. There should be a uniform way to collect that data including a scan on substance abuse for kids entering that system who are not department involved and hopefully not court involved. It is a great place to get some of the community data.

-DCF is focusing expansion of the services to care givers (about 60%) who are substance users and have children under age 6. They include the following:
- Family Based Recovery which we recently expanded to be statewide.
- Building Stronger Families serves substance abuse in care givers with kids aged 6 to 17. One area had this service - but has since expanded to add three more teams.
-RSVP -intensive case management that engages a care giver into substance abuse treatment at the time of the OTC and
-RCM is more of a preventive intensive case management that tries to help folks to not get to a critical point. Four of the six regions have these services but work is being done to build capacity to get all of them available statewide.
-The teams are contracted with providers- they and DCF are responsible to let the community know that they are offering this service. Yes were have become aware that the folks that are doing this work specially need the information then we realize other folks who are looking for the information really need it.

-Comment noted about the medication Noxilon which is given to people in the throes of an overdose. Do the providers that work with the department's children –have access to this drug. Police are now carrying this medication which has proven very effective.
Ms. Painter responded –that this is a DMHAS initiative and is currently available for first responders and care givers' family of folks who have an opiate issue. They can all carry it, and that is where it remains at this point. We don't want to expand further that.

-Domestic violence services. A lot has been done and there is still a lot of work to do. Internally, domestic violence was brought into the substance abuse unit and combined it into one division. The reasoning is that the two have high overlaps and they impact families in the child welfare system in a similar way. It permeates through so many of our families inter-generationally. It impacts families at the low, moderate and severe ends of the continuum. This change made it possible to add a program lead in CO who is entirely devoted to domestic violence services so that it can receive the attention that it needs because we want to build the service system that is needed for our families. Our model has also changed from having external domestic violence consultants to internal ones for two reasons- one, to be consistent with how all of the other consultants are operating within the department and second, to take all those funds that were being spent on domestic violence consultants and put it directly back into service delivery.
Seven consultants were hired initially, and five more are coming on board, for a total of 12. They have had a lot of training. Carla Stover an expert in DV and substance abuse, assessing risk and working with low to moderate offenders, was hired to design a training for the department. She designed a three-day training that is kicking off later this month (June). We plan to be able to offer cross-training from her to providers as well, after the internal staff is completed. A lot of other trainings with the staff is planned including coaching and mentoring with the DV consultants so they can carry this information back to the regions, direct line staff and the communities. Because we are really trying to work to have them part of the DV work that is happening in the community. That is what we are doing internally.

Externally with services.
We know we need a whole range of services. We have folks who are in very dangerous DV situations, we've got folks that have left those relationship – we have folks that are staying in those relationship. We have folks where there is low or moderate levels of DV, and substance abuse & DV. We need to be able to build that service system to meet the public's need.
We really the data and the ability to evaluate what we need. We are working to design an evaluation process to get more informed about what to build. In the meanwhile we know some of the things to build and we are starting that. We are in the process of arranging a contract with CCADV to bring in a trainer for mom's empowerment & kids club. This is an evidence based practice that is for mothers and children who have ended a DV relationship and we are bringing the model developer in to train the 18 shelters in the state and then provide a stipend to those shelters to be able to provide to those groups.
We are also bringing in SAFE Dates which is a prevention education curriculum for adolescent about healthy relationships and domestic violence prevention. That is also evidence based. We are bringing that model developer in and offering 30 slots to folks to get that training at which point, once you get that training in the curriculum per the developer, you are able to use that freely and also train other people. We going to try to get that out to whatever forums that can reach adolescence. So out internal adolescent programs of congregate care programs where ever folks want to use that. We want to support that.
We are also bringing in something called "Fathers for Change" which is an intervention for low to moderate offending men. To be appropriate most likely for our folks that are either going to stay together with the family and or having visitation contact with children.
This is what we are doing so far in terms of the Integrated Family Violence Services that we have in place. That's going to stay as is until we enhance it or redesign it.
We want to make a responsible informed decision about how to enhance it. It is not available currently in all the regions. It needs additional funding to be able to do what it was intended to do- which was really to be a hub and to be able to connect all the family members to the services they need.

-Question regarding the SAFE Dates training- it will be open to community provider and Mary Painter will get an email out to the SAC members.

-Region 3 has been tapping into Women and Girls funding to do basically SAFE dating and women's self-defense for exiting high school seniors going on to college and moving out college campuses. But what they really want to do is bring back that older middle school, early high school curriculum which we haven't found yet, but Donna Grant is prepared to write the grant to bring it to the young men in our community. They are very interested to learn more about that curriculum and would like to know more. Mary Painter will get some information to Susan Smith office to send to SAC.

-Comment: The middle school age group seems to be an appropriate focus. Dr. Painter noted that when they started asking young kids questions about the quality of the relationships they engaged, they are finding there is a lot of domestic violence going on, and can be tied into the bullying going on.

-Question regarding intimate, partner violence screens that are out there. Does DCF have our department children screened? Dr. Painter noted we have a screening we use. Part of what we had originally RFPd was for some consultation to look at that and see if it needed revision. That plan did not come through but we will be using Carla Stover to look at it instead because that is one of her areas of expertise about screening for low moderate high risk. She uses a pretty intensive screening process for her model that we may be able to use.

-Our Lead is Linda Madigan who is a DCF employee. She is excellent and been with the department for a long time. She very interested in this topic, committed and passionate about it and has done a fabulous job. She is very accessible to folks as well. You will get her contact information when you get the SAFE Dates training.

-In response to the comment of getting a sense of how much staff is involved. Dr. Painter responded that she has a fabulous staff. Teresa Foley, Melissa Sienna both very talented and have the work of six people in

them. Teresa is looking to retire and our hope is to restructure how we have this staffed to expand on a little bit. She built this whole system and don't think anyone else can replace that knowledge base in the way that she has. The department has been very supportive and is figuring out how it can be done. In addition, we have another 24 staff through the consultants in substance abuse and domestic violence.

Commissioner Katz added that 60 to 70% of our kids in families have either DV or substance abuse or both.
Donna Grant noted that looking at portals to access the department she would say 80% come through one of these portals.

-SAC looks forward to the list because the RAC chairs can then send it out and take it back to their regions.
-Dr. Painter invited SAC to email or contact her at mary.painter@ct.gov

Additional comment-
Elizabeth Duryea added: one topic at the July meeting is our social impact bond project which Mary Painter and Elizabeth have been coordinating for the department because they are looking to focus that on expanding capacity and the number of providers in our substance abuse treatment services. So looking at this existing service array which Mary handed out today but also bringing in some additional supports throughout the state. Looking at that needs assessment so recognizing where we have some lack of capacity and I know I've talked with a couple of the RA's region 3 and region 5 where we've got some challenges because there doesn't not seem to be enough capacity within the provider base. But also accessing what is already out there in communities. So some of this will get folded in and as Mary touched on – a critical component of that project is creating a very robust platform for evaluation and data reporting and just recognizing that scenario where data is lacking. We are hoping that that project is not only going to help bring additional dollars to expand capacity but improve our data capacity. We are excited about that and we'll talk more about that in July.

RAC and Community Updates

Region 4- Regina Roundtree
-Have completed the process of setting up the 21 member voting structure and the rest of the RAC community. They are interested in the CONNECT grant and the regional network of care proposed.
The RAC consists of sub-committees that deal with health, workforce development. They meet outside of the RAC meetings and return to present to the RAC. Their approved recommendations are then slated to present to DCF.
It has taken 6-7 months to reach this point. By fall the process will be in place and functioning as planned.

-Members stated they need more information from Tim Marshall regarding the CONNECT grant. It was noted that the regions drawn for CONNECT grant do not coincide with the DCF regions. It is very possible that a couple of RACs will fall within a region of the grant and it is not clear as to how those RACs will pull together those various resources.

-Ms. Elizabeth Duryea clarified some of the confusion.
The CONNECT grant was awarded to DCF from SAMSHA and structured there was a planning year phase 1 CONNECT grant for approximately $400K, which just wrapped up. DCF had to submit the second application for the Phase 2 funding which was submitted in March and that amounted to $4million over the next four years. The second phase of funding is intended to implement some of the concepts that arose during the Phase 1 planning phase. What complicated things significantly- aside from the fact that it is a network of care –The intent is to support the creation of a network of care. If you consider the direction in which the department is going, we want to infuse these sort of collaborations at the community level. That may or may not coincide with our regions- arguably you really want a network of care at the local level. You might have overlap between two regions or multiple networks of care within one region. I don't have particulars beyond that because we are in the limbo phase where we don't know what is going to happen

with the subsequent phase of funding. The other complication was the passage of public act 13-178. And so recognizing that that now gives us an additional set of mandates around coming up with this plan. Tim Marshall has been trying to take the job of connecting the two to make sure there is some synergy and overlap and that it is integrated and we are not going in diverging, conflicting directions. It could be that pending we get the subsequent funding it will be a nice companion to all the work we are doing under Public Act 13-178. So recognizing a lot of the recommendations we have been hearing in the community forums that have been ongoing and wrapping up this week- a lot of that can help to drive the implementation phase of CONNECT. If that is something you would want to hear more particular, specifics on, we can have Tim Marshall to come before SAC with more detail if that is helpful.
The grant was submitted at the end of March – assuming the normal time frames for notification follow suite, we should hear by September. Hoping early July at the latest. Some of the SAMSA notifications-last year we didn't hear until August.

-Ms. Roundtree stated that Region 4 had invited Mr. Marshall to meet with a small group. It proved to be very helpful for them.

-The question was posed as to where the $400K go? And who is determining the budget for the next $4 million. In response, Ms. Grant noted that there was a statewide steering committee for CONNECT that had a lot of input into the development of the proposal and budget which was required under the grant.

Region 5- Kelly Cronin

-They have formed sub committees and are looking at adolescent units. Have strong youth voice with youths sitting around the table, and connected with the Life Schools group. That is part of their curriculum now that they need to come to these meetings and learn how to interact at a business meeting.
-Have divided into education, workforce, mental health and the youth at the roundtable are saying things we as adults would want to say but feel we cannot. DCF is absorbing a lot of information. Concerned about the department kids that graduating high school and going on to higher education unprepared. A lot of the youth are going to the state schools Central, Southern and are not prepared for that. They are not doing well-flunking out- and if they get two strikes against then they are asked to leave the department. They became aware that there are two educational consultants covering entire state. We are further looking at that.
-Coming up with a plan that will be submitted to the Commissioner by September.
We are asking for specific programs funding in order to make things happen for these kids.
Very concerned about the 17 year olds. Hear a lot from that kids that once they 18 they are done. They want out of the department and we are looking at the homelessness issue that will spear head out of control.

Region 1 -Susan Sherrick

-In light of 13-178 broke out in to subcommittees to discuss the needs of the area both pro-active and reactively. The information will be submitted. Have and active RAC group, more community based health providers that attend.

Region 6- Elizabeth Cannata

The past year RAC has been developing and focused on the vision and expanding membership to have more representation from families and youth.
-They have not met since the last SAC meeting but the last time reported that they succeeded in having the 21 voting members to be very representative of families in the community. There are eleven family and youth voting members. We are in the process of electing our co-chairs so we have at least one family member as co-chair. Meeting this week to finalize the election. Ms. Cannata will continue as co-chair for another year and will add one or two family members to serve as co-chairs.
-A number of topics that seem to be of concern to the region have been identified. Once the structure in place then they will define their first agenda items in terms of recommendations.

Donna Grant RAC Region 3

-Are continuing to work on subcommittee – education, adolescent services, foster care and early childhood. In July a sub committees will be reporting out on some initiatives /action steps that they have taken over the last year on their work plans. All based on an outcomes-based kind of rubric with specific goals for each committee.

-Education is moving along –they are looking at two years data from a pilot project in Windham now around Project EAST the early assessment and support team and it is developing a specific structured support system between the community provider and the school trying to open the door of the school to get community supports available earlier in the life of children who may be identified through faculty at having a problem but not rising to the need of the department intervention- hopefully intervening before that happens. Using that model working with the new area director in Windham –Loida Reyes- in out posting more social workers with a very different work plan. (Instead of putting them in community out posts with their own caseloads that could have them going to a lot of places, tailoring their case load to be more specific to the community that they are out posted in, so they become an integral part of that school system or that community or hospital where they are out posed.) Met with Loida last week about looking at two more key school districts where we can create partnerships with to have embedded DCF staff.

-Early childhood is looking at connecting more with the discovery and school readiness communities in each of the areas- of Region 3 and will know more in July –

-Not quite as connected in the work of adolescent services which is covering the transitional piece. Offered to write a letter of support to echo the proposal in Region 5 about what happens when these kids fall off their 18th birthday- which is like the giant cliff over the deepest part of the ocean. They are identifying that and would love to support that request for supporting those kids at that point in their lives.

-Other work we are doing- addressing Regina Moller's concern about meeting for months and it does not feel like we are doing anything but providing this structure. There is article that was shared just before last year's collaborative. It is out of Stamford Social Innovation Initiative around collective impact. That article- The Five Tenants of Collective Impact by John Kania and Mark Kramer really speaks to what you are talking about. It is about sustained planning and organizing- it validates the process you are going through and helps you understand if we are going to make meaningful change-this is the process. It is the time it take to build trust among and between providers from diff sectors and different domains that have to come together if you are going to collectively solve a problem. It speaks to this work. If we plan to have local local efforts that are really becoming connected and making a difference in the lives of individuals who live in a region it might not line up with the boundaries of a DCF region so there might be two RACs because they overlap in a service area where one hospital serves multiple towns in that region or one school district is a regional school district. (Like the Marlborough/Hebron/Andover area) where east Hampton is part of that health care part but is in two separate regions of DCF. So it makes sense if we are going to get this work drilled down to the local local level that we will have multiple providers who see themselves as aligned in different regions coming together.

-In the Willimantic NE area we are continuing develop the concept of "the nest' which we have talked about before and the local local network of care. The challenges in development a local local network of care in a cultural context of an agency that has claimed words like collaborative and system of care and the challenges that creates is really interesting.

-The context as you are all working in RACs with collaboratives, the language to doing this work at various levels is a barrier in and of itself.

Item 6 –SAC Membership & Leadership Issues

Commissioner requested to take this item for discussion out of the Agenda order.

-Ms. Smith noted that we have had conversations over the past couple of meetings about the membership and assuring that terms are re -upped and hitting the vacancies.

-Reviewed the number of vacancies and categories that need to be filled.

-Dr. Carbonari noted that she had approached a colleague whom she felt would be a great asset to SAC suggesting she apply for appointment. She made several calls and never heard back from anyone and

eventually went by the wayside. She has approached her again in light of our vacancy situation and through the Commissioner's office, sent out an application but do not know the status. She feels that the process is cumbersome and there is no response, noting her own re-application receiving any acknowledgement that it had been received six months after she had sent it in.

Donna Grant noted she reached out to two colleagues in the area an attorney serves as probate judge (she has reached into her professional association and was told it was conflict of interest) and the other is child forensic physician who does all of our MDT physicals etc. -very connected in the system and the process. Very interested I don't know where to send her. No application on the website. This physician approached the CEO about getting permission from the hospital to serve and that is going to be a time-limited thing. She goes back six months later and says it finally came through- it needs to be more expedient if we are going to attract candidates.

-Questions that arose around membership application to SAC: Is the hindrance the process of application? The application in itself is extremely detailed.

-Discussion continued about making a change to the legislation and making it a Commissioner appointment as opposed of a gubernatorial appointment. To make the appointment process smoother.
-It would help the Commissioner to give her a broad base community view from a variety of perspectives and would have an interest in having that perspective.

-Ms. Roundtree noted that in light of the discussions about application for membership- as a SAC body, what are the results of our work? At what point has SAC developed and submitted a statement of recommendations. When are the members exercising an advisory role?

-Discussion continued with clarifying attendance requirement once on SAC.
Need to actively keep members attuned to the attendance requirement of missing three consecutive meetings or 50% of the meetings in a calendar year constitutes resignation.

-Ms. Grant noted that it is not so much an attendance issue as an attrition issue. Referring back to collective impact and what you need to sustain a vibrant collaborative there has to be mutual gain for people to come. Going back to an earlier comment of what is our purpose and mutual gain?

Taking into consideration the SAC responsibility as a CRP and building that recommendation body. We had discussed in past meetings about identifying some priorities areas for discussion and recommendation. This would satisfy the CRP requirement for receipt of the funds.

-The first order of business is to get membership worked out
-Josh Howroyd is expected to be here at the next meeting. He can advise SAC on how the membership was designed along with the process.
-Commissioner offered her assistance if SAC wants to pursue the transference of appointments from the Governor to the DCF Commissioner. She is interested to hear from the membership all the recommendations as to the people you wish to have serve on the SAC.
-If SAC wishes to pursue this action, then DCF will put it on our legislative initiatives this year and pitch it.

-In response to the comment of the dysfunction that would arise from an adversarial relationship between the advisory group and a commissioner, Ms. Smith noted that part of the discussion in past meetings has been that there would be a sub-committee/nominating committee that would do that vetting beforehand so there would be some independence on the part of SAC. This would be most useful if there were more interested parties than we would have applications.

-I was noted that the members try to identify applicants by the September retreat. The retreat would be an open and the applicant would be welcomed to attend – we are confident that the appointment process will be finalized soon.

-The process for application between today and August. They would contact Maria Obregon at the Commissioner's office. The application would be sent to the interested party. Once returned to Maria, the completed application would be sent to the governor's office with a cover letter. This would allow for proper identifier and tracking the progress.

-Commissioner asked for a list of people who are still pending and waiting re-appointment.
The Commissioner would follow up with the Governor's office to obtain the appointments for
-Janice Andersen (reappointment to June 30, 2015, 3rd term); Claudia Carbonari, M.D. (reappointment to 6/30/15, 2nd term); Patricia Lorenson (reappointment June 30, 2014, 3rd term); Regina Moller appointment pending application submitted in May 2014; to begin new terms, effective immediately.

-In response to the question to identify anyone on the list who was no longer active – Ivy Farinella, Dino Depina (new youth appointment that has missed four consecutive meetings). Samantha Pahde can only attend summer meetings because of class schedule and undependable transportation.

-There was concern among the SAC membership that the youth members needed support to attend the meeting. In light of Samantha's transportation situation-is there a possibility to do an advocacy for a college student to be able to serve on SAC would be great on her resume and if her advisor knew that is why she needed to be available one Monday morning, people at Eastern CT would find this valuable. Who is she connected to in the department that could provide some of that advocacy.
Donna will raise the question with the Region 3 Regional Administrator, Allon Kalisher, to see if a Willimantic worker in the midst of Storrs and Eastern CT could pick up those two students and bring them. It would be a matter of making sure their advisors at Eastern CT knew that is why they would be missing one class a month. Donna would be happy to do that advocacy to have their voices at the table. These are two kids that have life experience in the system that we want to engage. Wants to know who their case workers are.
Another suggestion to allow participation of students and not infringe on class schedules was to change the SAC meeting time or to have a web meeting.

RAC CRP Funding Application

Pat Lorenson presented the proposed DRAFT of the DCF Regional Advisory Council Application for SAC/Citizen Review Fund and Parent/Family/Youth RAC Stipend Form which were emailed in advance of this meeting.
-Pat Lorenson reviewed the format explaining the background of the form.
In the "Process" section,
2. The application period runs, May 31 to September 1, 2014 as the time frame for the application.
4. -Correct the typo for word "reserve."
   -Regarding the approval process, Pat and Janice Andersen would review the application and if it meets the guidelines then with go with it.

-The members decided to cut the sentence beginning "The DCF-encouraged stipend formula….."
and replace with "*A stipend form is required if RAC selects to use a stipend.*"
-The matter of the CRP report for funds disbursed in 2013 was discussed. Janice Andersen was working on this.

5. RACs must complete an *Interim Financial Report* to the SAC by March 15, 2015
   (This would be for all spent or encumbered funds) *with a Final Report due May 1, 2015.*

The deadline is September 1 for the application and the money has to be spent by March 15 (date of final report).
-Questions and discussions followed regarding the March 15 deadline. Federal grants require that dollars be obligated by a certain period of time and expended.
-Extensive discussion was held regarding the dates for the application

-**Members voted** to accept the draft application and stipend form with the changes noted.

-Donna Grant asked that on a future agenda, maybe in July that we invite someone from FAVOR and work out a timeline around these funds. At this point we are all submitting applications before September 1- they will have the benefit of that as they are preparing their proposal.

Meeting ended at 11:45 a

The following items from the agenda for this meeting were not discussed:
September Retreat
SAC Organization and Mission Issues